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**‘JOHAN BÉLA’  
NATIONAL PROGRAMME  
FOR THE DECADE OF HEALTH**

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# ‘JOHAN BÉLA’ NATIONAL PROGRAMME FOR THE DECADE OF HEALTH

Considering the poor public health trends in the country in past decades, the government has assigned top priority to fundamentally changing the public health situation and it believes the public is right in expecting to see Hungarian life expectancy at birth gradually approach the average level for the Member States of the European Union. The government realizes that a tangible improvement in the general health status of the population will require a long-term effort, one encompassing several parliamentary terms of office. Parliament has called on the government to update and expand the public health program ‘For a Healthy Nation’, and to present the ‘Johan Béla’ National Programme for the Decade of Health to Parliament, with a view to improving the population’s health.

In 1998 the World Health Assembly adopted an international declaration on health. According to this the enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being. The final objective of economic and social development is to improve the health and well-being of the people; on the other hand, it is an established fact that society’s good health is one of the prerequisites of socio-economic development. Reducing inequalities in health status plays an outstanding role in this process. Improving the health status is impossible without well-founded international, national, and regional political strategies.

The goal of the ‘Johan Béla’ National Programme for the Decade of Health is to give all Hungarian citizens the opportunity to live as healthily as possible. As a result, life expectancy at birth should increase by three years for both genders in a perspective of ten years.

There are two fundamental courses to attain this:

- protecting and improving the health of individual citizens throughout their entire lives;
- reducing the prevalence of major illnesses, injuries, and causes of death, and cutting down related suffering.

There are three fundamental values guiding us in designing the National Programme:

- the fundamental human right to health
- the reduction of inequality and solidarity and
- the participation of individuals, groups, institutions and communities, and the responsibility of all of them for improving health

The health status of the Hungarian population is extremely poor by international comparison, and is considerably below what would be possible, given the country’s general level of socio-economic development. Hungary ranks high in international statistics with regard to specific diseases and causes of death. At present male life expectancy at birth is 68 years, while for females it is 76 years, well below that of the European Union Member States. The exceptionally high mortality rate for middle-aged males is particularly tragic.

The situation is unacceptable and requires effective action. There are numerous historical, social, economic, and cultural reasons behind the exceptionally poor health status of the Hungarian people, but the direct and primary cause is related to lifestyle.

Hungarian dietary habits are unhealthy: people have too high intakes of energy, fat, and salt, and consume insufficient fibre, vegetables, and fruit. A significant portion of Hungarian

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adults are overweight or obese. The adult population spends no more than an average of ten minutes a day with physical exercise and six out of ten do not move either during the week or on weekends. Forty one percent of adult males and 26% of females smoke cigarettes more or less regularly and the proportion of smokers is rising rapidly, particularly among young women. There are 28,000 smoking-related deaths each year. The rate of alcoholism is high, and drug consumption is growing. A significant portion of the population is unable to cope with the problems of day-to-day life and mental health disorders are becoming widespread. This list of facts and problems could go on and on; indeed, the Programme takes stock of them in details, analysing each and defining the main thrusts for action to influence the unfavourable processes.

Influencing lifestyle in a way that is conducive to health is a difficult and extraordinary complex task, and it will take a carefully planned and coordinated process of action on the part of the government, public institutions, NGOs, players in business and social life, and the media to achieve it. Such actions will be underpinned by a ten-year, professionally coordinated strategy imbedded in social and political consensus.

The Programme offers a comprehensive and forward-looking political framework for selecting and implementing priorities, and for mobilising resources and communities in the service of health. Health maintenance and development cannot be viewed by the government as a mere input, an expenditure, or even a set of actions guided purely by ethical considerations. Implementing the program is a productive investment, a prerequisite to the socio-economic development of the nation. An analysis issued by the World Health Organisation in 2001 on the interactions between the macro economy and health gives scientific evidence that effective investments to promote health accelerate and escalate economic growth and social development. The challenge of the 21<sup>st</sup> century to governments is the extent to which they are able to simultaneously and interactively develop natural, economic, social, and human resources. The health of the people is the point at which all these intersect. Health development only can be implemented through effective intersectoral cooperation. The main features of this are as follows:

- Cooperation needs to be targeted at exercising favourable impact on the socio-economic determinants of health.
- Intersectoral cooperation is essential on nationwide, regional and local levels alike. With Hungary's accession to the European Union, the significance of international coordination will become defining.
- Intersectoral cooperation must extend to each and every line ministry, local government, public institution, to the private sector, to the NGOs and to the media.
- The impact of individual political decisions, and of socio-economic changes on the state of people's health must be monitored on an ongoing basis, with a particular focus on the differing and unequal health statuses of the different population groups.

Effective intersectoral cooperation occurs on multiple levels in modern public health. International and domestic experience shows that local level intersectoral cooperation is an effective tool in influencing health determinants. Supporting local government and other local initiatives also can become a foundation for effective intersectoral cooperation. On national level, evolving the organisational structures and operational models needed for intersectoral cooperation is a pivotal task.

An improvement in health status is often related to processes that are not directly targeted at health. These processes include economic growth, improvements in living conditions, and

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reductions in unemployment, which together may have contributed to a slow improvement in mortality rates in recent years.

Good health does not depend primarily on healthcare services or physicians. Our health status is defined primarily by our day-to-day decisions, immediate environment, families, schools, jobs, and homes. The primary job of the healthcare system is to cure illness. At the same time, the health administration and the health sector must play a leading role in designing and implementing the program, and the role of primary health care in providing prevention and health improvement services accessible to all is beyond question. The Programme is a basic pillar and an organic part of the healthcare reform.

The Programme is able to rely on deep-seated tradition, marked by the names of people like *Ferenc Pápai Páriz*, *József Fodor*, and *Béla Johan*, and the direct domestic history of the past decade and a half. Earlier strategies were unable to bring about a satisfactory improvement in the health status of the Hungarian people because of unfavourable socio-economic circumstances and insufficient resources to keep up with rapid change.

But, there is a foundation on which to build. We have diverse professional experience, operative programmes, and a network of public health institutions, active NGOs, local government initiatives, and many outstanding specialists. We have every reason to assume that the first decade of the 21<sup>st</sup> century will be a Decade of Health, and our long-term National Programme will get off to a good start. This time, we are relying on broad-scale professional and political consensus, which is the prerequisite for continuous efforts through multiple terms of parliament.

The Programme will be able to draw on international experience and resources offered by cooperation. The World Health Organisation's Ottawa Charter for Health Promotion in 1986 sets forth the main principles and key areas of modern health promotion. These are:

- build healthy public policy;
- create supportive environments;
- strengthen community action;
- enhance personal skills for the pursuit of health;
- giving stronger attention to prevention in the health services.

Many pertinent World Health Organisation documents, including the 'Health 21' Regional Strategy offer a professional background for designing the Hungarian Programme. The Programme meshes with the European Union's public health priorities and Hungary's accession to the European Union will offer a further boost to its successful implementation.

When selecting Programme priorities, the initial focus was on the most serious health problems of the general public. Improving opportunities for groups in socially disadvantaged positions was a priority consideration. Programme designers considered domestic and international experience, opportunities for implementation, and cost effectiveness.

To meet these goals, the Programme intends to move forward in four areas. Particularly in the political plane, special attention will be focused on

- youth issues,
- problems related to ageing,
- creating equal opportunity, and
- creating an environment that is conducive to health in the various settings of everyday life.

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Asserting primary prevention in society will become an important target. The areas that will receive particular focus are:

- controlling cigarette smoking
- alcohol and drug prevention,
- promoting healthy dietary habits and improving food safety,
- promoting physical exercise and activity,
- enhancing public hygiene and epidemiological safety, and
- evolving a healthy physical environment.

Measures will have to be taken to prevent premature and avoidable death, illness, and disabilities. Priorities in this area are:

- reducing mortality due to coronary heart disease and cerebrovascular disease,
- halting and reversing the trend towards a rising mortality due to neoplasms,
- reinforcing mental health protection,
- reducing locomotor diseases and resulting complications, and
- preventing AIDS and other sexually transmitted diseases.

In meeting the Programme priorities, it will be necessary to advance the system of healthcare and public health institutions:

- breast screenings have to be continued, and other screenings that are a priority to public health have to be introduced,
- the healthcare delivery system has to be advanced to achieve the greatest possible health gain on society-wide level. This means that developing primary health care, intensifying preventive work within primary health care have to be given top priority, and conditions for handling this work in PHC must be improved.
- resources must be improved in a concentrated manner in the multicoloured world of public health, to guarantee that we may be able to meet challenges from the point of view of qualification and skills of professionals, as well as with respect to financial and organisational resources.
- a monitoring system must be established and put in place that makes it possible to continuously monitor the Programme and to make the necessary corrections

Successful implementation of the program will contribute to the advance of the country and the nation on a variety of levels and in multiple areas.

### *Societal effects*

By the end of the decade the expected societal effects of the Programme can be summarised as follows

- life expectancy at birth for males will increase to at least 71years, and for females to at least 79 years;
- the number of healthy years of life will increase, and the overall quality of life will improve;
- inequalities seen in the health status of the population will be reduced;
- opportunities will be created for reducing the health and welfare gap of social strata in disadvantaged situations;
- a healthy lifestyle will become a society-wide model, and the order of values and day-to-day habits of the people will change accordingly;

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- intersectoral cooperation will evolve on all levels and become a regular way of working to promote health;
  - the role of community actions and of the civil sphere will become stronger in health development.

#### *Professional effects*

By the end of the decade the expected professional effects of the Programme can be summarised as follows:

- there will be a decline in avoidable and premature deaths, and in the early manifestation of chronic non-communicable diseases,
- there will be a decline in overall need for treatment and care of the diseases targeted in the Programme with a shift towards provision of care for elderly people,
- there will be a decline in regional and social inequalities in accessing healthcare services,
- preventive services will become a more advanced and varied part of healthcare services,
- there will be an improvement in the quality and cost effectiveness of healthcare services,
- the system of public health institutions will be transformed to meet modern requirements and it will be adjusted to EU norms,
- public health-related research and training will improve.

#### *Economic effects*

The long-term economic effects of the Programme are as follows:

- the Programme will be an investment in promoting human resources, and will have an escalating affect on the sustainable growth of the economy,
- the quality, efficiency, and competitiveness of the workforce will improve,
- intersectoral cooperation will mobilise new resources and reserves,
- the market for healthy products and services will expand,
- it will contribute significantly to improving general living standards.

Successful implementation of the program is a defining element of improving public welfare, of creating long-term opportunity, and of sustainable economic growth for the whole of the country. Through people-centric cooperation, we must reach the point at which health becomes a basic value in all walks of life. Every single act performed, whether in politics, government, society, economics, or in the media, should be judged by the extent to which it serves the cause of the health of individuals and of the Hungarian society. Our citizens must feel that society and the government are offering them all possible assistance to maintain their health, and that their job is to take responsible advantage of these opportunities.

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# CREATING A HEALTH-PROMOTING SOCIAL ENVIRONMENT

The health status of the Hungarian population exhibited unfavourable changes over the past three decades that were related to changes in socio-economic conditions. There are three questions that need to be answered for the purposes of developing an effective public health strategy:

- What are the determinants of the health of a specific population?
- What are the health service inputs that result in the fastest and most noticeable improvements in population health?
- What are the strategies that effectively promote a decline in inequalities in the individuals' health status in conformity with human rights?

Health is created within the settings of everyday life. The institutional framework for health-conscious behaviour is made up of the family's place of residence, the local community, the workplace, the school, and other social institutions.

International experience of the past decades has shown that a health promotion strategy relying on the existing institutions of everyday life can be effective and successful.

This type of approach:

- concentrates on areas which are pivotal in determining the population's general health status (such as the local community, the workplace, and the school),
- clearly sets out the framework and boundaries of the action,
- facilitates the selection and coordination of cooperating partners,
- is positive in direction (as opposed to risk reduction), since every institution has the potential to work better and in a healthier way
- offers opportunities to monitor and evaluate processes and impacts from the point of view of health,
- ensures the favourable social and economic effects of the Programme,
- by its very nature, is an incentive to intersectoral cooperation,
- mobilises community and institutional resources.

A public health approach based on settings of healthy life is supplemented very well by thinking in terms of life cycles.

A healthy start in life, and promoting health among children and adolescents are of particular importance. Preparing a child to live a healthy life is an investment in the future and a promise of a much healthier Hungary on long term. Chances for achieving a favourable change are best among children and adolescents, and this can influence the entire family.

It is our aim to offer the opportunity for healthy development to all young generations from the moment of their conception, and to see our schools become fundamental settings for health development.

We will be raising the standards of family planning services, while improving the effectiveness of the current system of institutions. It is particularly important to enhance the health visitor services that are accessible and available to all families, and to strengthen and support the preventive approach in hospital neonatal services and paediatric family practitioners. Elaborating a strategy to manage the iodine insufficiency affecting a significant

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portion of the population, and implementing an effective solution are national-level tasks. Ensuring proper oral hygiene requires combined methods applied simultaneously; this includes reducing the consumption of foods containing sugar, promoting use of oral hygiene products containing fluorine, particularly in childhood, disseminating and improving appropriate patterns and customs in oral hygiene, reducing tobacco and alcohol consumption, and advancing the accessibility of preventive dental check-ups.

As part of the Programme, we shall elaborate objective, operating and quality conditions through which education institutions might become settings conducive to health, furthermore, we shall be providing assistance to the owners of institutions in creating health promoting schools. Higher education should incorporate teaching of the basics of theory and practice of modern health promotion in teacher training.

Health habits of children and adolescents change rapidly and these age groups are more susceptible to outside influences. Studies of health behaviours of children and adolescents are essential parts of effective policy and program planning.

Changing the leisure habits of adolescents to become healthier requires simultaneous action in numerous institutions and life settings. Local coordination in the area is a key to effective intervention, and supporting this is a Programme task.

The numbers and social influence of senior citizens is growing steadily, and they too, must be given the chance to live an active life of self-fulfilment. It is in the interests of individuals and society to coordinate health and social policies, to offer appropriate services, and to mobilise community resources, which will result in a significant advance in this field. Teaching the unique problems of elderly people must become an integral part of education and training in the health and social fields. Society's outlooks need to be changed to enable most people to see old age as an active and useful phase of life, and this requires a commitment and informative work on the part of the local and national media. To improve the quality of life for senior citizens it is particularly important to advance certain elements of the healthcare and social institution system, and to change primary health care and the social welfare institutions so that they become more pro-senior.

Poverty and a disadvantaged position are the main social determinants of poor health, while chronic diseases and disabilities are at the core of being socially disadvantaged. In this area, a fundamental tenet of the Programme is to reduce inequalities and create opportunities. There are two ways of doing this:

- reducing inequalities existing in the risk factors and health status of the Hungarian population, and
- targeted improvement of the life chances, health status and lifestyles of disadvantaged groups.

The basic challenges are as follows:

- the dominant negative effects of social and economic disadvantages in the health-related elements of lifestyle,
- exclusion from, or poor access to healthcare, including preventive services,
- the difficulties of coping with problems,
- the absence of social supports, isolation
- the lack of reliable information concerning population health.

Therefore, the main opportunities for action are as follows:



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- intersectoral coordination, particularly with social policy, education policy, and employment policy, on the level of central and local governments;
  - promotion of self-organisation by people in disadvantaged situations, reliance on, and cooperation with NGOs operating in the area,
  - education and training of specialists, research;
  - critical analyses of international experience, implementing pilots;
  - furthering services to assist the development of individual coping strategies;
  - improvement of access to primary health care ;
  - reinforcement of the social support system;
  - informing the population about factors that have an impact on their health.

The primary target group is the Romany population, but the Programme includes the poor, the unemployed, and other disadvantaged groups, too.

Programmes focused on specific settings are intended to turn all communal settings where people spend a good portion of their lives into healthier ones. Here, the Programme relies on existing initiatives that have been operating successfully.

The design of local health development plans, and the presentation of health as a top priority consideration in regional development plans is the most suitable tool for mobilising local government resources in the service of health.

It must be made possible for workplaces to go beyond taking mandatory labour hygiene measures and to work toward promoting employee health. Central and local government employers and workplace health insurance funds are priority partners in this area.

In addition to offering curative care, healthcare institutions have an important calling in disseminating the concept of health as a value, and in transferring the information needed to make healthy choices, particularly within primary health care and specialist outpatient services. Hospitals are also capable of influencing the health-behaviour of patients and their families with a health-supporting work organisation and by setting examples for a healthy way of life.

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## PROGRAMS OF HEALTHY LIFESTYLES, REDUCING RISK FACTORS TO HUMAN HEALTH

The road to attaining the basic Programme goal requires the Hungarian public to make numerous favourable lifestyle changes along the way. The immediate manifestation of lifestyle is individual behaviour, which is influenced by values, norms, needs, and the immediate human and social environment including the family and local society, and macroeconomic and social conditions. Some lifestyle elements are deeply rooted in historical tradition, such as certain dietary habits. Therefore, exerting an influence on lifestyle as it relates to health is a diverse and complicated task, which would be impossible to carry out merely by disseminating knowledge and spreading information.

Today, the lifestyle of the Hungarian people is undergoing a rapid change. These changes are being triggered by economic development and a transformation in social conditions, but they also are influenced by globalisation. The otherwise contradictory and unavoidable process of globalisation can contribute to the spread of healthier lifestyle patterns (including diet, leisure, and sports).

The problem of making healthy choices is the key to the lifestyle programmes. There are two sides to this issue: the opportunity and the willingness to make healthy choices, the supply and demand sides. Transforming supply and demand simultaneously in the interest of healthy lifestyles require comprehensive political strategies. Building a bike path or offering a wider selection of vegetables in winter is not sufficient; at the same time, better information in itself does not necessarily lead to action, as shown by the examples of smoking, or doctors who smoke. The job of the program is to make the healthy choice the easier choice of the day-to-day life alternatives. Professional circles are well acquainted with the lifestyle-related facts of the Hungarian public, but the public itself does not have sufficient or sufficiently reliable information on the real nature of behaviours that are health risks. The picture is quite unfavourable by international comparisons, and time trends are not showing any significant favourable change (with the possible exception of some dietary habits). A thorough knowledge of the situation offers a chance for the appropriate monitoring and evaluation of lifestyle programmes.

In advanced industrial societies, the middle class is the force that promotes a healthy lifestyle. Health behaviour is worst and harmful habits are more frequent among poor, disadvantaged groups (in Hungary, particularly among the Roma), where there is a lack of ability to cope with the problems.

This also means that more highly educated strata in better financial situations are more open to the messages of a healthy lifestyle. They find it easier to move toward healthier lives. Therefore, there is a risk that an otherwise effective program of action might increase existing social inequalities. To combat this, differentiated and targeted program elements are particularly important to create the prerequisites of a healthier lifestyle for the disadvantaged strata.

There already is a wealth of domestic experience in which to ground healthy lifestyle programmes. Today's socio-economic conditions hold the promise of a much higher level of success on long term than had hitherto been possible. Lifestyle change is a slow and contradictory process, and achieving it requires endurance, strategic thinking, the mobilisation of community resources, and a switch from campaign-type promotion to a steady process of

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operation. The success of a healthy lifestyle program is closely related to the evolution of a health-promoting social environment and the prevention of avoidable death and disease. The Programme coordinates these activities. In the space of a decade, there are real chances for shifting lifestyle towards a healthier one on a societal level with regard to diet and physical exercise, to cut back on harmful habits (or in the case of drugs, to limit the growth of abusers), and to improve environmental health, doing all this with a particular focus on reducing the gap between disadvantaged strata and the mainstream.

Reducing cigarette smoking is a top area for intervention. It is particularly important to prevent young people from starting to smoke, but we must not forget our fellow citizens who already are addicted.

Cigarette smoking is an issue in the crosshairs of numerous partly or completely contradictory interests. For us, and for all professionals who have ever looked at health interests, it is clear that these interests have to be prioritised; it also is clear that to all responsibly thinking people, life prospects and quality of life, and the health of the young generation are of a higher order than the financial interests of specific economic groups. In this area, effective but circumspect intervention only can be realised through the operation of intersectoral mechanisms that accept the above principle. The health sector wishes to become the initiator and engine that drives this process. Tax policy, regulating marketing, distribution and product labelling, and exploring and disrupting smuggling are tools in the fight of controlling smoking just like health education and information in the traditional meaning of the word.

Our strategic partners in this struggle are non-governmental organisations, whose mobility and flexibility are inestimable in value as international recommendations suggest. Responsible thinkers working in the health services and teachers are other valuable allies. Operating the institutions assisting people in quitting the habit is a priority job for the healthcare sector.

It is necessary to offer the public detailed and regular information on the consequences of smoking both on personal and community levels, on the measures taken by the tobacco industry to attract young people, and on their techniques for asserting their interests, supported by the recommendations and methods of international institutions and professional organisations (WHO, World Bank). Improved research capacities and the availability of current data are the long-term guarantee of effective efforts.

Alcohol consumption habits go back for centuries, and are deeply imbedded in the culture. Alcohol abuse has a vast and diverse influence on society for it is often demonstrated to be behind crimes, family violence, and deaths due to accidents.

Effective prevention has to operate on several settings simultaneously. Programmes in schools and targeted at youth need to offer behavioural models in addition to providing information, and to develop response capabilities. This must be done simultaneously with an extensive project of offering information to society on the risks of alcohol abuse to individual, family, and community. Changing the outlook within the closer and broader environment, at workplaces and in small communities and sensitising them are key components of success.

At the same time, we must rapidly come to the assistance of people who have become addicted to alcohol and are unable to escape it by themselves. Early recognition of the problem should come from primary health care settings and workplaces, the first places where the damaging effects of alcohol on the personality and health are manifest. Recognising problem drinkers and their victims within the family is the basis for effective intervention, with the next step being the development of modern addiction treatment services.

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All of this requires support from committed professional and social organisations that are fully aware of the depths of alcohol dependence and its domestic consequences, and have the arsenal for community intervention. Sustainability depends on local-level coordination to combat alcohol, establishment of the structures required, inclusion of the involved parties in local cooperation (local governments, social service and healthcare providers and institutions, NGOs), and enlargement of the group of involved skilled professionals.

The fight against drug abuse is a part of our National Drug Strategy. The Programme focuses primarily on preventive efforts in the schools and among young people, drug health care professionals about the drug problem.

The basic elements of an effective nutritional policy are food safety, a guaranteed food supply, provision of consumer information, and support for a change in outlook. General nutritional habits can be influenced by improving education and meal provision in the schools, and improving mass catering services and making them healthier. Offering direct information to consumers through product labelling and improving the product information systems are effective tools that we plan to take full advantage of.

Interdepartmental cooperation is essential here, for changing the product supply is a good way to trigger demand, and not just meet it. Defining the framework and tools of a nutritional policy on the national level, improving food safety to conform to European Union requirements, and coordinated interdepartmental efforts mesh with the interests of consumers and agricultural producers.

Disseminating physical exercise and evolving a lifestyle rich in physical activity are the most effective ways of preventing numerous diseases of civilisation (such as cardio-vascular diseases, some tumours, obesity, the most common form of diabetes, etc.) on the population level.

The role of schools is to evolve lifelong behaviour models and appropriate physical condition, to create the opportunity for people to be healthy when entering the adult world. When improving professional training, the goal is twofold: to establish the opportunity for healthy physical exercise and to meet the needs of children with special needs and support in physical education programmes. We are financially supporting daily health-promoting physical exercise through a grant scheme, and on longer term, via a normative scheme.

Workplace physical exercise programs not only improve physical fitness but also offer help in overcoming the psychological load on workers.

When using money earmarked for building and renovating sports facilities, the interests of the population and health considerations in the broader sense of the term must also be met. Improving the health of the people requires increasing the overall demand for physical exercise, a demand that can be met by improving access to sports facilities.

Necessary responses to today's challenges include preparing the National Public Health and Medical Officer's Service (NPHMOS) for unforeseen emergencies (including disasters, accidents and terrorism), putting in place a rapid response system, and establishing and operating an information system that supports public health safety needs.

The most important measures here are advancing the NPHMOS system of institutions and transforming them to be able to effectively handle tasks. Methodology development, education and training of professionals, and preparing staff to manage changing tasks are all parts of the institutional development projects. The main thrusts here include updating the

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national profile on chemical safety, designing a comprehensive epidemiological safety program, and preparing a country profile on labour hygiene.

In addition to the foregoing, updated public health functions need to incorporate the operation of systems for informing the public, and the provision of reliable and credible information.

Creating a healthier environment has been an integral part of government efforts for some time. The National Environmental Health Programme of Action is part of the National Environment Programme to improve the environment. Resources will be expanded and augmented with EU accession funds so that creating a healthy environment becomes a realistic target. The main line of action coincides with international recommendations and the goal of establishing the conditions for sustainable development.

We need to draw up a map of environmental health hazards to learn as much as we can about them. Studying soil contamination in residential areas, preparing a dioxin map, and assessing the environmental load and health impact of electric power lines and telecommunication facilities will tell us of risk factors in the broader environment, while investigating the asbestos problem will yield information on the risk factors in the narrower, built residential environment. Improving air quality requires that pollen exposure be monitored and indoor air be investigated systematically.

All the data collection and research activity needs to lead to the formulation and implementation of local and national programmes and plans of action. The Programme will support the designing of local environmental health plans and the handling of local government-related tasks, through a grant scheme. Implementation will conform to priorities, and involve interdepartmental cooperation and active participation by local governments.

It is a priority task to guarantee that the general public has access to information on the environment and its impacts on health.

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# PREVENTING AVOIDABLE MORTALITY, MORBIDITY AND DISABILITY

The entire healthcare system is responsible for preventing avoidable death and disease, and this is a part of every single treatment. From the point of view of public health, curative care, prevention, and health promotion must exist in the system as a single, coordinated unit. Changed morbidity patterns, accessible current therapies, and the cost explosion have brought about a new system in the health services. The delivery system needs to take the individual and all of the surrounding circumstances as its point of departure, rather than just a specific disease. There is a need to have approaches on an individual and a population-level simultaneously.

There is no contradiction between medical care and prevention from the vantage point of public health. Prevention and therapy complement and support one another. At all meeting points, the system needs to approach the individual in a health-oriented manner. This is particularly important to primary health care.

Until very recently, disease prevention was focused on high-risk groups, while medium and low risk groups were essentially ignored. At the same time, although higher risk groups have a higher probability of morbidity and mortality, the majority of overall morbidity and mortality is in the medium and low-risk groups. Therefore, the Programme has combined the population level approach and the high-risk approach. Prevention aimed at patients who appear on their own is not enough.

Prevention must become an integral part of the healthcare system, focusing on high-risk disadvantaged groups while reducing the risk level for the entire population.

There was no significant improvement in morbidity and mortality patterns of the Hungarian public in the past decade; in fact, the incidence of specific types of disease (e.g., certain tumours) has shown a steady increase. Chronic non-communicable diseases account for a huge proportion of avoidable, premature mortality and morbidity.

Individual susceptibility to chronic non-communicable diseases depends on genetic, biological, behavioural and environmental factors. Though, in the light of research, it appears that hereditary factors are more important than initially assumed, the main course of prevention is to influence behaviour and the environment.

In general, scientific knowledge on preventing, diagnosing, and treating chronic non-communicable diseases is available. In Hungary, too, we have multiple decades of experience here. The Programme will be able to rely on cost effective, high quality strategies, from the public health as well as the clinical point of view.

- We require a comprehensive, integrated policy with a public health approach to influence behaviour and environment-related risk factors. This is all the more necessary since in many respects the risk factors influencing various chronic non-communicable diseases are the same.
- We need to design population-level preventive strategies that are based on screening and connected to systems of screening and continuing care.
- Case-recognition strategies based on physician-patient encounters are also needed.

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The success, monitoring, and evaluation of the programmes require the operation of a population-wide information system.

A separate part of the program will focus on particularly important mental health issues and matters closely related to social disadvantages. It will include AIDS prevention and public health safety. One of its main targets is to reduce the prevalence of major disorders, injuries, and mortalities. It is an integral part of the healthcare reform and meshes with the EU public health system.

We can sum up the professional healthcare outcomes expected over the next decade as follows:

- There will be a decline in avoidable and premature death and early occurrence on chronic non-communicable diseases.
- The need for therapy and continuing care will decline and shift towards treatment of the elderly in the groups of disorders targeted by the Programme, which on long term will reduce the burden on social insurance.
- There will be a decline in regional and social inequalities regarding access to preventive services.
- Preventive healthcare services will grow and become more diverse.
- The quality and cost effectiveness of preventive care will improve.

Over half of all deaths is due to cardio-vascular diseases. The situation in Hungary is very poor by international comparison. Introducing the preventive outlook to cardio-vascular therapy also has a significant influence on reducing premature death or disability. Secondary prevention, which means early diagnosis and treatment, is an effective complement to primary prevention on population-wide level. The interaction improves the efficiency of both approaches.

Improving primary health care is of fundamental importance. Early recognition and continuing care for hypertension has proved to be effective, increasing life years and improving quality of life on population-wide level. Our goal is to recognise and influence cardio-vascular risk factors (e.g. cigarette smoking, metabolic disorders such as multimetabolic syndrome, diabetes, etc.) as part of day-to-day practice.

Our goal is to offer uniform standards of patient care by promoting and developing higher levels of care in accordance with uniform considerations in keeping with professional guidelines. In education and continuing education, reinforcing the preventive outlook and including preventive elements in the care regimen will support sustainability.

Secondary prevention is extraordinarily effective in preventing complications both from hypertension, and coronary and cerebro-vascular diseases. The contribution of this program to increasing life expectancy might be tangible very soon. It reduces the need for inpatient care and costly surgical intervention. It improves quality of life.

The mortality rate due to malignant tumours has been rising for decades. It now holds second place to cardio-vascular diseases as a cause of death, with a frequency of about 25%.

In this group of diseases, the development and implementation of the preventive approach of the healthcare delivery system rely on early detection and treatment. Here, too, primary health care plays the dominant role. In addition, population-wide organised screening is significant in preventing cancerous diseases. The secondary prevention program only can be attained through providing current therapies and extended care to patients following early detection.

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In primary health care, we intend to heighten the concept of 'oncological awareness' by designing guidelines and protocols to be introduced through education and continuing education.

Extensive information campaigns focused on the public, presenting the risks of tumours and chances of early detection and effective treatment are also part of the national strategy. Treatment and continuing care for diagnosed patients by improving oncological patient care, managing and monitoring regional patient care under uniform considerations and maintaining continuous monitoring procedures will be ensured by the Programme.

Family practitioners' data on patient turnover suggest that people with mental illnesses make up a significant portion of their practices. Fifteen percent of patients have affective or anxiety disorders. Depression is one of the list-leaders, when it comes to the social damage caused by disorders. Suicide statistics are very unfavourable, borne out by international comparisons.

The primary prevention of mental disorders will be focused on families and school programmes as well as by training professionals who work in critical settings. Developing a crisis management network is intended to help reduce the number of suicides.

Conditions needed for the modern treatment of mental disorders include introducing community psychiatry, integration of the regional care network, regular continuing education for professionals to ensure professional development, training professionals who work with children and having them participate in local care, evolving cooperation between social welfare and family services institutions and primary healthcare, and designing model programmes focused on effective community-level prevention.

In their cooperation, the priority tasks of primary health care and the schools are early detection and intervention, which the Programme will assist through organising and supporting continuing education. A pivotal point of the Programme, rehabilitation must ensure that mental patients may return to and reintegrate into the community.

We are counting on the media to play an active role in overcoming prejudices surrounding mental disorders and in altering social stigmatisation. With this support, the media will be able to play an effective role in encouraging people to seek early help, which will contribute to the success of rehabilitation.

Locomotor diseases are particularly significant, not only because of their growing prevalence, but because of their consequences, their influence on disability, quality of life, and mortality. Effective prevention begins in childhood with posture-improving exercises to be included in school physical education programmes, the screening of spinal disorders and problems with limbs, and early initiation of treatment.

Among the programmes for the elderly, halting the growth in the number of hip fractures resulting from osteoporosis and improving rehabilitation conditions are primary tasks.

Graduate and post-graduate training in rheumatology will improve the expertise of primary and specialised care.

In AIDS prevention, the ultimate goal is to provide information on parenting as a part of school health education to promote the development of orders of value and personalities, to evolve responsible sexuality and drug avoidance. Credible information to the public on HIV infection and AIDS will reduce discrimination against infected individuals.



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The program includes targeted screening in high-risk communities (intravenous drug users, prostitutes, and homosexuals). Obtaining the participation and support of the civil sector is important here.

Including HIV prevention in the education and continuing education of nursing and allied health personnel reduces their occupational risk of infection.

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# DEVELOPING THE INSTITUTIONAL SYSTEM OF HEALTHCARE AND PUBLIC HEALTH IN ORDER TO IMPROVE HEALTH

Successful implementation of the program requires institutional developments that conform to the principles of the healthcare reform. This includes improving the preventive outlook of the healthcare system, public health screenings, and resource development, particularly as regards the training of professionals, research, monitoring, and information systems.

Primary health care focusing on prevention has been given a priority role in the Programme. The Alma Ata Declaration of 1978 says that primary health care is the decisive element of the entire healthcare service. Primary health care must offer easily accessible preventive, screening, and continuing care services, actively cooperating with the individual, families, and local communities.

The Programme is striving to

- continue to boost the preventive role of primary health care within the entire healthcare service;
- achieve an improvement in the quality of primary health care through reinforcing its preventive, health improvement function;
- have the local community cooperate actively with primary health care professionals;
- reduce social inequalities in access to primary health care .

Program targets include establishing uniform accessibility to certain screenings that are of public health importance. It will advance and reinforce the institutional, IT, and infrastructural hinterland to the newly established mammography screening program and intends to design, build, and operate a system for screening of the cervix and colon. The population-wide effect of screening for these three types of tumours has been certified to be favourable.

Successful implementation of the program will contribute to the integrated operation of the healthcare services, and to achieving a harmony of needs, disease prevention and health improvement, and of diagnosis, treatment and rehabilitation.

The primary goal is to boost contributions to developing primary health care, because this is the form of care in which considerations and activities of prevention can appear most effectively, and it also is the most easily accessible to citizens, including poor and disadvantaged groups.

The roles of participants in primary health care, including family practitioners, primary care paediatric physicians, health visitors, and healthcare workers offering nursing and rehabilitation, are equally important to the system, and the Programme intends to offer expert support to all primary health care staff to their health improvement activities. We will design a mode in which we will be able to include lifestyle counselling, the ability of individual risk assessment, roads to prevention and care for some particularly important disease groups (cardio-vascular disorders and tumours) in primary health care, and be able to regularly monitor primary health care to determine the effectiveness of its preventive activity and accessibility.

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Effective implementation of the Programme requires the reinforcement and modernisation of the public health system. The Hungarian public health system is particularly strong in traditional areas such as epidemiology, immunisation, protection of mothers and children, environmental health, and data provision. The significance of these areas will not decline, but we now need an infrastructure, an organisational expansion to handle prevention of chronic non-communicable diseases, health promotion, and public health planning and analysis. In all of these activities we will build on the results and proposals of analyses already completed.

One goal is to advance current tools in knowledge management and to make them accessible for all professionals concerned with public health. A priority area and the key to the long-term success of the Programme is extensive training in public health and management for professionals in public health and health-related areas (NPHMOS, local governments, NGOs) by expanding training configurations and making them more accessible. A prerequisite to high standard, international quality work in health development is scientific training in public health, which includes continuous support to training and research workshops and the regular and unbiased analysis of the efficiency of health development activity. Advancing and enlarging the higher education institutional basis to correspond to European models is a fundamental interest of the sector and of health policy. They will have to prepare the practical decisions for Programme-related research in a scientifically sound manner, and on issues of public health and social importance. With a view to enhancing sustainability, an independent institutional base will be established and university knowledge centres will be coordinated and supported.

The reliability of data on health status, and the knowledge of changes in health status and health determinants are the preconditions for Programme monitoring and evaluation. In conformity with international recommendations, we are building the program's monitoring system into the system of national health monitoring. Existing institutional bases will provide the institutional conditions, but we will need to build an infrastructure and personnel capacities.

The basic principle on which the public information systems will rest is general accessibility. The information system will not only manage and evaluate the Programme, but it also will activate involved individuals, and local and other communities. Communicating information and results is an integral part of the Programme.

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## DETAILED DESCRIPTION OF THE PROGRAMMES

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CREATING  
A HEALTH  
PROMOTING  
SOCIAL  
ENVIRONMENT

**PROGRAMS OF  
HEALTHY  
LIFESTYLES,  
REDUCING RISK  
FACTORS TO HUMAN  
HEALTH**

**PREVENTING  
AVOIDABLE  
MORTALITY,  
MORBIDITY AND  
DISABILITY**

**STRENGTHENING THE  
INSTITUTIONAL  
SYSTEM OF  
HEALTHCARE AND  
PUBLIC HEALTH  
TO IMPROVE HEALTH**

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## HEALTHY YOUTH

### The Goal:

- *Guaranteeing an opportunity for a healthy life to everyone, from the moment of conception*
  - *Making the school, in addition to the family, the fundamental setting for health development*
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- From 2003, developing planned parenthood counselling in order to promote responsible childbearing, to prevent frequent chronic illness and unwanted pregnancies,
  - In 2003, improving the professional conditions for mother, child, and infant protection measures, by improving professional conditions for health visitors, advancing the institutional hinterland, and defining actions,
  - From 2003, enhancing the conditions for childhood prevention programmes (dental, fluorine, iodine prevention),
  - Achieving daily health-promoting exercise for all children (see: 'Promoting Physical Activity'),
  - From 2003, consistently implementing laws that guarantee health-promotion considerations in paediatric primary health care and school health services,
  - By 2004, designing health-promotion curricular material for use in graduate education of teachers and the health professions (physicians, health visitors, nurses); furthermore, elaboration of the institutional frameworks for training,
  - In 2005, initiating a separate survey, in coordination with the research project 'The Health Behaviour of School Children', which also focuses on gender differences,
  - By 2005, building health promotion considerations into the quality assurance systems of institutes of public education,
  - In 2003, the objective conditions that make schools (pre-schools) safer places and at the same time suitable settings for health promotion should be designed; by 2006, such conditions must be in place ,
  - By 2005, having a continuous and regular transfer of integrated health development content in all pre-schools, primary schools, and secondary schools must be achieved,
  - Until 2004, advancing, and making general, education in public health for nursing and allied health personnel and the health visitors service,
  - In 2003, elaborating healthy ways in which young people can spend leisure time that should be supported; designing the support system and ways of providing incentives,
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- It is particularly important to develop and introduce programmes that truly reach isolated strata (Roma, people living in state care, and the homeless).

## **Situation assessment**

The live birth rate in Hungary has been declining year after year, while we lose nine of every thousand neonates. That figure is double the rate in the more advanced portion of Europe. Nine percent of neonates have a birth weight of less than 2.5 kg, and the number of congenital disorders is also high.

The chance for a 'healthy' life begins with conception, but the lifestyle, way of thinking, and information level of the parents at the time of conception play a dominant role in whether the child will have this chance. It is vital to responsible parenthood that unwanted pregnancies be prevented, and that preparations be made to childbearing. During pregnancy, the mother needs proper care, and it is necessary to prevent foetal hazards and damage, and prepare parents to care for the physical and emotional development of the child.

The newborn baby has the right to the safest possible neonatal care. Healthy nutrition begins with breast-feeding, for this is the only form of nutrition that promotes mental and physical health and affects the entire life of the individual.

Breast-feeding rate: 61.9% of toddlers over the age of one were exclusively breast-fed until the age of 4 months, and the figure for 6 months is 34.7%

According to a survey completed in 1989-1990, the nationwide average of goitre prevalence, suggesting iodine insufficiency among children, was 4.9%, but in some parts of the country it was as high as 10%! As far as dental disorders are concerned, Hungary has the poorest indices in all of Europe. Only 25-30% of 5-6-year-old children have caries-free teeth. Twelve-year-olds have an average of four permanent teeth that are decayed, 75% have inflamed gums, and 15-20% need orthodontic care. Only 66% of 18-year-old adolescents have full dentition.

Childhood obesity, hypertension, and asthma are increasingly common. In the past ten years, spinal disorders among young people have doubled. Some 60-80% of young people have poor posture. About 55% of youth do not participate in sports, and either do no physical activity or no more than 1-2 hours weekly. Childhood mental disorders, aggressiveness, and addictions (tobacco, alcohol, experimentation with, and abuse of drugs) are increasingly common at younger ages.

Eight percent of 11, 13, and 15-year-olds, 6.6% of boys in general and specialised secondary schools, 7.9% of boys in trade training schools, 9.6% of girls in general and specialised secondary schools, and 18.1% (!) of girls in trade training schools defined their own health status as unsatisfactory.

Research has shown us that unfavourable health behaviours are strongly correlated to disturbances in the socialisation process. To become a healthy and successful adult and to fit into one's environment, one must first learn the harmony of social relationships, maintain a balanced relation towards school, teachers, and study, have a firm vision and plans for the future. The school is the institutional setting for socialisation, and it can play a defining role in developing the necessary skills and abilities.

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We know that a significant proportion of diseases responsible for the poor mortality data are lifestyle-related. Therefore, within the schools we need to create circumstances and introduce methods that are truly able to influence and improve the lifestyles of future generations.

In past decades there have been very few initiatives in the area of school health, and even those have been uncoordinated. Meanwhile, the resources available for health development were appallingly low.

Priority groups being targeted for health education and health development are pre-school and school children (primary and secondary) and young adults, since the health behaviour of this age group will define the health status of the adults of the future.

The legislative environment for school-based health promotion (Section 10, Subsection (5) of Decree 28/2000 (IX. 21.) OM of the Minister of Education) offers a more extensive and, in principle at least, more accountable framework for school health-development programmes. Learning to think in terms of systems, and improving the qualifications of specialists involved, which is in this respect unsatisfactory, will fill the framework with desirable and current health-promotion contents.

The 'prevention market' is quite diverse regarding both quantity and quality of the programmes offered. There are many accessible early prevention programmes in a variety of settings, some of which are professionally dubious. Therefore, it is of pivotal importance to create a system of criteria for the accreditation of these programmes.

In themselves, trends in lifestyle models and contemporary health promotion information have only a limited influence. The eventual health status of youth is determined by the family's socio-cultural hinterland, the influence of early childhood education in the home, social stratum, and not by institutional influences. This is why it is indispensable to evolve a concept that also takes account of mental health promotion considerations. We also need to have important abilities and skills built into the behaviour and lifestyle of young generations for them to put the information into practice. 'Commercial' programmes that are used in schools in large numbers tend to be promotion-focused rather than serve health promotion goals, and other than transferring information, their methods do not assist in developing those abilities and skills. Initiatives centred on a single high-risk behaviour (diet, cigarette smoking, alcohol and drug abuse, etc.) without paying attention to the general rules governing behaviour are cause for concern.

Another difficulty is that curricular materials that reflect the updated outlook and methods are not becoming as widespread as they need to be. There are several such programmes in Hungary, but they are far less well known than they deserve to be. (Only about 4-5% of primary schools employ them at all.)

An issue of decisive importance is that the atmospheres and facilities of public educational institutions (pre-school, primary school, and secondary school) should be more efficient in receiving and passing on messages of health promoting lifestyles. This may be attained, among others, by providing education and continuing education in the methods to be used to teachers who are expected to communicate these messages. Appropriate measures need to be taken to ensure that teachers whose vocation is to teach children should have their skills and knowledge developed continuously. At present there are 20-25 accredited continuing education programmes for teachers that are connected to the programmes mentioned in the foregoing.

Often the effectiveness of health promotion activity in the schools is adversely affected by communication difficulties, occurring for reasons of both principle and practice, between school health service participants (primary care paediatrician, health visitor) and school staff.

Ad hoc degree programs and specialised postgraduate programs in health development have appeared in the graduate and postgraduate education of teachers and healthcare workers, but modern health development is not present in a mandatory, organised and institutional form.

A number of NGOs are active in health promotion. These organisations have an exceptional opportunity to transfer ideas and programmes on up-to-date health promotion to settings where there are ample opportunities to shape ways of life and lifestyles (family, school, workplace, etc.). Since there are no set criteria for accrediting and judging the operation of these organisations, they differ both in the content and quality of their work and their financing is haphazard.

Young people have hardly any opportunity to spend their leisure time in a healthy environment, leaving them at the mercy of commercial entertainment facilities where alcohol is consumed, and where sometimes there also is drug trafficking. There are only sporadic initiatives (such as a night time ping pong championship).

**Strategic directions of implementation**

TASKS	ACTIONS NEEDED
<p><b>Responsible parenthood, healthy start in life</b></p>	<p>Improving the level of planned parenthood counselling by developing community health visitors, school health visitors services, and boosting the Family Protective Service; improving the professional and methodological hinterland by coordinating and advancing the activity of the existing system of institutions.</p> <p>Early diagnosis of genetic hereditary abnormalities (family planning) and preventing the consequences of the predisposition through healthy lifestyles and medical interventions.</p> <p>Advancing the health visitors service, improving the personnel, objective, and continuing education conditions for professional supervision, by resolving upon and introducing uniform principles.</p> <p>Defining and introducing a uniform principle of prevention in women’s health care, mothers’ health care, and the care of children aged 0-18 years.</p> <p>Offering incentives for ‘family-friendly delivery clinics’, and using all possible means to popularise breast-feeding, making it a generally accepted and natural act.</p>

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**Childhood prevention**

Monitoring the physical and emotional development of children. Designing and applying a dental risk strategy.

Involving doctors and health visitors at schools into the world of the school; evolving cooperation models with school management.

Comprehensive establishment of an organised school dental network and initiating oral hygiene programmes.

Offering information to the public on increasing their intake of iodine and fluorine.

Investigating alternatives to fluorine intake, fitting them into oral hygiene programmes

Disseminating the use of iodised salt.

Medical examinations to determine iodine sufficiency, survey on the prevalence of goitre.

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**Education**

By 2004, a curriculum on health development has to be developed for the higher-level education of teachers and health workers (physicians, health visitors, nurses) together with the institutional framework for the training.

By 2004, public health education for nursing and allied health personnel and the health visitors' service must be developed and introduced on general scale.

By 2005, accredited and quality assured continuing education courses for professionals working in the school health services.

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**Research**

Launching a separate survey on the role of gender differences from the point of view of trends in health behaviour and the usefulness of health promotion programmes, in keeping with the research project on the 'Health Behaviour of School Children' (HBSC).

A top priority goal of the time to come is to design and introduce programmes to assist marginalised social strata (Roma, people living in state care, and the homeless).

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**Programme development**

The objective conditions for making schools (pre-schools) safe and for turning them into settings conducive to health promotion must be designed by 2003 and established by 2006.

By 2005, the health development considerations of the quality assurance system for schools must be designed and built into the system.

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By 2004, it has to be achieved that integrated health development contents that are in keeping with strategic goals in all ages are taught in a regular and continuous way in all pre-schools, primary schools, and secondary schools.

In 2003, the ways in which young people can spend their leisure time under healthy conditions which can be supported are designed, together with the system of support and ways of promotion.

From 2006, on concluding 11<sup>th</sup> grade in public education, students should receive a certificate of health-maturity based on individual risk assessment, which certifies that the student has the knowledge to protect and promote her/his health, knows how to apply that knowledge and skills. S/he has the ability to pass on that knowledge to friends, family, and future colleagues, in other words s/he is considered mature from the point of view of health.

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## **Expected results**

People starting up families will attend family planning counselling, and primary prevention programmes focused on chronic illnesses offered as part of antenatal care.

The proportion of premature infants, low-birth-weight infants, and congenital disorders will decrease.

By 2005, the rate of infants exclusively breast-fed until the age of six months will reach 70%, and 80% by 2008.

The prevalence of goitre in children aged 6-10 years will decrease from 4-5% to 2%.

By 2010, 50% of children aged 6 years will have intact teeth, children aged 12 years will have a maximum of three permanent teeth with decay, and 85% of 18-year-olds will have all of their teeth, and gum diseases among 12-18-year-olds will drop by 25%.

By the end of 2004, substantive, integrated health development activity will be underway in at least 50% of institutions of public education, and a substantive dialogue between school health services and teaching staff will evolve.

By 2006, modern health development content reflecting social embeddedness and accredited methods will be used in all public education institutions, to include richer programmes and program registers.

Shaping the institutional conditions for university and college education — In 2004, the newly developed curricular material will be tested as part of graduate education in at least 5 universities, and the tested curricular modules will be available.

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Starting in the 2005/2006 academic year, all students should gradually receive health maturity certificates. As a result of the school health development programmes, the mature student is able to recognise risk factors that pose a hazard to her/his own health, to evaluate her/his own health status appropriately, has evolved a demand for appropriate health behaviours, is aware of the factors and tools that can promote and develop good health and takes advantage of them, is aware that by developing willpower and by education, activities difficult to perform initially may be turned into skills; s/he knows how to pass on this knowledge to peers, the family and persons surrounding him/her and offers a personal example resulting in a positive approach.

Spread of modern teaching techniques when transferring the information on health development — We expect to see the number of recipients of these information services increase. In 2003-2004, at least 800 teachers will be participating in accredited continuing education in health development for teachers.

As a result of the extended 'Health Behaviour of School Children' and of other research, programmes will appear that take into consideration differences in gender roles, and the needs related to prevention of marginalised strata.

By 2005, the quality assurance system of schools will include health promotion considerations.

By 2006, the objective conditions that make schools (pre-schools) safe and at the same time, turn them into settings suitable for health development will become gradually predominant.

By 2004, the regular public health education of nursing and allied health personnel and the health visitor service will become general, including curriculum development and updating of content.

From 2004, improvements in the opportunities for young people to spend their leisure time at healthy activities will start.

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# IMPROVING THE HEALTH OF THE ELDERLY

## The Goal:

*To improve the quality of life for an aging population that is continuously growing in number*

### Situation assessment

Our senior citizens are not a homogenous group. They include individuals in a wide range of physical conditions from perfectly healthy to people suffering from serious chronic diseases. All must be assured respect and personally appropriate activeness. The care provided for them must be adapted to their condition, to include prevention, rehabilitation, habilitation, and the highest possible level of healthcare and social services.

The increase in life expectancy at birth throughout the entire developed world has led to an increase in the proportion of elderly people. In Hungary, this shift in proportion has been increased by a declining birth rate. Although it is hoped that the latter will grow due to measures to promote willingness to have children, proper treatment and care can lead to an additional growth in life expectancy, which would maintain the current rate.

From 1980 to 2000, the proportion of people over the age of 65 showed the following trend:

- European average: climb from 12.13% to 13.75%
- European Union: climb from 13.43% to 15.97%
- Hungary: climb from 13.43% to 14.58%

of the total population.

Another important figure is that while in Hungary in 2000, the proportion of females over the age of 65 was 17.65%, that of males was only 11.37%. Translated into day-to-day life, this means that there are many elderly women living alone in Hungary. This is equally defining from the social and the psychological points of view.

The social status of senior citizens is not defined primarily on the basis of finances, although it does exert a major influence because of the current low pensions. The fact that in Hungary, elderly people have less opportunity to put their experience, knowledge and skills to use, and general opinion views them as dependants though during their working lives they created the opportunities for today's economically active population has a strong influence on their social mood. In addition, their own social opportunities have declined because even if they are in a balanced state of health as appropriate to their ages, they are to an extent restricted in movement, and have slowly seen their friends 'pass away'; their opportunities to maintain relationships are sometimes restricted to the telephone which is not available or not affordable to all. The result is often introversion, depression, and in many cases, suicide. Most elderly people, including the newly retired, are reduced to lower living standards.

Studies have shown that the quality of aging is determined primarily by childhood education. For instance, 81% of people who defined their childhood home atmospheres as volatile became psychosomatically ill or neurotic in their old age.

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Childhood education also affected the social surroundings of the elderly groups investigated.

In addition to various measures, an improvement in the health status of senior citizens primarily requires a change in outlook, on the part of both society as a whole, and the elderly themselves. The 'health' of an elderly person is not the same as that of a teenager. Nevertheless, if the person lives in proper balance with her/his age and the natural processes of wear, and these processes do not act as an obstacle to day-to-day life activity, s/he can be considered 'relatively healthy'. Society has to recognise that aging does not mean vulnerability or dependence, and this outlook needs to be widely disseminated. At the same time, the seniors need to learn about, and take advantage of the opportunities that will hopefully be available to them to live a health-conscious, useful, and liveable life.

**Strategic directions of implementation**

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<b>TASKS</b>	<b>ACTIONS NEEDED</b>
<b>In healthcare</b>	<p>The specific problems of the elderly have to be taught in medical and health sciences education and in primary health care services.</p> <p>The media needs to regularly concern itself with aging processes, and easily understandable information on their effects on the lifestyles of the elderly. The goal is for the information to increasingly promote attempts to be self-sufficient and realisation of these attempts.</p> <p>Transitional facilities need to be established to promote the rehabilitation of senior citizens, towards a higher level of self-sufficiency.</p> <p>To improve feelings of security among elderly people related to healthcare, an infrastructure conducive to the use of alarm signalling devices (bracelet, chain, panic button) could be evolved gradually, in cooperation with furthering the home care service.</p> <p>To promote patient rehabilitation at the place where this is most appropriate for the patient, we are planning to build a 'chain of home nursing/lay caregivers', to include training, which later can be expanded by organising a system for taking people out for a walk and providing home companions.</p>
<b>Social and societal spheres</b>	<p>In the social sphere, it is essential to create fundamental financial security for senior citizens to guarantee their human dignity and the primary goal of ensuring them a liveable life.</p>

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In the societal sphere, the change in outlook and coordinated cooperation already mentioned are needed, from education in the schools to the media, with the assistance of programmes organised in part by the NGOs.

An environment of acceptance of elderly people must be established, meaning community forms in which the elderly can share in social life with other age groups (clubs, lectures on popular issues, sports programmes, etc.); multi-generation programs should be organised and the opportunities for contacts between children and elderly should be expanded.

A plan for elderly care that responds to local community needs should be put together with the involvement of the elderly.

Accommodations in nursing homes for both day-care and residents must be increase in order to put an end to waiting lists. Furthermore, home help services and skilled nursing care at home must be strengthened in order to avoid marginalisation of the elderly.

In order to avoid that population groups with multiple disadvantages become at-risk groups in old age, there is a need to strengthen based and specialised services, and to enhance the formulation of comprehensive care plans.

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**Other, general features**

In keeping with their interests and abilities, elderly people should be provided with study opportunities (ranging from teaching the illiterate to read and write through information on how to use a bankcard, to senior universities and language courses).

In keeping with the interests, health and mental status of the elderly, opportunities should be provided for voluntary work, and an appropriate system should be designed. Being engaged in voluntary work may contribute to strengthening the elderly person's feeling of usefulness.

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**Expected results**

The life expectancy of people aged over 65 years will increase, and there will be improvements in their quality of life that may be demonstrated both objectively and subjectively.

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## EQUAL OPPORTUNITY FOR HEALTH

### The Goal:

*To improve the health of socially excluded population groups — the Roma, persons with disabilities, the homeless*

- Seeing to it that causes leading to health status in socially excluded population groups (Roma, persons with disabilities, the homeless etc.) that is considerably poorer than in the majority society are decreased in the short run, and terminated in the long run.
- Ensuring that socially excluded population groups can have equal and discrimination free opportunities of accessing the health services, types of care and prevention programmes.
- Putting an end to attitudes of prejudice generating discrimination among healthcare workers within the health services and to other causes giving rise to discrimination.
- Completing undergraduate and postgraduate education in medical and health sciences with knowledge on the health status, socio-economic situation and specific cultural features of the socially excluded, in the first place of the Roma population, and with training to strengthen sensitivity to being different and tolerance.
- Developing screening and continuing care services for the socially excluded population groups.

### **Situation assessment**

In the European Union's guiding principles, a distinguished place is assigned to equal opportunities and to the protection of and respect to minorities. This statement is considered to be pivotal in the health sector, too, since the access to primary health services (family practitioner's services, emergency services, screening and continuing care) for the socially excluded population groups and for those living in colonies is more difficult. The underlying causes may include geographical, infrastructural causes, or causes that relate to low educational level, deprived income status, living with disability, or discriminative attitudes displayed by the care provision system. For the required measures to be planned, it is indispensable to identify these causes accurately and to map out the system providing care for the socially excluded population groups.

The 'Equal opportunity for health' subprogram may launch its activities in coordination with the other subprograms. It is with this in mind that the 'Equal opportunity' subprogram pays special attention to improving the health status of Roma people, persons with disabilities and

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the homeless, and to making the relationship between healthcare workers and patients more harmonious.

In the 'Equal opportunity for health' subprogram, it is necessary to specifically name the Roma because discrimination against them in different places affects them as Roma persons (and not as disadvantaged persons); on the other hand, the effect of this discrimination aggravates their disadvantaged situation.

Today in Hungary, about 30% of the poor are Roma, which means that the poor are more likely to be found among the Roma than among the non-Roma population. However, poverty among the Roma is often deeper, prolonged and inherited from generation to generation. The public health consequences of poverty do affect everyone alike: unhealthy housing, diets of inappropriate quantity and quality. The poor cannot comply with advice on leading healthy lives, they cannot follow a diet and cannot buy the pharmaceuticals – due to all these factors, their chances of recuperation are worse.

We are not fully familiar with the relations between the Roma population and the different types of institutions of the healthcare delivery system (family practitioners, specialist outpatient clinics etc.), neither do we know exactly the prejudices that healthcare workers in general have when approaching the Roma (and vice versa: what prejudices or fears do the Roma have in connection with the health service or its workers). Based on data it is possible to identify the impact that communication problems in the doctor-Roma patient relationship have on the appraisal of disease behaviour patterns. It is, however, a much more serious issue that family practitioners tend to ignore the more unfavourable health status and mortality patterns of the Roma, consequently, they are highly unlikely to pay more attention to their Roma patients than to the average patient.

Among the poverty factors accounting for the higher morbidity levels among the Roma population, low educational level, unemployment and deprived housing conditions have the most important, often combined, effect. The health status of those living in colonies is especially poor. Public utility supply and the infrastructure in colonies are extremely backward all over the country. It is fair to say that the interconnections of the aforementioned factors that are at play in causing multiple disadvantages for the Roma population have been well identified and demonstrated by research conducted so far.

Estimates put the number of persons with disabilities at 4-500,000. Among them, there is a considerable number of elderly, with the proportion of those aged over 60 years being 38% (this is double the proportion within the population at large). About 32% of the persons with disabilities have been suffering from the disability since birth. The greatest proportion is made up by persons with physical disabilities and mobility impairment (40%), the proportion of persons with mental handicap, of the blind and persons with visual impairment is 20% each and another 20% suffer from other disability (hearing, speech). The employment opportunities for these people are usually very bad and only about 1/6 of the persons with disabilities are economically active. Today persons with disabilities, especially those with serious multiple disabilities, find it very difficult to have access to appropriate health care, which is due to several reasons:

- there are not enough adequately trained doctors and healthcare workers who could handle a child or an adult with mental handicap or multiple disability, and who would be able to carry out the necessary examinations and therapies;

- due to the lack of making the environment obstacle-free, doctor's offices and hospitals are often inaccessible for them,
- hospitals do not tolerate patients who require increased attention and supervision, who disturb their fellow-patients and who communicate with difficulties.

Families are left alone in the face of the society's actions at discrimination and must cope with prejudice and exclusion alone. Very often, a single parent, in most cases the mother, raises the child with a disability with all its mental health consequences: she/he is ousted from the labour market, gets isolated from the environment and neglects her/his healthy child.

In Hungary, there are about 30,000 homeless persons, mostly in big cities. Homelessness has become chronic by now, i.e. a considerable proportion of the homeless has been living in the street for 5-10 years, practically excluded from society, and this applies to their access to healthcare: the healthcare delivery system will not receive, or receive with some reservations, the homeless. And even if it accommodates them, it will discharge them as 'fit to leave for the street' when they would need nursing care only. By today, lower standard, parallel and separate healthcare provision has evolved for them. However, this does not solve their problems, and does not ensure, for instance, the necessary nursing care and caring, or compliance with instructions concerning the necessary lifestyle in the period of recuperation.

Homelessness very often goes together with a health problem, which is partly a cause, partly a consequence. They include alcohol abuse, skin infections and tuberculosis.

## Strategic directions of implementation

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### TASKS

### ACTIONS NEEDED

#### Research

Research to study the opportunity of access to health services, the attitudes of healthcare workers (primarily of family practitioners, health visitors, specialist doctors) towards the Roma population, and to reveal the causes and mechanisms of discrimination.

#### **Grant scheme to support measures and programs aiming to involve into health care persons living in colonies or colony-like neighbourhoods, inmates in social welfare institutions providing long-term residential care**

It is the goal of the strategy to ensure that members of the target groups may get to the very location of primary health care and specialist care (use of public transportation, support to the cost of transportation etc.) The project may refer to screening-continuing care services, services involving acute intervention, or participation in the programs of 'centres of independent way of living' that improve quality of life (primarily for persons with mobility impairment). The programs may be implemented by the already operational regional development projects, local self-governments (or village managers employed by local governments), NGOs.

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**Community rehabilitation with health and social focus**

In colonies, small settlements and parts of settlements with a high proportion of Roma population, complex community rehabilitation should be undertaken in order to ensure health and infrastructure coverage and to eliminate environmental hazards. The local minority self-government in cooperation with the municipality should implement tasks that are mandated by the Act on Local Governments (e.g. drinking water supply and sewage system, garbage collection). Another special priority goal is to ensure obstacle-free mobility for persons with disabilities in all communities, as an organic part of the development programs of the local government.

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**To terminate overrepresentation of Roma children in special schools for mentally challenged pupils**

Evolving unified practices for the county Rehabilitation and Advisory Boards Testing Learning Aptitude, primarily with regard to health issues. Assessing the real status of children qualified as having mental handicap; identifying the real proportions of persons in the individual categories of mental handicap across the country, carry out authentic measurement of the valid representation of Roma children. Formulation of unified standards, ensuring unified evaluation of the questionnaires. Identifying, and integrating into the educational structure, the directions for development of children with special learning needs.

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**Screenings**

Implement regularly advanced and/or extended screenings targeted at the socially excluded population groups in the following areas: TB, hepatitis, tumors (with special regard to gynaecological tumors), paediatric screenings (with the involvement of health visitors and paediatricians). Utilisation of mobile screening stations. Review of the system of subsidies towards transport fares.

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**Mental health support programs for parents raising disabled children**

Elaboration of accredited programs that assist family members raising and caring for persons with disabilities to cope with the task and to ease their isolation.

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**Continuing care examinations for socially excluded persons and inmates in social welfare institutions providing long-term residential care**

It is indispensable to provide continuous care and follow-up care for the homeless and other marginalized groups that are difficult to reach (e.g. children in state care, care in case of behavioural disorders). To ensure this, there is a need to support social workers involved in the care of the homeless, on the other hand doctors participating in continuing care (in a modality reimbursed by the National Health Insurance Fund). The same strategy has to be adopted in the case of inmates in social welfare institutions providing long-term residential care, primarily in the field of psychiatric follow-

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up care, and among the Roma in order to motivate increased activities from the care provision system in antenatal care (with special regard to disease of mothers and providing closer control of delivery and the perinatal period.)

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**Preventive health development programmes for the socially excluded population groups.**

Designing and introducing education and teaching programs for the socially excluded population groups. In addition to enhancing the health consciousness of the Roma population, there is also a need to develop trust in them towards both screening and health interventions, and medically justified compliance.

Comprehensive family and community care plans should be formulated among the socially excluded population groups and families, with the involvement of family support services, health visitors, nurses, family practitioners, social workers, child welfare services, minority self-governments, churches, as well as civil and charitable organisations.

Young persons could be trained on the secondary or higher levels who undertake to engage in social work in their neighbourhood, in cooperation with primary health care personnel.

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**Education programs**

Elaboration of programs intended to strengthen multicultural, discrimination-free approaches (the values of open society) and antidiscrimination practices should be designed and introduced into the graduate and postgraduate curriculum of institutions offering education in medical and health sciences. Family practitioners and patients rights advocates should be trained in the fields of unprejudiced behaviour, social isolation and specific problems of the Roma.

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**Expected results**

- Effective detection by screening and rehabilitation of persons with disease in socially excluded population groups (within 3 years).
  - Growing rate of participation in health care and continuing care of persons living in deprived neighbourhoods and housing conditions, as well as those living under long-term disadvantaged social conditions (within 2 years)
  - Improved opportunities for socially excluded population groups in acceding equal and discrimination-free health care services (within 3 years)
  - Bettering of the health behaviour of socially excluded population groups (within 5 years).
  - Improved obstacle free traffic and mobility conditions for persons with disabilities (within 5 years)
  - Considerable improvement in the quality of continuing care examinations for the socially excluded individuals and inmates in residential social welfare institutions (within 3 years)
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- Improvements in the morbidity and mortality rates of the socially excluded population groups (within 10 years)
  - Decrease in the absolute rate of persons with unjustified classification into the category of other disability, and among them, decrease of the relative proportion of the Roma (within 3 years).

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# HEALTH PROMOTION IN SETTINGS OF DAILY LIFE

## The Goal:

*To see health-promoting political practices in operation in day-to-day life settings, in settlements, schools, workplaces, and in healthcare institutions, to effectively implement health promotion, using methods of prevention*

- The health promotion plan should be an organic part of the regional and micro-regional development plan
- The Hungarian school system should not only protect the health of students but should promote health protection and health development for teachers and the family members of students
- Above and beyond taking mandatory occupational health measures, workplaces in Hungary should put a top priority on health promotion for their workers
- The healthcare system should engage in preventive and health promotion work, in addition to its curative activities. The hospital should be a healthy workplace.
- The body of knowledge of education for health and health promotion should be taught in postsecondary education for public administration, health and medical sciences as well as teachers' training, including the entire scope of preschool teachers and school teachers.

## **Situation assessment**

The World Health Organisation first suggested thinking in terms of the settings of daily life over fifteen years ago. Hungary also began to think in terms of settings fifteen years ago. The first movement was the Healthy Cities movement, followed by Healthy Villages, Health Promoting Schools, Health Promoting Workplaces, and Health Promoting Hospitals. Activity in the various settings was uncoordinated, and lacked a national level public health concept. In addition, financing was uncertain.

At this time, twenty Hungarian cities are members of the movement of Healthy Cities, and over 200 small communities have health plans. Only some of the country's 3,522 pre-schools participate in the Healthy Kindergartens Network, while only a few of the 3,423 primary schools and 2,000 secondary schools are members of the National Network for Health Promoting Schools. In the past, the primary target was the health education of students, and different subject development activities were undertaken. In addition to continuing to advance



the curriculum, it has become extraordinarily important to improve health-related abilities, not only among the students, but also among their parents and teachers. The teacher and the doctor are two opinion shapers in local society whose own health, and health behaviour, are models for the entire community. Health promotion models acceptable to parents and families are the pillars of advancing equal opportunity.

The Association for the Health Promoting Workplace has 42 members. The workplaces where the employee herself/himself serves as a model for behaviour, such as the National Public Health and Medical Officer’s Service (NPHMOS) or the local governments and their institutions (pre-school, school, the local government itself, hospital) are particularly important from the point of view of workplace health protection. The Association for Health Promoting Hospitals has 16 members. Health development for family members of inpatients, or for hospital staff was not included among past targets.

Clearly, there are other important venues among the settings of everyday life, such as public transport, shopping malls, places of entertainment or, for example, playgrounds, of the smallest unit of society, the family itself. The sub-program focuses primarily on shaping policy and not on organising short-term actions.

**Strategic directions of implementation**

<b>TASKS</b>	<b>ACTIONS NEEDED</b>
<b>Expanding the Healthy Cities movement</b>	Regional training and cooperation so that health promotion appears with the weight it deserves in the development plans of all Hungarian cities. NGOs and the business sector are to be included in shaping the health development concepts of the communities. Community health plans should cover the most important institutions of the community. The lifestyle and disease prevention programmes of the Public Health Programme should appear in an effective way
<b>Healthy Villages</b>	The health plan should become a part of village development plans. Micro-regions should engage in development activities on the basis of coordinated health plans, where possible.  The lifestyle and disease prevention programmes of the Public Health Programme should appear in an effective way.
<b>Health promoting schools and educational institutions</b>	The owners and operators of educational institutions should make it possible for health promotion to appear as part of the school curricula in a manner that accords with their significance. The educational institutions should make it possible to practice healthy lifestyles within the school walls (mass catering, consistent, daily physical education, stress free environment, etc.) The schools also need to provide

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opportunities to the family members of disadvantaged students in learning the elements of a healthy way of life. The school should become a healthy workplace for teachers

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**Health promoting workplaces** This movement needs to be expanded. Government and local government employers should be in the forefront among the healthy workplaces. Workplace voluntary mutual health funds should be elevated as special partners in workplace health promotion.

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**Health promoting hospitals and pharmacies** In addition to curative activities, prevention should be given greater emphasis. This requires an infrastructure and financing. Patients' families should be involved in the health promotion activities. The hospital should become a healthy workplace. The preventive approach should be assigned greater role in pharmacies and in the work of pharmacists.

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**Higher education** A textbook on health promotion political practices should be prepared for people working in public administration by 2004. The theory and practice of education for health and health promotions should be taught in the entire scope of teacher training. The elements of a public health approach should be included in the training of health professionals.

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## Expected results

- ❑ Health and health development considerations will become a part of daily life, health-consciousness will improve as will the ability of the public to make conscious choices.
- ❑ The efficiency of health promotion programmes will increase.
- ❑ The principle of equal opportunity will be asserted in the settings of everyday life with respect to health and health promotion.
- ❑ The general state of health will improve and inequalities in health by social and demographic factors will decline.

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CREATING  
A HEALTH PROMOTING  
SOCIAL ENVIRONMENT

**PROGRAMS OF  
HEALTHY  
LIFESTYLES,  
REDUCING RISK  
FACTORS TO  
HUMAN HEALTH**

PREVENTING  
AVOIDABLE  
MORTALITY,  
MORBIDITY AND  
DISABILITY

STRENGTHENING THE  
INSTITUTIONAL  
SYSTEM OF  
HEALTHCARE AND  
PUBLIC HEALTH  
TO IMPROVE HEALTH

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## CUTTING BACK TOBACCO SMOKING

### The Goal:

*To cut back cigarette smoking by 8% a year until 2005, and to reduce the prevalence of regular smoking by 6% (to about 35% among males) by 2010*

- To achieve a 20% reduction in the time spent by an individual passively smoking, and to reduce the hazards of passive smoking by additional restrictions on places where smoking is allowed and by strictly enforcing compliance with current regulations
- To increase the rate of never smoked people by reducing the number of children and youth who take up smoking
- To enforce and tighten up legal and other regulations on consumption of tobacco products and to adopt European Union and WHO recommendations as early as possible.
- To reduce social acceptance of smoking and the tobacco industry by evolving a social environment in which non-smoking is the norm

### Situation assessment

A research report for 2000 issued by the National Population Health Survey (NPHS) found that 40.7% of males in the Hungarian over-18 population and 26.3% of females smoke (regularly or occasionally). Per capita cigarette consumption in 1999 amounted to 2,400 cigarettes/person, while the figure for the European Union is 1,600 cigarettes/person. A survey conducted by the Fact Institute in 1999 found that 65% of the Hungarian population was at risk from the hazards of passive smoking, spending an average of 270 minutes/day in an indoor setting in which they inhale other people's tobacco smoke.

Data published by the Central Statistical Office (CSO) in early 2002 showed that in Hungary today, the death of 28,000 people each year may be ascribed exclusively to smoking. This is roughly double the number of fatalities from alcoholism, drug abuse, accidents, violence, suicide, and AIDS combined. Hungarian males have the world's largest lung cancer mortality rate.

In the past decade and a half, male smoking prevalence changed slightly but female smoking grew by 30% from 1986 to 1999, while children are smoking their first cigarette at younger and younger ages, becoming regular smokers an average age of 17.9. According to CDC data for Budapest nearly half (46%) of secondary school leavers were regular smokers and among females, the prevalence of regular smoking was slightly higher than among males.

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## Strategic directions of implementation

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### TASKS

### ACTIONS NEEDED

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#### Communications

In communication with the public, we need to include continuous media activities, made even more effective with pamphlets, a website, and a free call-in number. We need to intensify communication among professionals, and to offer training and continuing education to present effective anti-smoking measures. The communications strategy has to extend to decision-makers, particularly to committees on health and welfare, economics, finance, and farming.

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#### Community programmes

We need to support local and community (setting-oriented/age-specific) programmes, with a particular emphasis on workplace programmes/workplace anti-smoking policies including the testing and introduction of comprehensive hospital anti-smoking programmes (smoke-free hospitals, assisting staff in quitting smoking, counselling for smoker-patients). Comprehensive anti-smoking policies need to be designed for schools (use of study materials, teacher-training, inclusion of parents, assistance in quitting) as priority projects, augmented by the methods of peer educators, programmes designed and executed by students and including parents, measures to reduce smoking among pregnant women and young mothers, and programmes focused on Romany and disadvantaged youth. A network to assist people in quitting smoking needs to be promoted (review of operations, reform, improved marketing, extension to primary health care physicians and dentists).

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#### Research

A detailed research plan has to be designed, which should include analyses of domestic campaigns, and relevant campaigns in other countries, prevalence studies, analyses of the key persons working in the area and their anti-smoking activity, researching tobacco industry documents and making them accessible to the public, monitoring, evaluating and publishing the results of publicly funded community programmes, monitoring adherence to laws and other smoking-related rules, researching ways of making methods of quitting smoking more accessible, studying the presence and development of the issue of smoking in curricular materials, and designing guidelines to regular cooperation between state-owned institutions and the tobacco industry.

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**Health policy goals**

We intend to regularly raise the price of tobacco products by a rate that exceeds inflation and to introduce a product fee to be used to finance the struggle against smoking. We will continue to reduce tobacco industry advertising and sponsorships. We will increasingly monitor adherence to the law on protecting non-smokers (NPHMOS task). We will introduce a new labelling law and will cut back on the tar and nicotine content of tobacco industry products in keeping with the European Union, and we will participate actively in designing the Framework convention on tobacco control and in introducing it domestically as early as possible.

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**Expected results**

The action program aimed at reducing smoking, with special regard to furthering quitting, will contribute to increasing life expectancy at birth already in a ten-year time frame. A well-organised anti-smoking campaign can significantly increase the number of people who quit, leading to a decline in the prevalence of smoking-related chronic and acute diseases. In ten years, we also expect to have major achievements in cutting back sales of tobacco products, stopping young people from starting to smoke, and reducing the number of people exposed to passive smoking.

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# ALCOHOL AND DRUG PREVENTION

## The Goal:

*To reduce alcohol and drug consumption and prevent the health-related and social damage they cause*

- To significantly reduce per capita alcohol consumption by 2008, and substantively reduce it by 2012
- To substantially and measurably reduce the number of alcohol-related psychosocial problems (principally, damage to families and the children of those families, and alcohol-related accidents)
- To significantly reduce the prevalence of alcohol consumption and the amount of alcohol consumed by young people. To substantively reduce experimentation with alcohol among children and adolescents, to occur much closer to adulthood
- To reduce consumption of illicit drugs
- To hold the level of drug-dependent persons constant to 2008, and then to reduce the number to 2012

## **Situation assessment**

Per capita alcohol consumption has reached a standing high level, and continues to show a rising trend. The alcohol-related mortality and morbidity rates are high (particularly as concerns hepatic diseases).

It is considered probable that there are frequent alcohol-related hidden problems that do not surface (moonshine, low-quality products that damage the health, bootlegging, etc.), and there is a high rate of alcohol-related accidents. Alcohol plays a major role in criminological phenomena.

Alcohol is often a cause of serious hazards to families (injury to children, divorce, family disorganisation, etc.)

In addition to the above, alcohol plays a central role in becoming homeless and among the health hazards to the homeless.

There is a high prevalence of alcohol consumption among young people, and experimenting with alcohol is common among the very young.

The number of drug-dependent persons, particularly as regards opiates, is rising, and so is the mortality rate among them. Consumption of amphetamines is growing and related complications are rising. The prevalence of drug use among the young is increasing, and early experimentation is characteristic.

Polysubstance dependence, i.e. the misuse of more than one drug at a time, is common.

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The infrastructure for management and rehabilitation is undeveloped, and the effectiveness level is low. Hazard reduction efforts are undeveloped and efficiency is low.

Supply control is relatively underdeveloped and not particularly effective.

**Strategic directions of implementation**

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**TASKS**

**ACTIONS NEEDED**

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**Improving prevention**

Primary and secondary prevention needs to be improved among children and in schools

‘Minimal intervention programmes’ need to operate within primary health care. Programmes have to be operated to protect the children of alcohol abusers.

Attention needs to be paid to the activities of cults, and of radical reference-groups and movements that avow antisocial values, particularly to youth groups (e.g. groups that behave disruptively at sports events) for there is likely to be alcohol and/or drug involvement among them.

Actions in the sub-project will be implemented within the framework of the National Drug Strategy and will attempt to reinforce it, with a particular mind to advancing Coordination Forums on Drug Issues (CFDI), and the school drug coordinator network.

We need to train physicians, healthcare workers, and social activists (particularly as regards recognition, motivation, effective assistance, and therapeutic behavioural influencing techniques).

We need to include clinical psychologists (health psychologists) in prevention and treatment, and to offer them special continuing education.

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**Developing treatment institutions**

We need to establish up-to-date institutions for treatment and rehabilitation, to improve the effectiveness of operations, accessibility, and increase their use (particularly as regards the principle of early initiation into treatment).

Workplace-based early initiation into treatment.

Early recognition of multiple psychiatric disorders and effective treatment initiation, with particular respect to young alcohol abusers

Applying an arsenal of treatment initiation methods (detoxification, medication, psychotherapy and sociotherapy), quality assurance for effectiveness, optimising the infrastructure and financing, particularly

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focusing on outpatient opportunities.

Reinforcement of the National Drug Strategy, with particular respect to a network of low-threshold services for drug counselling and therapy, and improving the effectiveness and quality of healthcare treatment of drug problems.

Increased organised and methodical cooperation between NGOs and self-help configurations in dealings with institutions and organisations offering treatment and rehabilitation.

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**Sensitising society**

Advancing NGOs and self-help groups, expanding opportunities.

Evolving youth prevention and hazard reduction programmes (religious groups, leisure programmes, life settings, such as malls and workplaces, etc.).

Work with the media and media strategy to shape a social outlook.

Support for cultural and social movements and processes aimed at reducing alcohol and drug consumption (e.g. community sobriety), promoting development psychology methods, particularly group and community cultures, to build healthy identities (traditions that have positive values, community responsibility, etc.) and to attract them through the media to share in the social alcohol and drug debates.

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**Advancing monitoring**

Establishing the conditions for modern institutional statistical data collection and scientific research, regular, annual epidemiological surveys.

Epidemiological and social science research (e.g. alcohol and drug-related research with the assistance of research workshops and volunteer social science institutes).

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**Expected results**

As a result of the program, alcohol and drug-related damage will be reduced, because:

The number of alcohol abusers, binge drinkers and problem drinkers will decline and by 2012 the estimated number of alcoholics will be less than 500,000.

The prevalence of alcohol-related diseases will drop by 10% and its incidence by 15% by 2008, and by 2012 the two figures will be down by 20% and 25%.

Alcohol-related mortality will drop by 10% by 2008 and by 25% by 2012.

The supply of illegal drugs will not exceed the 2002 level and may decline

The number of drug dependent persons will not exceed the 2002 level and may decline.

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# HEALTHY NUTRITION AND FOOD SAFETY

## The Goal:

*To reduce the prevalence of nutrition-related disorders and to improve the general state of health through healthy nutrition*

- To disseminate information on healthy nutrition to specialists and all of society
- To grow (farming) and produce (food industry) sufficient and quality food for healthy nutrition through a policy of sustainable farming and stock breeding, and through protection of the environment
- To implement the guidelines for healthy nutrition in mass catering
- To establish family nutritional safety - to see to it that all children have enough quality food, by expanding the school meal system
- To improve food safety, reduce food-borne diseases and to prepare for new challenges.

## Situation assessment

In many countries of the world, and Hungary is one of these, diseases related to nutrition and lifestyle play a significant role in the health of the overall population and in the resulting mortality trends. Half of all deaths in Hungary are the result of circulatory disorders, and one-fourth are the outcome of tumours. Two-thirds of the Hungarian male population and one-half of the female are overweight or obese. Other problems, such as hypertension, Type-2 diabetes, and disturbances of the lipid metabolism occur twice to three times more often in overweight persons.

A significant portion of nutrition-related diseases could be prevented with healthy nutrition. According to a report prepared for the European Commission, over one-third of under-65 cardio-vascular mortalities in Europe are nutrition-related. It is likely that healthy nutrition would reduce the risk of circulatory system disorders by the same rate. In Europe, 30-40% of tumours could be prevented with healthy nutrition. Diseases that could be prevented through healthy nutrition include osteoporosis, tooth decay, and dental erosion.

Healthy nutrition could increase the number of disease-free years of life, prevent some of the disorders already listed, and with that a significant portion of the related burden on the individual and society. This is supported by the fact that the circulatory and tumour mortality rates in the Mediterranean countries, where dietary habits are typically healthy, are one-half to one-third of the rates in the rest of Europe. At the same time, we can see the importance of healthy nutrition by looking at Finland, where risk factors were gradually eliminated and healthy nutrition introduced. In 30 years, there was a 65% decline in the mortality rate due to cardio-vascular disorders among 35-64-year-old males. The examples show that every

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country has to design and introduce the food and nutrition policy recommended by WHO. The sub-project for healthy nutrition rests upon the elements of this food and nutritional policy.

The diseases mentioned and the risk factors for them are known to be part of Hungarian dietary habits — too high an intake of energy, fat, animal fat, cholesterol, and salt, and too little elemental fibre, fruit and vegetables, whole grains — and the principles and practices of preventive, healthy diets are also known. The job then is to disseminate the information and put it into practice in food provision and group meals.

## Strategic directions of implementation

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TASKS	ACTIONS NEEDED
<b>Advances in education</b>	‘Healthy nutrition begins in the family’ - teaching health visitors and mothers on the need of breastfeeding infants to the exclusion of all else until the age of 6 months, and the proper way to wean the infant. Instruction in the basic principles of healthy nutrition from pre-school till college graduation, with particular emphasis on adolescents and pregnant women. Regular education to the public on healthy nutrition - through workplace, neighbourhood and other small communities: in hamlets and villages, and municipal districts, primarily with the participation of NPHMOS staff, health visitors, dieticians, educators, doctors, pharmacists and catering managers. Religious communities, NGOs, activists from local governments, social workers and the Red Cross must be involved in spreading information on healthy nutrition. All this should be backed by the media, and coordinated by NPHMOS.
<b>Improving mass catering (canteen meal services)</b>	The basic principles of healthy nutrition (less fat, animal fat, cholesterol, salt, and more vegetables) need to be introduced to menu planning. Among public meals, there always should be a choice of vegetables (in the spirit of the above).
<b>National Nutritional Policy</b>	Considering that conditions are about to change (accession to the EU), national priorities should be set, and intersectoral cooperation should be established to promote the national goals, relying on conscious use of the political arsenal.  A comprehensive food safety program has to be designed and introduced (coordinated by the health ministry).
<b>Improving foods/labelling</b>	To facilitate healthy nutrition, there needs to be a broader selection of better quality foods (less fat, animal fat, cholesterol, salt, and added sugar, and more elemental fibre),

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which means more research and project development, in coordination with the agriculture ministry. Distinctive logos need to be introduced to facilitate choice, and supports should be offered for advertising them.

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### **Improving monitoring**

Regular, annual analyses (achievements, failures, things to do). Within food purchase statistics (macro and micro) it should be possible to monitor demand for healthy nutrition (whole-grains, lower fat milk and dairy products, etc.). It is essential to investigate the dietary habits and nutritional status of a representative sample of the public. The resulting data can serve as a basis for comparison when evaluating results 5-10 years from now. This nutritional investigation must be initiated in 2003 at latest. In addition, it is particularly important to investigate high-risk groups. For instance, no representative survey of nutritional habits among the Romany population has ever been conducted in Hungary. It also is necessary to study the nutritional habits of single-person households, the elderly, children (1-3-year-olds, adolescents) and the homeless. It would be desirable to coordinate the sub-project with the activities of the NGOs participating in the dissemination of healthy nutrition.

The systems under which food safety data is collected and serviced need to be re-examined, standardised, and updated.

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## **Expected results**

If the sub-project is implemented successfully, the following results can be expected:

- the proportion of energy from fat within nutrition will drop to 33-35% from the current 38%
  - the energy proportion from saturated fat will drop to 10-12% from the current 15-16%
  - the consumption of added sugar will drop
  - consumption of fruit and vegetables will rise to 400-450 grams/day from the current 300 (Family Budget, 2000)
  - the proportion of people who consume fruit and vegetables daily will increase by 50%, while the rate of people who consume three servings a day will double
  - consumption of whole grains will increase by 50%
  - consumption of low-fat milk and dairy products will rise by 10%
  - mortality due to diseases related to nutrition will decrease, or will not increase
  - the prevalence of overweight or obese people over the age of 18 will remain on its current level
  - the prevalence of Type II diabetes will remain on its current level
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- the mortality rate from nutrition-related severe diseases (circulatory, tumour) will decline by 5%
  - in response to preventive measures, the average serum cholesterol level of the population can drop by 7-10%, according to international data
  - the number of infants exclusively breastfed through the age of six months will increase by 10-15%
  - within 10 years the number of food and/or toadstool poisonings occurring in private households will decline by 30%, mass food poisonings from children's meal facilities will go down by 30%, education in the basic principles of food safety will begin in the schools, a system of administrative food safety inspections will increase and HACCP (Hazard Analysis Critical Control Point) specifications will be met
  - there will be a decline in low-nutrition dietary habits, nutritional-insufficiency disorders will decline
  - a policy supporting a uniform national nutritional structure will be established within the given system of conditions.

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## PROMOTING PHYSICAL ACTIVITY

### The Goal:

*To promote an active lifestyle in the broadest possible sectors of the population, to see physical exercise become an internalised need, and to see participation in sports become a generally accepted community and social program.*

- ❑ The people within the population who participate in sports as often, as long and as intensively is physiologically necessary must be increased by at least 15%
- ❑ The number of residents whose physical exercise is not physiologically sufficient, but who nevertheless evolve a lifestyle with increased physical exercise must be increased by at least 25%
- ❑ High level interdepartmental cooperation must be achieved within the area of health, and physical fitness for health, which is an organic part
- ❑ Conditions must be ensured in public education for daily physical exercise and regular sports activity, in keeping with Act 74 of 1993 on Public Education
- ❑ Everyday classes in the theory and practice of physical education must be built into the educational curricula for all children in all types of schools where students attend classes full time.
- ❑ Continuous and extensive information through the media on the importance, advantages, and accessibility of regular exercise and sports
- ❑ Leisure sporting opportunities must become available for all age groups and all social strata in an appropriate number of satisfactory quality sports facilities throughout the country.

### Situation assessment

The central elements of the major lifestyle strategies that define health are: healthy nutrition, regular physical exercise, an absence of addictive behaviours, and sufficient, proper quality rest. Everyone knows and recognises the physiological and psychological importance of regular movement, exercise, sports. Everyone knows the damage to health caused by sedentary lifestyles, and sooner or later almost everyone experiences it as well. Nevertheless, the average time per day spent by the population at some physical activity does not exceed ten minutes a day. Less than one-fifth of adults participate in any physical activity with some

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degree of regularity. In the reverse, people who regularly exercise and move, experience growth in both their physical and intellectual performance.

According to an empiric survey completed by social research institute TÁRKI (1998): ‘Deliberate physical exercise is not widespread among the population. The economically active portion of the population is the most sedentary. Six out of every ten adult workers do not move either on weekdays or weekends - they do not go for walks, excursions, or participate in sports. There is a clear linear relationship between educational level and deliberately chosen sports. The data show that small private businesses and farm workers exploit their bodies to a higher-than-average degree, and here men are at greater risk than women.’

Not even in the defence sector does a physically active lifestyle play an important and necessary role, best shown by the higher rate of cardio-vascular and spinal disorders appearing in armed forces health statistics than among the civilian population.

Among people expected to do duty and on-call service (e.g. military, police, healthcare workers), a healthy lifestyle deserves to be underlined, since meeting these service tasks appears as a risk factor, meaning an additional physical and mental burden. Evidence of this is that for soldiers, life expectancy at birth is lower than that of the civilian population, even during peacetime.

To assist the individual in making a healthy choice -- assuming that will be her/his choice -- there is much that the political decision-makers, the media, teachers, health workers and parents can do, according to a WHO survey.

An absence of leisure, related to living standards, plays one of the leading roles in evolving a sedentary lifestyle. However, the system of socialisation, which does not promote physical exercise, is also at fault. Cooperation between the government health and sport organisations is unsatisfactory. Sports policy, in its actions, continues to be oriented to high-level competitive sports. While the supply of leisure sports has increased, the financing available for it has dropped. The Hungarian media almost wholly ignores the issue of a physically richer lifestyle, of leisure sports, and of sports for one’s health. Extra-curricular sports opportunities for students are insufficient. Physical education within the schools often tends to be centred on specific sports and performance. The training of physical education teachers has to be altered to introduce proper physical education that conforms to a healthy lifestyle.

**Strategic directions of implementation**

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<b>TASKS</b>	<b>ACTIONS NEEDED</b>
<b>Advancing cooperation</b>	Evolving and developing regular and appropriate intersectoral — government, non-profit, and business sectors cooperation to promote physical fitness and sports for the general public. It also is necessary for the various government departments, such as health, education, youth and sports, environment, defence, regional and settlement development, media, farming, family affairs, etc., to work together and in coordination.

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**Expanding education**

Every day, health-promoting physical movement and sports — physical education — must be made mandatory in public education. This requires more specialists and more sports facilities, meaning that there is a need for resources and a shift in outlook. Current physical education, which, for the most part is performance centred, and sports clubs, which for the most part are focused on training new competitors in top Olympic sports, need to change their outlooks, which requires a re-examination of the way sports trainers and sport teachers are trained. The training should include an appropriate rate of quality training in way-of-life sports, and in exercises needed to maintain a healthy spine (Sub-project 1. locomotor diseases) Teachers should combine their expertise in sports with way of life sports, taught regularly in physical education classes, in which students can be moderately successful and improve their self-confidence. Regular physical fitness exercises for health must be an integral part of training for teachers on all levels. In the 2002/2003 academic year, another grant scheme with participation of the Ministry of Health, Social and Family Affairs, the Ministry of Education and Ministry of Children, Youth, and Sports, and KOMA – Public Foundation for the Modernisation of Public Education, relying on the experiences gathered so far and offering the best practices. Within the state budget for 2004, systematised financing should be initiated and gradually spread to all schools until 2012. Parallel to this process, the lacking professional and objective conditions should be established gradually, in cooperation between the Ministry of Education and the Ministry of Children, Youth and Sports.

Physical education in full-time trade training schools is also important.

Properly trained specialists need to begin working with all categories where there are duty and on-call services, but particularly with the armed forces.

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**Education, training and continuing education for health professionals**

Health professionals, particularly in primary health care, should undergo training and continuing education, for instance through the 'credit' system, where the focus is almost exclusively therapy, or in a lucky case, also on preventive care, should be expanded to embrace health development and its vital parts, i.e. basic knowledge on regular physical exercise and sports. The network of school physicians needs to be strengthened by regular physical exercise as a basic preventive factor. Healthcare professionals are responsible for influencing decision-makers, for showing them the importance of their work, and for supplying newsworthy information to the media on an ongoing basis.



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**Close cooperation with the media, both printed and electronic**

Physical culture needs to be appropriately emphasised within the social order of values, with the assistance of the media. The media is second only to political decision-makers in shaping opinion to influence the population of a country to make healthier choices. Support from the national, but particularly from the local media through professional materials, news, and messages from experts that are understandable to the public is vital. Leisure sports must be presented and models reviewed far more often than occurs at present.

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**Increasing the number and improving the quality of sports facilities**

Increasing and improving sports facilities are expensive. In general, local resources are available in almost all communities. Enlargement can begin in any way, ranging from an expensive bicycle path to a swimming pool, to simply renovating a dressing room and shower, to setting a simple room for gymnastics to 'nature is the sports facility' approach. It is important that all bids for funds be made as public as possible and everyone should be encouraged to bid.

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**Supporting people with disabilities**

We need to increase the number of citizens with disabilities who regularly participate in physical exercises. All physical education teachers should learn the special information on sports for people with disabilities, to be able to do professional level work with such students who are mainstreamed, or if not, to be able to find the right professionals for them. Sports trainers need to learn the basics of their sports as adapted to be played by persons with disabilities.

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**Jointly monitoring the National Programme and its sub-projects**

It is absolutely essential to monitor changes in the most important health specifics of the public resulting from a higher level of fitness and better physical performance, by applying an appropriate system of indicators. Measurement and benchmarking through an established and internationally accepted indicator system, as we approach EU accession, are necessary in order to attain the objective.

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**Expected results**

- ❑ The public will increasingly choose a more physically intensive way of life and physical training and sporting opportunities will become a community and social program for people of all ages (from extra-curricular training to dance communities for retirees).
- ❑ Employers and employees will become interested in health promotion and will be willing to do something about it.

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- ❑ On national level, there will be fewer absences from school and fewer days spent by workers on sick leave.
  - ❑ By continuously increasing physical fitness to promote health, in 10 years, such activities will be part of public education, and there will also be a minimum opportunity to participate in sports in higher education.
  - ❑ Everyday physical training will be introduced on general scale on conclusion of the armed forces reform, and will become more effective in the practices of the defence sphere
  - ❑ The National Core Curriculum and the framework curriculum will be amended after being re-visited.
  - ❑ Physical education instructors, recreation experts, sports instructions, and sports trainers will receive the appropriate training and be sufficiently prepared to meet the increased demands of the public for physical fitness and sports.
  - ❑ Health professionals, particularly professionals in sports health and primary health care, such as family practitioner, school physician, military physician, health visitor, will have the knowledge to handle health development.
  - ❑ The media will offer regular and continuous messages on leisure sports to the entire population.
  - ❑ There will be a measurably increased set of facilities for leisure sports, and a broader election of leisure competitions in more leisure sports associations. Within this, school sports facilities will be open from morning till evening, and their capacities will be available to local governments, local supporters, NGOs, etc.
  - ❑ There will be a larger number of healthier people in a better mood within the country.

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# PUBLIC HEALTH AND EPIDEMIOLOGICAL SAFETY

## The Goal:

*Using primary prevention to offer healthy years of life and a safer, longer life.*

- To rapidly recognise all unusual events (including those where terrorism is suspect) that can threaten public health, and to establish a rapid reaction ability within NPHMOS (based on existing systems) able to effectively avert the threat.
- Reinforcing chemical safety to prevent damage to health or the environment caused by hazardous chemicals.
- Reinforcing radiation safety to prevent radiation sources from causing any health hazard.
- Designing a surveillance system to monitor biological emergencies, to achieve the early recognition of microbiological or biological threats, so that they can be averted rapidly.
- Preventing workplace-based health impairments.
- Giving rapid assessment of risks to public health coming from manufacturing facilities, managing and communicating the risks.
- Developing and operating an information system that supports public health safety.

## Situation assessment

### *Acute impacts, extraordinary events - rapid response*

The number of unexpected events seriously damaging human health has been rising at an alarming rate.

In the past 20 years nearly three million people have been killed in natural disasters. Since 1990, six million people have died in armed conflicts, and there also has been a sharp global rise in conflict-related diseases. Each and every year one in five members of the United Nations faces a major crisis (WHO/EURO, 2002). The number of on-the-job accidents amounts to roughly 120 million a year, and about 200,000 of them prove fatal (it is the equivalent of having 2-3 Jumbo jets crash every single day). To this, of late we have had to add famine and consumption of contaminated food, which has made more than 10 million people ill and killed nearly 2 million children, fatal communicable diseases (HIV/AIDS, tuberculosis, malaria), very high rates of infant and maternal mortality, and acts of terror employing widely diverse pathogens.

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In Hungary, we have traditionally had to contend with natural disasters (floods and earthquakes) but today we also have to consider the risk of one mass or a large number of individual on-the-job accidents, communicable diseases (e.g., HIV/AIDS, tuberculosis, or other Category 3 or 4 pathogens), acts of terrorism or where terrorism is suspected, of particularly hazardous materials that can be smuggled into the country (banned agents, radioactive materials), along with the possibility of food poisoning and food contamination affecting a high number of consumers at the very same time.

The concerns are exacerbated by:

- The unfavourable epidemiological situation in some of the surrounding countries; the chance of introducing a communicable disease through global air travel; tourism, which can 'export' epidemics; or the appearance of new types of infection due to less known or emerging pathogens.
- As borders disappear and goods flow freely, hazardous materials or radioactive agents can slip through public health screenings, to eventually show up 'on the market'.
- Globalisation — international food chains are built up, and materials and products from 'third' countries appear on the market where they may put the population, consumers at risk.
- As chemicals become widespread, we sometimes see environment-related illnesses the origins of which cannot be properly determined (hidden contaminants); seeking medical advice and medical treatment for these puts an added burden on the healthcare system.
- We are now seeing new technologies which may give rise to less known risk factors (genetic manipulation, biological plant protection, cloning).
- The spread of strains of resistant bacteria, due to the improper use of antibiotics

The significance of these unexpected events is that their consequences are complex, in some cases (for instance, with acts of terrorism) the causes may not be recognised immediately, but the consequences (and finding the cause) require immediate responses from the health authorities. Delays or unprofessionalism could lead to mass avoidable deaths and serious permanent damage to health. Readiness to rapidly respond to extraordinary events presenting one or more hazardous factors, involving institutional operations, instrumentation, and human resources, is a top priority if we are to maintain public health safety. The EU expects the health authorities to create a rapid response capacity, and the WHO and other UN organisations strongly recommend that we do so.

### ***Repeated, Chronic, Delayed Effects - Primary Prevention***

Although physical (e.g., radioactivity, noise, vibration), chemical (various hazardous materials), biological (e.g., viruses, bacteria) and other factors appear repeatedly or regularly in our environment, and we also face increased physical or emotional loads, the consequences are not as spectacular as the extraordinary events requiring rapid reaction, but their public health significance is far greater.

Each year, 58-150 million people in the world of labour suffer occupational diseases, and among non-workers, many more than that (we have no reliable statistics) become ill because of unacceptable hygienic conditions. In Hungary the number of notified cases of occupational disease is less than 1,000, but we know that the real number has to be 7,000-10,000 per year. Calculating with internationally accepted data we assume that there are 1,200-1,400 work-

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related tumours each year, and we also know that 75-85% of malignancies are triggered by environmental pathogens (meaning that these pathogens are responsible for 35,000-28,000 of the 33,000 fatalities in Hungary due to malignant tumours). In Europe, diseases spread by food affect 130 million people each year. We need only to think of the diseases of poverty, environmental allergies, poor quality drinking water, unsafe foods, unacceptable radiation contamination, insufficient measures to halt the damaging affects of chemicals (unsatisfactory chemical safety), polluted air, soil contaminated by improperly treated waste materials, and the mass of diseases they cause. Today there are about 15 million chemical agents registered in the world, of which 110,000 are commercially available. According to WHO, each hazardous chemical agent has to be considered a potential pathogen that will cause at least one disease; in other words, the world's chemical agents can potentially cause more types of diseases than all the pathogens currently known in the world. We know little about the affects of chemicals containing agents that currently qualify as being below a contamination threshold value, and what pathological affects they may have. These low-dose chemicals may trigger susceptibility to non-communicable diseases (e.g., cardio-vascular diseases). What we do know is that we now have to calculate with their immunotoxic effects, impact on the IQ, and their ability to disrupt endocrine regulation, etc.

### **The role of NPHMOS in maintaining public health safety**

Pursuant to Act 11 of 1991, NPHMOS is responsible for handling all public health government tasks related to prevention.

Including the achievement of public health safety within the framework of the public health program has the following rationale. The introduction of legislation to the Hungarian system in harmonizing EU law, which, when effectively implemented (enforcement and judicature) is equal to successfully implementing a prevention program. Although NPHMOS staff is mandated to control the enforcement of these legal instruments, it needs an appropriate infrastructure and satisfactory information to do the job effectively.

Therefore, it is a vital public health interest for NPHMOS to receive support ignored till now, first of all support requiring training, which is necessary to achieve, via a genuinely primary prevention program, that not only life expectancy at birth, but the number of healthy years of life expected at birth, which is currently at an unprecedented low point (< 60 years, WHO/Euro, 2002) should start to grow significantly at last.

## **Strategic directions of implementation**

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### **TASKS**

### **ACTIONS NEEDED**

#### **Institutional development**

To build the capacities to recognise and identify chemical, biological, or physical hazards in time, to quickly and reliably determine and diagnose consequences, relying on existing systems with a mind to long-term sustainability.

In emergency situations i) ensuring the special conditions for healthcare tasks beyond the scope of NPHMOS, such as patient transport and placement (isolation, quarantine),

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managing tasks related to the deceased, professional healthcare personnel, healthcare services that guarantee the accessibility of medications and other necessary tools, databases on medications and implements storehouses, ii) establishing a multidisciplinary standby operative specialist unit for epidemic diseases in managing microbiological emergencies.

Setting down the mandatory tasks of a rapid reaction policy in a law.

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**Professional, methodological advances, data collection monitoring systems**

The professional and methodological foundation for rapid reaction: the establishment of a chain of alarm, of procedures, of professional sampling (unknown sample, samples for chemical or biological testing), transport (samples that are chemically, microbiologically or radiation-contaminated, or unknown samples), processing, reporting results, measures in elaborating protocols and methodologies.

Establishing and disseminating the guidelines and rules that promote the management of emergency situations (including ones where terrorism is suspected) and coordination in the response to the emergency with the other authorities or service providers, transferring patients with highly hazardous contagious diseases (tourists, businesspeople, etc.) across national borders, establishing the legal specifications behind measures regarding hazardous materials and radioactive materials brought into the country illegally, and building up a monitoring system suitable for discovering all hazardous materials at the border. Elaborating a comprehensive epidemiological safety program

Elaborating a comprehensive epidemiological safety program (including measures of protection from epidemics emerging in the neighbouring countries or the region).

Updating the national profile for chemical safety and a national program of action for chemical safety based on the conclusions.

Making the professional and methodological preparations needed to survey the environmental health hazards of industrial facilities.

Elaborating a national program of labour hygiene (a country profile) using ILO – WHO/Euro guidelines

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**Training, education, abilities**

Training, education and continuing education, with a particular focus on emergency situation information and operations, training in and presentation of professional algorithms i) for NPHMOS staff, ii) for specialists in

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occupational health services, iii) and for persons involved with sister authorities operating in radiation protection.

To improve public health safety, we shall design the expectations in professional training for both NPHMOS staff and staff from sister organisations, as well as continuing education, which will include testing. NPHMOS will be in charge of this operation

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**Communication (with the profession, the public, the media)**

Distribution of large issues of dietary recommendations (food health procedures to be used in the household, advice)

Distribution of information on food, chemical safety, radiation health, and epidemiology in small communities (NGOs, villages, municipal districts) on introducing the basic principles of food and chemical safety, radiation health, and epidemiology to formal school education as a mandatory subject (mandatory education and secondary schools), to include trade training schools.

Offering information to the public on environmental and health hazards resulting from industrial activity, possible damaging effects, and on prevention.

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**Organisation, coordination**

Updating the NPHMOS' organisation (Office of the Chief Medical Officer and municipal institutions to be reinforced, county institutions and national centres, regional centres to be rationalised and revamped).

Designing the quality control for the healthcare service and setting it into a law.

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**Expected results**

- ◆ Designing, introducing and extensively presenting the 'rapid reaction' policy, establishing the legislation for the rapid reaction policy.
- ◆ With infrastructural developments, NPHMOS's rapid reaction capacity and strategy and practice in discovering and identifying chemical, biological, and physical (radioactive) hazards will be designed, making it possible to quickly and reliably define and diagnose consequences.
- ◆ Recognition of radioactive and hazardous materials banned from the country at the border, preventing them from entry, and managing them safely.
- ◆ Continuing to reduce the occurrence of communicable diseases. Rapid recognition and localisation of epidemics, rapid diagnosis of communicable diseases brought in from other countries and preventing the spread within the country, recognising the significance to public health of nosocomial infections, making hygienic and infection control recommendations and applying protocols to prevent them. Operating a rapid reaction system that conforms to the epidemiological monitoring system operating within the EU.

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- ◆ Mandatory education for children and young specialists, and an opportunity during higher education to learn the vital principles of chemical safety, and to be able to apply them in practice.
  - ◆ Achieve a reduction in fear of extraordinary events among the public, an improvement in the general sense of security, and in the psychological comfort level.
  - ◆ NPHMOS, in partnership with the supervisory authorities of all areas involved, will implement the 141 EU guidelines, decisions, resolutions, decrees and recommendations in the area of public health safety (including epidemiology, environmental health, workplace health, chemical safety, food safety, and radiation health) that have been transposed into the Hungarian legal system (with the Ministry of Health as 'primary' sponsor). As a result, in the next five years there will be no further increase in the number of environmentally triggered allergies, a 10% decline in the prevalence of job-related locomotor diseases; within 5 years the rate of successfully treated tuberculosis patients will be increased to 85%; by 2010 the prevalence of tuberculosis will be reduced from 32.5/100,000 to 15-20/100,000; within 10 years the prevalence of cardio-vascular disorders caused by environmental and workplace factors, lifestyle-related hazardous materials, and physical pathogens will be cut by 10%; within 10-25 years the prevalence of tumours of environmental origin (including food contamination) will be reduced by 10-25%. When tumours are caused by environmental factors the latency period between the time the pathogen infiltrates the body and the malignancy (tumour) appears ranges from 10-40 years, thus the earliest time at which results can be measured after starting the program is 10 years.



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# NATIONAL ENVIRONMENT AND HEALTH ACTION PROGRAMME

## The Goal:

*To promote the evolvement of a health-supporting environment by reviewing and prioritising the most important environmental health problems, and then resolving them on national, regional, and local level, so that an adequate prevention system can become viable*

- ❑ To reduce the frequency of airway allergies and improve the general health of the population by reducing the concentration of biological allergens.
- ❑ To analyse soil contamination in residential areas and the damage to the environment caused by waste disposal sites, followed by recommendations for measures to restore the status quo ante.
- ❑ To pinpoint all buildings with insulation that contains asbestos, to determine the urgency of the asbestos removal, to remove the asbestos
- ❑ To prepare a dioxin map, to establish a dioxin sample bank
- ❑ To promote human adaptation to the global effects of climate changes, to reduce mortality and morbidity related to climate changes
- ❑ To improve the hygienic safety of recreational waters and mineral and therapeutic waters
- ❑ To establish an electromagnetic environment survey program and set up an exposure database
- ❑ To design tests needed to estimate the risk to the public from radon exposure, which will include a radon map of the country, to elaborate the surveying methods, and to prepare for implementation
- ❑ To prepare a noise map with special regard to big cities and areas with heavy traffic, as well as areas visited by children and youth who are especially sensitive to noise or continuous noise exposure (nurseries, schools, playgrounds).

## Situation assessment

*The National Environment and Health Action Programme* was initiated in 1997 as a sub-project of the *National Environment Programme*, in the wake of recommendations made in a declaration at the 2<sup>nd</sup> Conference of Environment and Health Ministers (Helsinki, 1994). (The

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program was adopted for 6 years by parliament in 1997). Its fundamental goals are to improve the health of the public and promote the evolvement of an environment that is supportive of health. This involves reviewing the most important environmental health problems, setting priorities, reviewing opportunities for solution on national, regional, and local level, and designing concrete actions and projects to promote an environment conducive to health promotion, which can be financed. The second six-year plan of the National Environment Programme has been designed, and includes the tasks of the National Environment and Health Action Programme, which is connected to it.

The National Environment and Health Action Programme is set within the framework of the Johan Béla National Programme for the Decade of Health , and considering its experience and achievements, in which it has intended a priority role for smaller and larger local communities and governments, it has become necessary to design new challenges and programmes. The National Environment Programme and the Action programmes within the National Programme intend to complement one another in attaining the planned targets. The basis for the National Environment and Health Action Programme within the Johan Béla National Programme for the Decade of Health is to provide the basics needed for sustainable development.

The World Conference and Earth Summit in Johannesburg in August and September of 2002 stressed the issues of sustainable development as strategic elements. The role of public health in implementation: to significantly reduce the prevalence of water-borne diseases it pledged to cut the number of people who do not have reliable drinking water supplies by half by 2015; by introducing intensive programmes to reduce water pollution it pledged to reduce health hazards and protect the ecosystem; it pledged to reduce environmental influences that are health hazards with a particular mind to the specific requirements of children and to the relationship between poverty, the environment, and health; it pledged to reduce diseases to the airways caused by atmospheric pollution with a particular mind to women and children; to reduce environmental and workplace chemical exposure; to support implementation of the Prior Informed Consent (PIC) and Persistent Organic Pollutants (POP) Conventions, and to ensure a significant role to the treatment of chemical agents along the strategic lines set forth by the Intergovernmental Forum on Chemical Safety (IFCS) on the basis of the Bahia Declaration, and to heighten scientifically founded risk assessment of chemical agents and waste, considering human health, the water tables, disease vectors, biodiversity, and the ecosystem.

International experience reports that 70% of agents harmful to the health enter our bodies through food, 10% through water, and 20% through the air. In past years, with a reduction in industrial output and the modernisation of household heating systems, there was a significant decline in heat-related industrial and household effluents, but at the same time there was no decline in transportation-related pollution.

The Hungarian public has seen a steady rise in allergy-related illness, year after year, with the most serious problem caused by ragweed pollen.

Almost the entire population has access to mains water, but the quality parameters of the drinking water in many communities is not up to valid threshold limit values (e.g., the nitrate content, and the high concentration of natural arsenic.)

Certain sections of the rivers are unsuitable for swimming, while the quality of stationary waters (lakes) is satisfactory.

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## Strategic directions of implementation

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### TASKS

### ACTIONS NEEDED

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#### Soil analysis

Investigate soil contamination in communities in the county seats/cities of the various regions, with a particular focus on the city centres and residential areas around current and former industrial areas.

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#### Asbestos removal

Discovery of buildings containing asbestos insulation, determining how urgent the asbestos removal is, and removal of the asbestos. (Note: this task relates only to the portion of the country east of the Danube, since the Environment Ministry has already surveyed Transdanubia, i.e. the area to the west.)

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#### Preparing a dioxin map, establishing a dioxin sample bank

Analysis of environmental and biological samples, establishment of a collection of representative environmental and human biological samples (environmental sample bank) [The basic reason why it is necessary to determine the presence of dioxins and compounds containing toxic dioxin is to enable comparisons to be made between the situation in Hungary and the other, more advanced countries of Europe, and to be able to follow the historic trend of dioxin contamination in Hungary (preparing a dioxin map of Hungary). Once the amount of dioxin in the various compounds becomes known, the various samples will make it possible to determine the extent of the hazard to the public.]

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#### Advancing education and information

Providing information to the public on adjusting to the changed weather situation, dissemination of appropriate lifestyle, nutritional, behavioural habits, with the participation of health visitors, teachers and NGOs, coordinated by NPHMOS. Appropriate environmental health programmes of instruction have to be designed to cover all education from pre-school to secondary school. Compilation of the pre-school material, with the material for the upper grades of primary school available of an interactive CD-ROM available through SULINET [Computer-based National Schoolnetwork, a national ICT program]. Informative materials are to be prepared for the public and made available through the Internet. Regular briefings and informative materials will be made available to adults through the media, designed by media professionals,

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with the participation of teachers, health service workers (primarily health visitors), and activists from NGOs and local governments, under the guidance of NPHMOS.

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**Improving monitoring**

The NPHMOS Aerobiological Network which provides continuous monitoring of pollen levels for the entire country will be expanded to include new stations, and the existing network will undergo maintenance. A surveillance system for airway allergies will be designed. Sensitisation level will be investigated on a representative sample of the population.

The monitoring system will be augmented to include studies of water quality changes after it is joined by precipitation run-off (there will be a particular focus on salmonella, various viruses, and pathogenic protozoa). Bathers will be investigated to examine the allergising and skin irritant effects of cyanobacteria when algae proliferate.

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**Developing methodology**

The investigative methods for demonstrating the presence of viruses and protozoa will be designed and advanced to study people bathing in natural water and artificial pools.

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**Improving information**

Information will be provided on recreational water-borne diseases through the media.

Information on water quality will be continuously available to the public on site and in other accessible places (local and national media, Internet)

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**Quality assurance for mineral waters and therapeutic waters**

Developing a system of hygienic regulation for mineral and therapeutic waters being used for different purposes, and making the system a part of quality control. Elaboration of a monitoring system and introduction to the areas being sampled.

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**Computer modelling and measurement of environmental exposure to radio frequency relay stations located in the residential and natural environment**

Preparing a computerised model of the radio frequency load on the environment, using the technical data of radio transmitters.

Collecting data from on site measurements to validate the model

Establishing a data base and making it accessible to the public (e.g. website)

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**Preparing a model and conducting on site measurements of environmental and human exposure to the 50Hz electric and magnetic fields brought about by the transport and**

Preparing a computerised model of the magnetic and electrical load on the environment, using data from high voltage power lines and transformer facilities.

Making on site measurements, which will be collected to validate the model

Establishing a database to be made accessible to the public

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**distribution of mains current** (e.g., a website)

**Data collection** Mapping out the organisations and ways of collecting data for the radon model, and designing it

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**Advancing measurement method** Selecting a measurement method on an appropriate professional level, after studying international experience and considering domestic conditions, modifying it if necessary, and designing the system.

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**Selecting measurement tools** Prepare proposal on procurement of the measurement tools needed for the measurement method selected.

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**Preparing a noise map** Measurements of population exposure to noise due to transport and big cities, mapping out the current situation and initiating the formulation of possible means to decrease noise levels

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## Expected results

Counting on the cooperation of larger and smaller communities and local governments, when the targets of the 10-year program are met, we can attain an environmental health situation which can resolve (eliminate) the most significant problems, creating a setting in which primary prevention can be applied, offering a point of departure for sustainable development. In other words, after this point it will become possible to effectively use different resources, to reduce waste to the lowest possible level (re-use and recycle), to reduce environmental pollution to a tolerable level, to protect diversity, to meet local demands from local resources, to offer acceptable living conditions to meet the right to life, to clean water, to a satisfactory amount of food, to information, and to access knowledge. It is important to stress that the investigations on attainment of the targeted goals are not an end in themselves, but promote the evolvement of public health conditions in which the tools of primary prevention can operate.

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**CREATING  
A HEALTH  
PROMOTING SOCIAL  
ENVIRONMENT**

**PROGRAMS OF  
HEALTHY  
LIFESTYLES,  
REDUCING RISK  
FACTORS TO HUMAN  
HEALTH**

**PREVENTING  
AVOIDABLE  
MORTALITY,  
MORBIDITY AND  
DISABILITY**

**STRENGTHENING THE  
INSTITUTIONAL  
SYSTEM OF  
HEALTHCARE AND  
PUBLIC HEALTH  
TO IMPROVE HEALTH**

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# REDUCING MORBIDITY AND MORTALITY DUE TO CORONARY HEART DISEASES AND CEREBROVASCULAR DISEASES

## The Goal:

*To cut premature mortality due to coronary heart and cerebro-vascular diseases by another 20%*

- ❑ To cut premature mortality from coronary heart disease by at least 20%
- ❑ To reduce premature mortality due to cerebro-vascular disorders by at least 20%
- ❑ To improve the effectiveness of screenings for hypertension so as to identify at least 75% of all hypertensive persons
- ❑ To increase the rate of people receiving treatment for hypertension to at least 60%
- ❑ To increase the rate of patients with blood pressures below 140/90 Hgmm by at least 30% through effective treatment of hypertension
- ❑ To make at least 80% of the adult population aware of the symptoms of impending myocardial infarction and stroke, and to be aware of both the need and the way to seek medical assistance
- ❑ To implement professional college guidelines on type and duration of treatment for at least 80% of acute cases
- ❑ To make the achievements of Evidence-Based Medicine broadly accessible to both the professional community and the public

## Situation assessment

Over half of overall mortalities in Hungary are the result of cardio-vascular diseases, and coronary heart disease is the number one killer. While in western countries, mortalities due to cardio-vascular diseases (cardio-vascular disorder: coronary heart disease, cerebro-vascular accident, peripheral vascular disease and aorta diseases combined) have been cut by 20-30% since 1970 because of changes in dietary habits, exercise, and up-to-date treatment, in Hungary the mortality rate from cardio-vascular diseases has increased. By 1997, the situation deteriorated to the point where premature death from cardio-vascular disease, and within that from coronary heart disease (in those aged 0-64 years) is three times the European average and even exceeds the average for the nations of Eastern and Central Europe. Of the risk factors for cardio-vascular disease, high cholesterol levels, obesity, diabetes, and hypertension are closely linked to nutrition and are involved in 30-80% of cardio-vascular diseases. In past decades, effective prevention and, to an extent, drug administration, significantly reduced cholesterol levels and blood pressure in the Western countries, but the rate of obesity and newly diagnosed diabetes increased by over 10%, just as it did in Hungary. In other words,

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success in cutting the influence of these four factors was only partial in the West, and nil in Hungary. It appears realistic for Hungary to focus on reducing high cholesterol levels and hypertension, while only focusing on keeping obesity and Type II diabetes prevalence from rising. The international experience mentioned above shows that attempts to reduce consumption of animal fat were only partly successful, so we need to devote equal attention to reducing energy intake, which is demonstrating a similar growth trend to that in Western countries, and to increasing energy outflow (exercise). In screening and continuing care, we need to pay special attention to people with multimetabolic syndrome, diabetes and ischemic disorders. We have to see to it that emergency medical care practices include the professionally indicated interventions set forth in guidelines, throughout the country.

## Strategic directions of implementation

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### TASKS

### ACTIONS NEEDED

#### Primary prevention

Improving public information on health (and on diseases) on the broadest possible scale, together with their abilities, conduct and behaviour. Attention has to be drawn on proper dietary habits, the importance of, and engaging in, regular physical exercise, on the damaging effects of cigarette smoking, and efforts have to be made to evolve appropriate behaviours.

More attention needs to be focused on the preventive role of physical activity. Regular physical activity has favourable effects on weight, blood pressure, the carbohydrate metabolism and on insulin sensitivity, and most likely also has a direct protective influence, preventing acute cardiac accidents. In addition, regular physical activity has a favourable psychological effect. This considered, physical activity of an appropriate intensity, duration and frequency is an important part of a healthy lifestyle and prevention of coronary heart diseases.

The public must be made aware of basic knowledge relating to blood pressure (hypertension) obesity, high blood lipid levels, and diabetes.

- School programmes (curriculum, school settings), disseminating influence to other settings
- The adult population needs to learn the risk factors. Educational initiatives can be outside the various settings, including club networks or regular programmes.
- Certain target groups, such as media professionals and political officials need particularly extensive briefing for this is the only way to guarantee the sustainability and success of the program.



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<b>University education</b>	A two-week integration course on prevention, treatments, and rehabilitation of public health diseases in the last undergraduate year when, concentrated decisively on practical patient care.
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<b>Continuing education</b>	The personnel and objective criteria for acquiring appropriate specialist qualifications (such as ‘Physician Qualified in Continuing Care of Hypertension’, ‘Qualified Diabetologist’, ‘Obesity Specialist’, ‘Lipidologist’, ‘Angiologist’, <i>Specialist in Cerebrovascular Diseases</i> ) are partly defined (e.g., hypertension, diabetes), partly will need to be defined in conformity with European and American qualifications. The preventive outlook and the program targets need to become part of the methodology. Primary health care and occupational health services staff need to get acquainted with issues related to the prevention of cardiovascular disorders, and application of these methods should become a key element in judging the quality of primary health care services.
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<b>Developing registry systems in continuing care</b>	Records need to be made up to contain the most important clinical data on patients using modern means of information and communication technology to actively assist caregivers. They are to be used in the place where compiled, such as in family practitioners practices and outpatient specialist centres.
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<b>Expected results</b>
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Attaining the goal of the sub-project to reduce morbidity and mortality due to cardio-vascular diseases depends to an extent on the combined and successful implementation of several other sub-projects. These include reducing cigarette smoking, promoting healthy nutrition and physical fitness, alcohol prevention, and even improving mental health. If all of these sub-projects are completed, not only will there be a significant improvement in the mortality rate from cardio-vascular diseases, but also in overall mortality, which could even increase life expectancy at birth. In the 10 years of the program it may be possible to reduce the six-year-gap between Hungarian life expectancy and the average for the EU.

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# REDUCING MORBIDITY AND MORTALITY DUE TO NEOPLASMS

## The Goal:

*To stop the rising mortality trend due to tumours*

- Establishing a uniform system of Oncology Centres
- Enforcing 'oncology awareness' in primary health care
- Introducing uniform graduate and post-graduate education
- Continuously providing the infrastructure needed to meet oncology tasks
- Regularly improving data collection systems on oncological activity and tumour occurrence
- Building up a nation-wide network for the rehabilitation of oncology patients

## Situation assessment

Mortality rates due to malignant tumours have been extremely high for decades, putting them behind cardio-vascular mortalities, as the second leading cause of death, with a prevalence of about 25%.

In major European and international mortality surveys, Hungary holds first place for males and second place for females. So we have the right to ask why so many of us die from or become ill with cancer, whether there are points at which we can break out of the cycle, and if so, where are they?

In the past ten years the National Institute for Oncology has regularly analysed the above phenomenon, established a National Cancer Control Programme conforming to international expectations and domestic possibilities, and thanks to extensive cooperation, it published a long overdue handbook containing a significant amount of information that can serve as a guideline in many areas of oncology. In order to reduce the particularly high mortality rate due to tumours, we need to know the data made available by mortality statistics and the National Cancer Registry, which was already operating reliably in 2001.

The burden on society due to tumours may be decreased primarily by preventing malignancies from developing and by diagnosing them early. In keeping with this, the main thrust of the program is to implement in practice an outlook focused on prevention.

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## Strategic directions of implementation

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TASKS	ACTIONS NEEDED
<b>Oncology awareness in primary health care</b>	<p>To introduce a mandatory primary care physician guideline and examination protocol to physically examine conditions that are suspicious of cancer. Teaching the identification of pre-cancerous conditions.</p> <p>Regular periodic check-ups of individuals who qualify as high-risk for tumours, and monitoring to be completed primarily by the family practitioner, the dentist, and the heads of alcohol clinics and TB screening stations.</p> <p>Design and introduction of screening-continuing care guidelines of continuing education, and of quality assurance criteria in primary health care.</p>
<b>Education, increasing public awareness</b>	<p>Adding basic oncology information as an integral part of secondary school health education programmes. Increasing nation-wide public awareness of cancer prevention with the involvement of the Hungarian League Against Cancer.</p> <p>Preventing tumours, patient management linked to oncology screening, home care for tumour patients.</p> <p>Using the National Program for uniform basic and continuing education in oncological patient care, with the involvement of university and college departments.</p>
<b>Ensuring hospital beds and improving rehabilitation</b>	<p>Separation of chemotherapy and radiation therapy beds is a significant element of the proposal as is the continuous development of rehabilitation activity.</p>
<b>Oncology centres</b>	<p>The Oncology Centres will be in charge of regional patient care management and quality assurance. The Oncology Centres are to be established by integrating the regionally responsible oncology work stations.</p>
<b>Improving data provision systems</b>	<p>Establishment of a National Oncology Data Clearinghouse.</p> <p>Operating an oncology portal to provide continuous information to the public. Organising and publishing population-wide screenings and appropriate screening methods.</p>

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## **Expected results**

Stopping the rise in tumour deaths

Uniform graduate training in oncology, writing the textbook. Training 350 specialists in oncology and 300 specialist nurses by 2010.

Offering all patients equal opportunity to access qualified professional care.

Organising the Oncology Centres on the basis of uniform principles. Density: 2 centres/1 million residents.

Establishing a database on the status of oncology care in Hungary, to assist screening and the coordinated operation of the National Cancer Registry

Setting up a system of rehabilitation institutions.

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# STRENGTHENING MENTAL HEALTH

## The Goal:

*To improve the population's overall mental health and quality of life, to improve health consciousness and demonstrate mental health as a value*

- ❑ Primary prevention of mental disorders
- ❑ Early recognition and treatment of psychiatric disorders, sensitising primary health care staff to psychiatric disturbances
- ❑ Improving mental health promotion services in primary health care
- ❑ Reducing the suicide rate of minors by at least 20%
- ❑ Reducing the number of suicides to no more than 20/100,000
- ❑ Achieving at least a 30% improvement in the number of persons being treated for depression
- ❑ Improving the mental health promotion outlooks of teachers and people in the helping professions, and increasing their levels of knowledge to help students to promote their mental health.

## **Situation assessment**

Improving and promoting mental health require long-term planning and consistent implementation. Representing mental health as a value in a modern and high-standard may offer a unity of interdepartmental programmes that are able to integrate differences in interests, and to transcend terms of office.

Asserting mental health considerations in all areas of public life is an essential government task requires high-level representation.

Hungary's mental health data are extremely unfavourable, at the same time we have to realise that there really is little reliable data available regarding either mental resources or mental disorders and the factors behind them.

Domestic data show that over 15% of the population undergo at least one episode of major depression in a lifetime. According to family practitioners, 15% of their patients have affective or anxiety disorders. In the advanced nations, one-third to one-half of patients with depression are under treatment, a rate that is far lower in Hungary. It is quite well known that untreated depression causes the most societal damage of all disorders (WHO 2001). The damage far exceeds the cost of treatment; damage to the economy resulting from the absence of mental health promotion is enormous.

Until 1994, Hungary led the world in suicides, with 45.9/100,000. Since then it has dropped by nearly one-third, the greatest improvement in the world. Nonetheless, it is still very high (32.1/100,000 in 1997). Of particular concern are suicides among adolescents, which is one of the most common causes of death for 16-24-year-olds. Schools and teachers have not been trained to recognise the signs or to prevent it. In 1997, child psychiatric morbidity was 15-25%, compared to 12-20% in more advanced countries.

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<b>Strategic directions of implementation</b>
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<b>TASKS</b>	<b>ACTIONS NEEDED</b>
<b>Survey of resources and epidemiology</b>	<p>Comprehensive resource orientation, and completion of epidemiological studies to determine the country's prevention opportunities and acquire precise data on the state of mental health, designing uniform survey, methods, organisation of regional surveys.</p>
<b>Primary prevention</b>	<p>Designing and implementing primary prevention programmes of action based on the assessment of needs and resources</p> <p><b>1. Priority settings:</b> The family, the school, the helping professions, religious organisations, NGOs, labour safety</p> <p><b>2. Project types:</b> Training, assessment of needs and resources, mental health promotion actions, prevention programmes, communications development, and networking.</p> <p><b>3. Content:</b> <i>Preparing the family</i> to relay values and norms that help young people become able to evolve constructive, full lifestyles</p> <p>Designing programmes to prepare families, supporting implementation of these programmes</p> <p>Expanding services that help maintain family functions with the participation of mental health promotion professionals</p> <p>Training family helpers, professionals</p> <p>Organising communities of families to help themselves and one another and to offer them mental health promotion support, to train the animators of family communities in mental health, to support NGO initiatives and volunteer work.</p> <p>To <i>prepare the school</i> to meet its mental health promotion role. To make the effort to advance the school system which does not automatically meet the requirements of the era, so that it supports individual children even if they are disabled or are less talented.</p> <p>To make integrated mental health promotion a part of public education.</p> <p>Education for a healthy life must become a part of public education.</p> <p>Maintenance of mental health should be given priority in adult education, ahead of general and professional targets and contents.</p> <p><u>Accredited mental-health promoting post-graduate <i>training needs to reach out to the largest possible number of people</i></u></p>

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*in the helping professions*, who sometimes are the only ones to come into contact with at-risk people, and do so in the natural media of their work (teaching, psychological counselling, social work, somatic medicine).

Teachers and people in the helping professions must be offered the opportunity for supervision, for meeting in groups to discuss cases, for training to avoid burn-out, and for establishing self-help networks.

Designing and initiating mental health promotion programmes to prevent or eliminate exclusion.

Including information on mental health promotion in the teacher-training curriculum.

Designing professional protocols for peer assistance, establishing a peer assistance network, and organising supervision by peer helpers.

Coordinating mental health promotion professionals and organising supervision for them.

*Preparing communities*, supporting religious organisation and NGO community relations that build the community and have a social calling.

Preventing workplace mental hazards should become the job of labour safety.

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**Suicide**

Introducing mandatory reporting of attempted suicides.

Setting up crisis management sections in psychiatric wards.

Establishing crisis intervention centres.

Setting up suicide prevention centres with emergency 24 hour/day crisis care.

Treatment and extended care following failed attempts.

Continuing education for healthcare workers enabling early recognition of suicide warning signs.

Developing and coordinating telephone hot-lines, supervising and assisting the staff manning the phones, network building, improving phone service operation conditions with peer assistance.

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**Up-to-date care of mental disorders**

The goal is to attain an optimum quality of life.

To update the system of mental health institutions, and to shift the network of psychiatric institutions towards community psychiatry.

- The decentralisation of psychiatric extended care facilities
  - Incentive financing for extended care facilities
  - Increase the number of professionals working in extended care.
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- Ensure regular supervision for professions working in extended care facilities
  - Training of rehabilitation professionals in community psychiatry nursing, social work and labour rehabilitation.
  - Support experiments with models.
  - Design group practices with psychologist services
  - Build and enlarge psychotherapy outpatient facilities
  - Increase the number of child psychiatry extended care facilities, replace 'neurology extended care' centres with 'Houses of Health' operating with multidisciplinary teams.
  - Ensure the conditions for a liaison psychiatric service to operate, extend the service nation-wide, and make it accessible to primary health care and other professions
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**Early recognition and intervention**

Coordinating training and continuing education and curricula for teachers and for other participants in school health (school physician, health visitor)

Preparing teachers to safeguard students' mental health

Running a sensitising program for people working in primary health care

- Effective instruction in psychiatry as a subject during residency of family practitioner
- Organising accredited continuing education for primary health care staff

Offering regular supervision to professionals in primary health care

Organising psychological services connected to primary health care

Training in child psychiatry for paediatricians

Starting up programmes for early involvement in treatment.

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**Rehabilitation**

Advancing community rehabilitation broken down by welfare and healthcare institutions.

The rehabilitation programmes should be accessible for all groups and the programmes should include a broad range of activity.

The rehabilitation services should be accessible in local communities.

Daytime clubs should be established with work-rehabilitation programmes, skills development and a continuing care plan based on individual need.

Training of labour-rehabilitation specialists.

Ensuring regular supervision during rehabilitation.

Offering regular supervision for rehabilitation staff.

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	<p>Design concepts of protected living.</p> <p>Set up day hospitals for chronic patients for patients who need medical control and professional assistance.</p> <p>Child psychiatric rehabilitation.</p> <p>Special homes, schools, child protection institutions that rely on the professional knowledge of child psychiatry.</p> <p>Set up multidisciplinary intersectoral teams to support children (bio-psycho-social protective network).</p> <p>Organise communication with labour market, making retraining possible for people with mental disorders, design halfway houses</p>
<b>Media</b>	<p>Health, as a value to be built into the public consciousness.</p> <p>Media needs to emphasise the importance of quality of life.</p> <p>Present constructive, positive lifestyle as value in the media, and reduce presentations that say otherwise.</p> <p>Disseminate knowledge on mental health.</p>

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## **Expected results**

Reduce the prevalence of mental disorders

Advance the mental health outlooks of teachers and other people in the helping professions, increase their knowledge and improve their helping skills

Reduce the number of suicides and within that, the rate of suicides by minors

Improve the proportion of people with depression who are treated (by at least 30%)

Improve the reintegration into society of psychiatric patients.

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# REDUCING MORBIDITY DUE TO LOCOMOTOR DISEASES

## The Goal:

*To improve quality of life for patients with chronic locomotor diseases*

- To slow down the quantitative growth in locomotor diseases
- To help patients with chronic locomotor diseases to retain their motion on the highest possible level
- To establish up-to-date care and education in rheumatology
- To disseminate a preventive outlook regarding locomotor organs on the broad scale, combined with health education, provision of patient information and professional continuing education
- To further prevention programs that have been initiated in physical education at schools (spreading posture improving gymnastics, daily physical exercise at school)

## Situation assessment

The three most common disorders of the locomotor organs are arthrosis, low back pain, and osteoporosis. These pathologies are of outstanding significance not only because of the increasing frequency with which they occur, but also because of their consequences, which include disability, deterioration of quality of life, and mortality. Domestic surveys show that about 60% of people afflicted with inflammatory or degenerative joint or spinal disorders are dependent on others for assistance, family life deteriorates for 30% because of the illness, and two-thirds of them are thrown into financial crisis. In Hungary, locomotor diseases are in second place among the causes of disability and these patients make up 15-20% of all encounters with the family practitioner. In addition to individual suffering, the direct and indirect costs of the disorders are a huge burden on the individual, the family, and society.

Representative epidemiological studies have shown that over the age of 50, some 900,000 Hungarians have osteoporosis, about 100,000 have rheumatic joint inflammations, and over 2 million have arthrosis. Locomotor diseases account for one-half of the chronic illnesses in patients 60 and older. Low back pain is the second most frequent cause of sick leave. Bone density in Hungary is the lowest in all of Europe, and as a result, spinal disk fractures occur the most often here. About 2,500 to 3,000 patients die of hip fractures resulting from osteoporosis each year, and it is estimated that in 1998, HUF 15 billion was spent on treating these fractures.

A comprehensive national program to combat osteoporosis got underway in 1995. In keeping with a National Osteoporosis Programme, a network of national osteoporosis centres was established. A nationwide school physical education program, with the active involvement of the Hungarian Spine Society has been underway since 1995 to prevent degenerative spinal

disorders. Recognising the huge significance of locomotor diseases, the UN declared the decade from 2000 to 2010 to be the Bone and Joint Decade. Hungary was one of the first to join the movement. The movement is offering extended support to countries focusing on prevention, patient care, education, and research. One reason the issue is so pressing is that by 2010, for the first time in history, Europeans over the age of 60 will outnumber the ones under the age of 20, which means that the costs of treating disorders of the ambulatory organs will rise dramatically.

In the current decade Hungary has a much bigger gap to bring in than the advanced nations of Europe with respect to locomotor diseases. The outpatient services system and primary health care networks need to be improved, to make them suitable for definitive care. One reason for the gap is the lack of graduate training in rheumatology at Hungary's universities. A significant portion of rheumatology patients are not treated in specialised facilities, particularly when it comes to inflammatory immunological and metabolic bone disorders. Only about 20% of osteoporosis patients are diagnosed and treated. We have no reliable database on locomotor system disorders, and treatment is not offered on the basis of uniform diagnostic and therapeutic principles. The molecular genetic examinations and bio-therapy offered on a general scale in Europe have not been introduced to practice in Hungary at all. The public has little information on locomotor organs, and the power of patient advocacy groups is not significant.

## Strategic directions of implementation

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### TASKS

### ACTIONS NEEDED

**Targeted locomotor organ screening and prevention programmes**

In 'normal' physical education at school, posture-improving exercises should be carried out regularly as a means of primary prevention of diseases due to wear of the spinal disks. Effective screening, early and efficient treatment of spinal and other locomotor diseases of schoolchildren (remedial gymnastics should be provided by physiotherapists). Children should not be referred to remedial gymnastics because of posture problems and flatfoot: as prevention should be implemented comprehensively, this should take place as part of normal school physical education. Developing maximum bone mass for children is promoted by daily physical exercise and extensive lifestyle information.

Early screening and care, within rheumatology and orthopedics services, of joint inflammations, wear of joint cartilages as well as osteoporosis in the young adult and middle-aged population. Already initiated locomotor programs should be adapted as models.

We hope to halt the rise in fractures of the forearm and wrist, vertebra and hip s and reduce them as possible by screening and providing extended care to the most at-risk

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	<p>population. The targeted group is the over-60 population, with a particular focus on people living in communities (nursing homes, old folks' clubs, etc.) We intend to apply the methodology of treatment to control osteoporosis and of locomotor rehabilitation of individuals who have sustained various fractures throughout the country, and to extend the currently available institutional rehabilitation capacities.</p>
<p><b>Assessing quality of life changes and social burdens caused by locomotor diseases</b></p>	<p>To assess the individual burdens of locomotor diseases, functional losses caused by the disease and changes of quality of life in low back pain, rheumatoid arthritis, wear of joints and osteoporosis, as well as in childhood locomotor diseases.</p>
<p><b>Education -continuing education, health education tasks</b></p>	<p>Introduction of rheumatology as a mandatory graduate subject in all four faculties of general medicine in Hungary. Up-to-date rheumatology must be taught as part of continuing medical education. Using modern communication channels (Internet, distance learning), we will organise continuing education programmes for the specialist network. In addition to specialist training we are paying special attention to training for specialist physicians who work with locomotor organs, physical therapists, family practitioners, health visitors, nurses, and physical education teachers who participate in various locomotor organ programmes.</p>
<p><b>Modelling the care system in primary health care</b></p>	<p>Modelling the professional treatment of acute low back pain and neck pain in primary health care. Elaboration and adaptation of locomotor prevention and continuing care programs among family practitioners.</p>

## Expected results

- Implementing spine and joint protection, automatisisation of correct posture and conscious use of the spine in physical education at schools
- Reducing the number of days patients with chronic joint disorders spend with serious pain
- Reducing the proportion of patients with locomotor diseases who are inhibited in their daily activities
- Seeing to it that patients with locomotor diseases are primarily treated at specialised wards
- Improving the locomotor disease care offered by the outpatient services system and the family practitioners network.
- Introducing mandatory graduate training in rheumatology at all four university medical schools
- Significantly improving the outlook serving the prevention of locomotor diseases with the help of mass media.

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## PREVENTING AIDS

### The Goal:

*To reduce the number of new infections with Human Immunodeficiency Virus (HIV) and to improve the rate of diagnosed cases of infection*

- ❑ To prevent new HIV infection, maintain a low incidence of infection, and reduce AIDS morbidity by 20% and mortality by 25%
- ❑ To design the forms and contents of primary prevention programmes and to fit programmes for young people into the school health education curriculum and into drug-prevention programmes. To design special prevention programmes for groups that have a high risk of infection
- ❑ To design a grant scheme and to establish a grant fund to finance the above programmes
- ❑ To increase the effectiveness of HIV diagnosis, principally among persons with high-risk behaviours

### **Situation assessment**

HIV/AIDS prevention is a specific sub-program in the European Union's Public Health Programme containing uniform health recommendations. The Hungarian sub-project has conformed to these recommendations to the greatest degree possible.

Its significance is clear from the following epidemiological figures and from the fact that the spread of the infection can be completely prevented. According to an estimate by UNAIDS, the Joint United Nations Programme on HIV/AIDS, there are currently 40 million people in the world living with HIV/AIDS. In 2001, they estimated that 5 million people were newly infected, and 3 million people died. The overall mortality due to AIDS was 21.8 million. Over three-quarters of the prevalence of HIV/AIDS and over 80% of incidence are in developing countries, where over 10% of the infected persons and about one-fourth of the mortalities are infants who were born with the infection.

In Hungary, the first HIV infections were diagnosed in 1985, and since then the number of diagnosed cases of HIV has increased to 1,006. It has predominantly spread through homosexual relations, but in recent years there has been a growth in the rate of heterosexual infections. It is estimated that 3,000 people are actually infected. The first AIDS patient was diagnosed in 1986. Since then the number of diagnosed patients has increased to 411, and 242 have died of AIDS complications. Typical of the domestic epidemic is that in addition to spreading the disease through homosexual relations, of late it also is spreading through heterosexual transmission. Some 40% of the infections diagnosed in 2001 were transferred heterosexually. There has been an increase in the number of HIV-infected foreigners, who came to Hungary principally through migration. The three IV-drug users diagnosed with HIV last year also were from this group.

HIV/AIDS epidemiological data suggest that Hungary is in a good situation, but the fact that our epidemiological environment has changed significantly requires new efforts. We know that from 1994 to 2000 Western European data showed that the incidence of new HIV infections (per million population) dropped from 64 to 21. Meanwhile, in Central Europe it rose from 2 to 5 (in Hungary from 6.2 to 8.5). In contrast, in Eastern Europe it increased from 10 to 300. This 30-fold increase is accounted for by a huge HIV-epidemic that broke out starting in the mid-90s, resulting in what is estimated to be 1 million people infected with HIV in Ukraine, Moldova, Belarus, and Russia. The epidemic was driven primarily by IV drug use, while a smaller portion was through heterosexual transfers, related principally to prostitution. Typical of the dynamics, the number of people infected with HIV has been doubling every year.

In past years the number of HIV/AIDS primary prevention programmes in Hungary declined, particularly among the high-risk groups. There were major shortcomings in the mandatory examination of prostitutes, particularly as regarded HIV tests. Only limited tests were completed on IV drug users. There has been a significant change in care for HIV/AIDS patients. Thanks to combined treatment, quality of life has improved significantly, life prospects have expanded, and treatment has shifted from an inpatient to an outpatient setting. These trends conform to those in the European Union. Unique to Hungary is that two-thirds of the newly diagnosed AIDS patients were not known to have been HIV infected. Treatment has raised new problems, such as boosting cooperation in treatment, and the evolvement of medication resistance, which has to be measured and monitored. The number of homeless patients has increased, and in parallel, so have requests for social services. Current treatment results confirm that the life prospects of HIV/AIDS patients in difficult social circumstances are significantly worse, despite the combined therapy. Terminating the National AIDS Committee made it more difficult to organise HIV/AIDS prevention programmes, and reduced financing to an even lower level.

**Strategic directions of implementation**

<b>TASKS</b>	<b>ACTIONS NEEDED</b>
<b>Prevention</b>	<p>Teaching family life information in the schools as part of health education, assisting young people to evolve an order of values and personalities, to lead to responsible sexual behaviour and drug avoidance.</p> <p>Preventive programmes for high-risk communities, with the active participation of organisations and members from these communities (gay communities, prostitutes, IV drug users).</p> <p>Regular information to the public on how to prevent HIV infection, on how AIDS as a disease has changed, demystification of the disease and a reduction in discrimination against and segregation of infected persons.</p> <p>Strengthening the role of people infected with HIV in prevention programmes</p>

	Building a welfare network and reinforcing the existing one to offer support to socially vulnerable HIV/AIDS patients.
<b>Targeted screenings for HIV infection</b>	<p>Increasing voluntary testing based on informed consent among high-risk groups. Re-introducing anonymous HIV testing combined with counselling.</p> <p>Enforcing the legally regulated regular mandatory health examinations of prostitutes, and monitoring implementation</p> <p>Work-related HIV exposure of health service workers, and preventive treatment following exposure to the virus</p>
<b>Education/continuing education</b>	Building information on HIV/AIDS into medical education, medical specialist training, and college courses. Regular continuing education for family practitioners and primary care paediatricians, as well as for doctors and dentists who may potentially treat HIV patients.

## Expected results

To stabilise the number of HIV infections, to reduce the number of people infected with HIV but not diagnosed, to reduce the number of AIDS patients by 20% and mortality by 25%.

To increase responsible, low-risk behaviour among young people and high-risk groups.

To stabilise the number and achieve a 30% reduction in communicable diseases transmitted sexually or through blood (e.g., syphilis, hepatitis C, etc.)

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**CREATING  
A HEALTH  
PROMOTING SOCIAL  
ENVIRONMENT**

**PROGRAMS OF  
HEALTHY  
LIFESTYLES,  
REDUCING RISK  
FACTORS TO HUMAN  
HEALTH**

**PREVENTING  
AVOIDABLE  
MORTALITY,  
MORBIDITY AND  
DISABILITY**

**STRENGTHENING  
THE INSTITUTIONAL  
SYSTEM OF  
HEALTHCARE AND  
PUBLIC HEALTH  
TO IMPROVE  
HEALTH**



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## PUBLIC HEALTH SCREENINGS

### The Goal:

*To reduce mortality due to tumours by 5-10% among the under-70 population by 2012 by way of organised and targeted screenings of the public*

- To have 70% of women between the ages of 45-65 participate in mammography screening repeated bi-annually, and this to reduce mortality due to breast cancer by 30% by 2012.
- To reduce mortality due to cervical cancer by 60%, through gynaecological cervical screening including cytological testing of all women aged 25-65, which, if negative is repeated, every three years, and which embraces at least 70% of the targeted population
- To organise colon and rectal cancer screening for men and women from age 45-65, using the laboratory-testing of stool-blood samples

### Situation assessment

The poor health status of the Hungarian population is well known. Within the overall picture, mortality due to malignant tumours is very high, in second place following mortalities due to cardio-vascular diseases. Its prevalence is about 25%, and when compared to vascular diseases, we find that it takes away more of the 70 potential life years than cardio-vascular disease (Central Statistical Office 2001). In the past 25 years, the proportion of patients disabled by malignant tumours doubled, despite the fact that eligibility conditions for disability were tightened up.

The situation is worst for male lung cancer, female colorectal cancer, and cancer of the lips and oral cavity for both genders. In this particular area, we are list-leader in both mortality and incidence. We are 'only' in second place regarding male colorectal cancer. With regard to other cancers, the situation is somewhat better but nowhere are we placed really well.

We have been doing quite poorly with ratios for laryngeal, pancreatic, hepatic, pulmonary, thyroid and male oesophageal cancer, and leukaemia. In all of these cases Hungarian mortality data is published by Central Statistical Office reports and yearbooks. When comparing mortality data for 1999 and 2000, we noticed an unusual phenomenon. This was the only 'turn of year' in decades when the rising mortality trend was stopped. Although the decline in mortality was only 2%, in the past, we have not seen even that much of a decline. Recently published Central Statistical Office mortality data for 2001 show that the trend has continued, with a slight break.

In past decades we have not been able to figure out morbidity data. We only have been able to estimate cancer prevalence among the public, estimating the types and number of new cases in a year. This method leaves too much room for error and biased results. A National Cancer

Registry was established by the National Institute of Oncology, to provide credible data, on which we can increasingly rely. Incidence results for 2001 have already offered a great deal of assistance in giving us an overview of the Hungarian tumour situation.

Last year a total of 58,772 new tumours were reported for both genders. In contrast with international morbidity statistics, the figure includes a comparatively large number (6,379) non-melanoma tumours of the epidermis. Calculating with this, and with the chance that sometimes double or multiple tumours are reported separately, we are certain that in 2001, 51,136 new tumour patients were registered. The tumour/patient ratio in the Cancer Registry was 112/100. We must continue to ‘cleanse’ data in the registry, meaning that we need to design a program which can refine the morbidity data accessed from the Cancer Registry.

**Strategic directions of implementation**

<b>TASKS</b>	<b>ACTIONS NEEDED</b>
<b>Mammography</b>	Continuing the mammography screening already underway. Providing additional information to targeted and non-targeted people (through NGOs), including programmes to convince the largest possible number of people to appear for screening (the target: 70% of the female population). Increasing emphasis on quality control. Monitoring mammography facilities to determine the extent to which professional and technical capacities are used.
<b>Screening for cervical cancer</b>	Offering information to the targeted population on the importance of participating in the screening. Using the experience and materials of NGOs on cervical screening. The goal is for at least 70% of females between the ages of 25-65 to participate in screening for cervical cancer as often as set by international standards. Work by gynaecologists, cytopathologists and NGOs need to be coordinated to attain a higher level of effectiveness.
<b>Screening for colon cancer</b>	To set the foundations absolutely necessary for colon cancer screening

**Expected results**

By introducing screenings of the population we expect

- Mortality from breast cancer to decline by 30%
- Mortality from cervical cancer to decline by 40-80%
- Mortality from colorectal cancer to decline by 20%.

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## IMPROVING THE PROVISION OF CARE

### The Goal:

*Purposeful development of the general healthcare system in line with the public health priorities, which, as a result, will operate with optimum efficiency*

- Expanding the sphere of primary health care activity, introducing lifestyle counselling
- Influencing the outlooks and behaviour of healthcare professionals on the various levels of care provision in order to achieve definitive care as quickly as possible
- At the various levels of care:
  - Improving the preventive outlook in care for cardio-vascular diseases
  - Improving the preventive outlook in care for oncological diseases
  - Developing rehabilitation systems for patients with locomotor diseases

### Situation assessment

The Hungarian healthcare network has a huge capacity, and as a system it is generally divided up well and professionally. Despite this, many people die prematurely of diseases that could have been treated if the patient had been diagnosed in a timely manner and taken to a facility where treatment conditions were in place. There are many illnesses that come about as a result of a patient's earlier illnesses and how they were treated. There are many cases in which the individual suffers and the insurance company pays a huge cost (e.g. renal insufficiency that requires frequent dialysis), a good portion of which could have been avoided if the patient's blood pressure and diabetes had been properly treated in prior years.

An examination of mortality data and hospital healthcare tasks suggests that, sadly, the current healthcare system gives little support to diagnosing and treating diseases as early as possible. One component of this is that the financing system supports more serious illnesses that already have evolved instead of early detection, so a significant portion of patient care occurs later than necessary and on a higher level. Another factor we need to look at is that fewer healthcare professionals that necessary have appropriate knowledge, or lack the instruments and technology that would be needed at that time and in that place. We also need to mention earlier medical practice and the general outlook, attitude and form of behaviour that evolved amidst older medical technologies, and which among today's morbidity conditions and medical technologies, are no longer acceptable. Each of these factors maintains a high level of inertia and as a result, the system is very slow to change: we need a

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decade for there to be real results, even if the changes are consistent, well coordinated, and touch on all of the above factors.

## Strategic directions of implementation

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<b>TASKS</b>	<b>ACTIONS NEEDED</b>
<b>Primary health care</b>	<p>A situation analysis of the family practitioner system from the points of view of tasks to influence lifestyle and the endeavour to provide definitive care with respect to borderline problems of social welfare and healthcare issues.</p> <p>Situation analysis of the family practitioner system from the point of view of how prepared physicians are to diseases of public health importance (with a particular focus on hypertension).</p> <p>Review of opportunities that the family practitioner has for early detection.</p> <p>Training personnel who participate in risk assessment and lifestyle counselling, adjusting their activity to fit within family practices from the organisational and financing points of view.</p> <p>Critical points of communication between family practitioners and specialists, and the organisational and financing methods to improve the situation.</p>
<b>Investigating and influencing behaviour and attitude</b>	<p>Situation assessment among healthcare workers in primary health care, outpatient care, and inpatient care; attitude studies, evolvement of information dissemination and debate forums.</p>
<b>Circulatory diseases</b>	<p>Overview of the tasks on the various level of care, and on conditions under which infarction, stroke and vascular stenosis are treated.</p> <p>Analysis of patient care pathways, defining critical points as well as detailed study of technology, organisational, and financing conditions and vested interests in general and in economically disadvantaged regions</p> <p>Examining medical information and practice (including with case studies).</p> <p>A preventive outlook must operate in healthcare, and treatment and continuing care must be organised in an expedient way for the program to be successful.</p> <ul style="list-style-type: none"><li>• Screening and continuing/extended care for hypertension</li><li>• Surveying the conditions for preventing chronic heart disease and establishing those conditions in primary health care</li></ul>

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- Developing cardiological intervention centres and a network of stroke centres according to uniform principles; providing emergency medical care for patients who have suffered a myocardial infarction or stroke in line with professional guidelines and in a comprehensive manner.

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**Oncological diseases**

Review of tasks on various levels of care, and of the conditions needed to treat cancer patients.

Analysis of patient care pathways, analysis of regional inequalities in access, defining critical points as well as detailed study of technology, organisational, and financing conditions and vested interests in general and in economically disadvantaged regions

Study of medical knowledge and practices (including case studies)

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**Rehabilitation**

Situation analysis (complex, including rehabilitation of cardiological and locomotor diseases).

Exposing the regional inequalities of the network.

Causes of shortage of skilled personnel, training.

Possible ways of fitting rehabilitation tasks into the organisation

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**Expected results**

In primary health care, the physician's attention should include the risks faced by the residents/patients (who appear with complaints or for any other reason) and they should receive profession lifestyle, way-of-life counselling.

As far as circulatory diseases are concerned, we would like to improve the care provision and have targeted reducing the indices of ensuing disability and mortality.

With regard to cancers, we would like to advance diagnostics so that tumours are detected as early as possible, and that patients have equal chances of being seen by a specialist in any part of the country and (by expanding opportunities for therapy) they should receive adequate treatment. We want to significantly improve opportunities for the early detection of tumours of the oral cavity (See description in sub-project on reducing tumour incidence)

By improving the general conditions for rehabilitation, we need to reach a point in 5-10 years in which all patients who can benefit from rehabilitation have access to effective treatment.

With the whole of the healthcare system, we would like to see staff understand their exact role in preventing the patient's condition from deteriorating and preventing the development of conditions that are harder to treat, and thus should be avoided, no matter where in the care network they happen to work. Within a few years, we have to reach the point in which incentives as expressed by financing supports this outlook and activity.

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## RESOURCE DEVELOPMENT

### The Goal:

*To build an infrastructure for specialists, authorities, NGO activists and researchers and to organise targeted education and continuing education that promote effective public health activity on all possible levels*

- ❑ Increasing workplace Internet access to 100% for public health professionals
- ❑ Increasing public access to public health data collected within the public health program to 100%
- ❑ Ensuring that at least 80% of non-health degree holders working in public health undergo appropriate specialised training
- ❑ Continuous expansion of public health resources over the years
- ❑ Establishing institutional basis for doing health impact assessment studies

### Situation assessment

Successfully implementing the public health program requires the establishment of the most expedient circumstances. The primary target of the sub-project to increase resources is to provide resources, information, and knowledge to the organisations and groups participating in the program, and to active participants in public health. The sub-project has to design and bring about the resources that will make the program executable in an effective manner. Some Hungarian public health capacities are already available, but in many cases they require improvements. The improved resources have to be able to increase their positive impact on the general state of health, which means that the system must be in close contact with communities and the environment, and the system must have the capacity to rapidly resolve problems. Improving resources includes designing and establishing an organisational structure, designing and establishing an infrastructure for the executive organisation, building human resources on a professional foundation, and creating the opportunities to include additional resources in the system.

## Strategic directions of implementation

TASKS	ACTIONS NEEDED	ORGANISATIONAL DEVELOPMENT
<b>Metaanalysis of studies made earlier</b>	Preparing a summary study on institutions and organisations in public health which considers the targets and structure of the 'Johan Béla Public Health Programme for the Decade of Health', EU norms and requirements, legislative and financing tasks needed for health improvement, and an analysis of relationships between earlier studies.	
<b>Organisational planning</b>	Designing the organisational and institutional system for the public health program, to include organisational and institutional tasks, responsibilities, persons responsible, and their relationships to one another.	
<b>Implementation</b>	Completing the steps to implement the organisational structure of the public health program, on the basis of the above plans.	
<b>Quality assurance</b>	Building a quality assurance system in the institutes, institutions, local governments and NGOs participating on the organisational structure, which guarantees a high level and broad range of accessible public health services.	
<b>Knowledge management</b>	<p>Dissemination of Internet access in public health (on short term, primarily NPHMOS, university faculties), and parallel training programmes to improve ability to navigate the Internet.</p> <p>One part of the public health program involves establishment of a portal to serve as an information and communication tool for public health professionals, other related professions, and anyone among the public who is interested. The portal also can be used for distance learning projects for public health professionals, for development and maintenance of databases, etc. To increase effectiveness, the on line project can be combined with an off-line magazine on public health.</p>	INFRASTRUCTURAL

<b>Database development</b>	Establishing databases and improving existing ones to support decision-making levels on hazards, risks, and trends.
<b>Improving data collections</b>	One important element in developing databases is to improve the collection of data, which involves both infrastructural and organisational development.
<b>Improving communication</b>	Improving communication among authorities, institutions, NGOs and local governments active in public health, which includes easy access to professionals in the area and which, in given case, also promotes international professional contacts.
<b>Improving the accessibility of services</b>	Guaranteeing access to public health services and preventive services to the largest possible portion of the public
<b>Advancing relations with NGOs</b>	Intensifying relations with NGOs in an informal structure, considering that they are essential elements to program implementation. When advancing the relationship, one major goal is for the NGOs to offer data on their activity since this fundamentally aids the higher level public health decision-making bodies.

DEVELOPMENT

<b>Continuing education of NPHMOS staff</b>	Steadfast presentation of the public health program projects in continuing education for NPHMOS staff in
<b>Public health manager training</b>	Management training for active participants in public health (including NPHMOS staff, local government staff, administrative staff and NGO representatives), for this is a prerequisite to implementing the various elements of the program.
<b>Post-graduate education</b>	Increasing PhD programmes in public health and the number of students, resident training to include the public health program and building specialist examinations in the public health program sub-projects into various curricula.  Training public health medical officers in an accredited system.
<b>Graduate training</b>	Transfers of information related to the public health program in a structured way in higher education concerned with public health (schools of medicine, pharmacy, health sciences colleges,)

HUMAN RESOURCES DEVELOPMENT



<b>Continuing education, distance learning, on-the-job courses</b>	Organised public health instruction for people active in public health (including NPHMOS staff, local government staff, administrative staff and NGO representatives), conforming to the organisational level, introduction of scholarships, mentor programmes, and rotations set up as made possible by workplace opportunities.	<b>HUMAN RESOURCES DEVELOPMENT</b>
<b>Learning Internet skills</b>	Disseminating Internet skills among people active in public health, and teaching use of the Internet.	
<b>Monitoring performance</b>	Performance will be monitored during the phases of program implementation and in accordance with the maturity of the organisational structure, starting on institutional level and gradually moving down to individual level.	
<b>Monitoring calls for applications</b>	Continuous monitoring of domestic and international calls for applications in areas related to the public health program and when possible, ensuring that application criteria are met, and/or guaranteeing the presence of specialists in preparing high standard domestic and international applications/proposals	<b>DEVELOPMENT OF FUNDS</b>
<b>Planning of funds</b>	Planning for financial resources intended for public health based on professional targets or needs based on the program, and deciding on the method of distributing available resources	
<b>Cooperation with business capital</b>	Neutral appearance of business capital in areas of the public health program where this can happen without harming business or political interests.	
<b>PhD training</b>	PhD research in public health, and monitoring and professional evaluations of the resources devoted to this.	<b>RESEARCH &amp; DEVELOPMENT</b>
<b>Grants for basic research</b>	Initiating public health methodology research and, in the light of the results, formulating proposals on model experiments and projects.	
<b>Model projects</b>	Initiating methodologically supported pilot projects on the basis of the planned models	
<b>Health impact assessment</b>	Continuously measuring the likely impact of strategic decisions, public health interventions and laws, with creating the institutional arrangements	

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as the first step of this strategy.

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**Outcome evaluation**

Measuring the impacts of completed projects and programmes on health

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**Expected results**

When the goals of the resource sub-project are met, we will have an EU-conform public health infrastructure and a human resource capacity able to respond quickly and effectively to public health challenges. This activity will be able to offer substantial support to decision-making levels and to various government administration and economic players. As a result of the development it may happen that NPHMOS will not play the main role in implementing public health actions, for the emphasis may shift to the NGOs, which, together with the local governments, will be able to constantly rely on the expertise of NPHMOS.

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# MONITORING – INFORMATION TECHNOLOGY

## The Goal:

*To monitor progress of the Programme, to measure changes in population health status and health determinants taking place as a result of Programme implementation*

### Situation assessment

The ongoing monitoring of Programme implementation will provide efficient support to Programme management, thereby making a significant contribution to the Programme's success. The early identification of eventual fallbacks and problems, as indicated by Programme monitoring, will make it possible to take rapid and effective remedial actions. On the other hand, monitoring will be able to provide information that is necessary to coordinate actions taking place in the individual sub-programmes simultaneously.

To ascertain effectiveness, it is indispensable to measure the impact brought about by the Programme. The impact of actions accomplished may be demonstrated by the population's lifestyles and their environment becoming healthier as well as through improving general health.

The current data collection exercises within the Hungarian health monitoring system fail to provide sufficient information on a considerable proportion of indicators included in the Programme, especially as regards lifestyles and the incidence of selected non-communicable diseases. It is therefore a prerequisite for assessing Programme efficiency to update and further develop the Hungarian system of health monitoring.

The following data provide information on the population's health status: mortality data, data on people using healthcare services, data collection exercises in representative family practices, involving specific population groups, as well as data from health behaviour surveys on a representative sample of the total population.

### Strategic directions of implementation

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#### TASKS

#### ACTIONS NEEDED

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#### Programme monitoring

Developing a method which is suitable for monitoring Programme implementation; preparation of quarterly reports to be submitted to Programme management.

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**Developing the health monitoring system**

With a view to coordinate the activities of institutions that take part in the health monitoring system and in order to align with health information developments in the EU, a committee should be established led by the Ministry of Health, Social and Family Affairs that is responsible for coordinating and overseeing the development of the health monitoring system.

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**Evolving an indicator system, determination of health status at baseline**

Compilation of indicators in the individual subprogrammes, analysis of their availability and measurability. Identification of the necessary data sources; where no data source is available, elaboration of proposal to alternate data source or data collection to be developed.

Putting together a study on the Hungarian population's health status at the start of the Programme as part of the four-yearly public health report.

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**Expansion of data collection**

With a view to monitoring Programme effectiveness, a national representative questionnaire health behaviour survey should be implemented at regular intervals.

To continuously collect morbidity data and data on healthcare practices, a Family Practitioner Monitoring Program shall be launched based on nationally representative family practices.

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**Expected results**

Implementation of the subprogramme will ensure monitoring of both Programme achievement and Programme effectiveness.

A methodological basis will be established for monitoring population health, and its institutional background and management system will develop.

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**THE OEUVRE  
OF  
BÉLA JOHAN**

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## THE OEUVRE OF BÉLA JOHAN (1889-1983)

Béla Johan was born in Pécs, Hungary, in 1889, where his father was a chief medical officer. From 1907, he lived in Budapest, where he received a degree in medicine in 1912 at the Budapest University School of Medicine. He turned his attention to bacteriology, influenced by the epidemics that occurred during World War One, and participated in preparing vaccines against cholera and typhoid for the armed forces. In 1925 he was appointed director of the National Institute of Public Health, which was established by law at that time. Subsequently, he received a Rockefeller scholarship and studied the systems of central public health institutions in the United States and several European nations. He began working as institute director in 1927.

He called the attention of government and society to the dire health situation in the villages and the immediate need to improve conditions. He believed that the primary job was to provide well-trained health personnel and established 20 branches of the public health institute, initiated a system of notifying infectious diseases, reformed medical officer training and began the training of health visitors, who were members of the Green Cross Public Health Service.

In 1935, he was appointed a state secretary at the Ministry of Internal Affairs, but he continued his daily work at the National Institute of Public Health. The result was tight coordination between the Ministry and the public health institution. In 1936, to achieve the uniform guidance of health authority enforcement activities, he established the medical officers' service, and later nationalised the public health (family practitioners and health visitors) service, and formulated the necessary laws.

In recognition of his scientific work, he was a guest professor at the Budapest University School of Medicine in 1919, and in 1927 became a professor extraordinary. He became a corresponding member of the Hungarian Academy of Sciences in 1942. In 1943, in addition to his duties as state secretary, he again took over the direction of the National Institute of Public Health. In 1944, after the German occupation, he was deprived of his position and interned.

Sadly, he was not restored to his proper place in public health after the war. He worked for the company 'Phylaxia' on antibiotic research and was concerned with preparations for the domestic production of penicillin. After 1945, American professionals contacted him, and turned over a penicillin strain to him that became the basis for domestic production. In the 1950s, this relationship qualified as suspicious, and as a result he was interned to Kistarcsa (North-Central Hungary), and was deprived of his corresponding membership in the Academy of Sciences.

Later, he got work at the Kőbánya Pharmaceutical Factory, where he continued his efforts past the age of 90, gaining significant merits in domestic vitamin B 12 research and manufacture. His work was honoured with the awards 'Outstanding Innovator', 'Outstanding Inventor', and 'Outstanding Chemical Industry Worker'. In 1972, he was rehabilitated, and received the 'Labour Order of Merit - Gold Level'.

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His healthcare concept proved correct and stood the test of time. He devoted his life to protecting the health of the people under very difficult conditions.

In 1989, on the 100th anniversary of his birth, the Hungarian Academy of Sciences restored his membership in the Academy. The National Institute of Public Health adopted his name and unveiled a bust, bowing its head with respect for the efforts of Béla Johan in the interests of public Health. In 1998, when the National Institute of Public Health was revamped, the National Epidemiology Centre adopted Béla Johan's name. After receiving recommendations from the citizens, the board of the Foundation for Hungary declared that Béla Johan is a part of the Hungarian Heritage for the outstanding role he played in organising Hungarian public health.

The Golden Book containing the name of winners of the Hungarian Heritage Awards now contains the name of Béla Johan.

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**'JOHAN BÉLA '**  
**NATIONAL PROGRAM**  
**FOR THE DECADE OF HEALTH**

**APPENDIX**



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**CREATING  
A HEALTH  
PROMOTING  
SOCIAL  
ENVIRONMENT**

**PROGRAMS OF  
HEALTHY  
LIFESTYLES,  
REDUCING RISK  
FACTORS TO HUMAN  
HEALTH**

**PREVENTING  
AVOIDABLE  
MORTALITY,  
MORBIDITY AND  
DISABILITY**

**STRENGTHENING THE  
INSTITUTIONAL  
SYSTEM OF  
HEALTHCARE AND  
PUBLIC HEALTH  
TO IMPROVE HEALTH**

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## HEALTHY YOUTH

### **Actions to be implemented in 2003-2004**

1. Integrate family planning counselling into the activities of the network of Family Protection Services in 2003.
2. Define common principles and competences and develop methodology of prevention in women's, mothers' and 0-18 year-old children's health care.
3. Develop personnel, physical and continuing education conditions of supervision system in health visiting; define, approve and implement its common principles and criteria.
4. Review existing school health promotion programs by unified criteria; prepare register and publish data in order to allow system of institutions in public education to make professionally sound and well-founded decisions regarding the programs to be applied. Develop criteria for accreditation based on the above.
5. Develop standards of operation for health promoting, and within it safe, schools (kindergartens) that are tailored to local features.
6. In the light of data evaluation, it might become necessary to conduct a competition in which we shall call upon expert professionals in the field to develop programs that are missing from the offer or are insufficient from a professional point of view.
7. Identify institutions of higher education that are willing to cooperate in order to organically incorporate health promotion knowledge into undergraduate education of teachers (as an element of the module on the craft of teaching).
8. Transform legislative context so that accomplishment of courses of this topic are made part of the qualification requirements.
9. Develop course curricula and pilot teaching material when ready in cooperation with the volunteering institutions of higher education.
10. Provide accredited continuing education of at least 30 hours to an additional pool of 800 elementary and secondary school teachers within the framework of the system of existing continuing education courses for teacher that have qualified as professionally appropriate.
11. Make preparations for forthcoming 'Health Behaviour of School Children' survey, expand questionnaire to meet objectives, participate at international preparatory meetings.
12. Elaborate appropriate system of tools, based on international and domestic professional literature, to be used in carrying out needs assessment concerning the prevention needs of marginalizing strata (using the Rapid Assessment and Response Technique).
13. In the light of assessed needs, review existing health development offer, make proposals for reconsidering programs and developing new ones.

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# IMPROVING THE HEALTH OF THE ELDERLY

## Actions to be implemented in 2003-2004

1. Invite offers to develop curricula for the education of doctors, nurses and social workers and postgraduate education in family practice that contains special features of old age (e.g. in the fields of physiology, pharmacology, use of medical aids, psychiatry) and promotes provision of geriatric/gerontologic care in teams.
2. Set up working groups for media workers to address PR issues and opportunities related to old age.
3. Assess number of families or single persons who would need transitional care or rehabilitation services.
4. Expand to nationwide coverage the alarm system that was launched in 10 counties with 1,500 devices.
5. Further develop the home care system by incorporating the participation of physical therapists and occupational therapists, which requires the training of professionals in appropriate numbers.
6. Start planning a benefit in-kind in addition to the increase of old-age pension that has been initiated. For instance, use the social welfare fund at each municipality to cover painting, spring-cleaning, cleaning of clothes, etc. with the involvement of entrepreneurs whom the municipality would contract for these services. Arrangements to this end must be preceded by a survey of supply and demand, furthermore, information leaflets should be published that discuss participation criteria and the offer. Thus, it may be possible to implement this action in the next biennium.
7. Organise green phone number service where the elderly may indicate areas where he/she could and would like to be useful. This opportunity should be advertised in the media and brokering services offered could also be done via the media (e.g. in the form of 'the radio's answers to listeners').
8. Assess placement needs in homes of the elderly based on the existing waiting lists, and assess extent of coverage of those requiring special diets (with the involvement of the primary health care and basic social welfare services). Based on the findings, an incentive system should be elaborated which promotes the creation of places that meet the demands and the provision of quality home care.
9. Ensure possibility for elderly people living alone to apply (e.g. like teachers) for personal computer or internet access. Publish this arrangement and the criteria in the media.
10. Ensure greater publicity to the already operational university of the elderly and elaborate other forms of teaching with the involvement of the Ministry of Education, taking into account the specific needs of the elderly. Organise programs for the dissemination of knowledge for the elderly in clubs for the elderly, on television and in residential homes of the elderly.
11. Implement safe home environment, initiate pilot with procedures to tailor homes to the needs of the elderly so that they meet EU standards of comfort but are not costly: removal of thresholds, mounting of handrails, demolishing some walls, build in shower etc.
12. Gradually establish 'home nursing care, lay carers' chain'.
13. Start developing research in geriatrics and establishing model centres of geriatrics/gerontology.

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# EQUAL OPPORTUNITY FOR HEALTH

## Actions to be implemented in 2003-2004

1. Study opportunities of access to health care services in marginalized groups, with special regard to primary health care that is available to them. The study should embrace, in view of the known GDP figures and unemployment rates, the following counties and towns: Baranya, Borsod-Abaúj-Zemplén, Heves, Nógrád, Somogy and Szabolcs-Szatmár-Bereg Counties, and the poorest neighbourhoods in Budapest. In the same areas, identify interrelationship of discrimination within the health care system among the Roma on a representative sample (case studies).
2. Invite offers to support measures and programs that aim at ensuring that people living in colonies or colony-like neighbourhoods and the homeless are involved into healthcare.
3. Implement targeted screening examinations at sites of research into equality of opportunities (TB, hepatitis, neoplasms, paediatric diseases etc.). Utilise mobile screening stations.
4. Invite tenders to design and introduce information and teaching programs for marginalized social groups with the involvement of the health visitors' network, social workers, primary health care physicians and institutions of the Roma (minority self-governments, non-profit organisations, community centres, etc.)
5. Put out designing teaching modules for tender that can be inserted into the teaching activities of institutions that offer medical and other vocational health education (at undergraduate and postgraduate levels) and whose aim is to increase sensitivity for being different or disabled.
6. Launch campaigns, both in connection with other antidiscrimination public relations campaigns and as independent initiatives, that promote discrimination free health care at all levels (communication strategy of the Public Health Program, public media, professional materials).
7. Increase efficiency of benefits that aim marginalized population groups and are reimbursed by the Health Insurance Fund.
8. Select and/or elaborate procedures of analysis and monitoring to carry out efficiency control of actions serving the attainment of objectives.
9. Invite offers to support programs of providing medical care to persons with multiple disabilities.

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# HEALTH PROMOTION IN SETTINGS OF DAILY LIFE

## **Actions to be implemented in 2003-2004**

1. Map ongoing activities – establish 'Health promotion in settings of daily life' database.
2. Implement joint training for representatives of different settings by regions, subsequently put together long-term plan based on consensus and broken down by settings, tasks, institutions, and civil partners, in close cooperation with the persons in charge of the other programs of the public health program.
3. Invite offers, adjudicate and finance them in line with the objectives.
4. Elaborate regulatory and legislative options for decision-makers at communities to advance health promoting community development and policies; compile collection of template municipality regulations.
5. Define methods and indicators for the necessary research, monitoring and evaluation.
6. Align marketing strategy with other elements of the public health program.
7. Appearance at domestic and international events.
8. Publish the program in writing and ensure that it is accessible and searchable on the Internet.

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**CREATING  
A HEALTH  
PROMOTING SOCIAL  
ENVIRONMENT**

**PROGRAMS OF  
HEALTHY  
LIFESTYLES,  
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**STRENGTHENING THE  
INSTITUTIONAL  
SYSTEM OF  
HEALTHCARE AND  
PUBLIC HEALTH  
TO IMPROVE HEALTH**

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# CUTTING BACK TOBACCO SMOKING

## **Actions to be implemented in 2003-2004**

1. Set up tobacco control coordination office.
2. Analyse campaigns in this country and in relevant other countries; make proposals to the contents, message, media-mix, budget, management, follow-up and control of the National Tobacco Control Campaign in preparation
3. Launch National Tobacco Control Campaign.
4. Launch green phone number and internet-accessible quitting program.
5. Develop tobacco control pages at the public health portal.
6. Put together quitting smoking kit.
7. Create hot line to report violation of regulations and laws related to tobacco use.
8. Promote communication among professionals via the homepage.
9. Revive and operate National Tobacco Control Forum.
10. Revive and operate 'Smoke Filter'.
11. Launch monitoring of activities in Hungary of the tobacco industry and communicate findings.
12. Hold regular press conferences addressing this topic.
13. Analyse key actors in the field and tobacco control activities.

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# ALCOHOL AND DRUG PREVENTION

## **Actions to be implemented in 2003-2004**

1. Provide (proactively) support to teaching in alcoholology and addictology at medical universities, training institutions of psychologists, social workers and teachers; include this body of knowledge into postgraduate education of professionals.
2. Implement alcohol minimal intervention programs in primary health care, specific ambulatory and institutional settings of somatic specialist care; implement pilot and demonstration programs; offer training and care management.
3. Implement demonstration programs of workplace-based early treatment (alcohol; action system within the organisation, care management, monitoring, outcome studies).
4. Collect epidemiological data concerning alcohol consumption; join surveys and carry out survey on national representative sample (as baseline or pre-study for regularly repeated surveys.)
5. Initiate prevention and correction programs for children raised in families of alcohol and drug addicts (with the assistance of NGOs and faith-based organisations), model programs
6. Offer therapeutic outpatient and outreach services using low-threshold counselling and health psychology intervention techniques (in continuing care facilities of TÁMASZ and at faith-based service provision sites, as well as in the frames of service delivery centres)
7. Assist and advance non-governmental organisations of alcohol addicts who have successfully recovered; and self-help groups in the alcohol and drug fields.
8. Apply innovative treatment techniques in the early ambulatory and institutional treatment of drug and alcohol addicts (family therapy, hypnosis, cognitive and behavioural techniques, NLP, etc.)
9. Apply intensive care models (on an inpatient or outpatient basis, or in the form of day sanatorium) for alcohol and drug addicts with a strong motivation to change
10. Train journalists, support special programs, mobilise students in communication, design media marketing for the specific program elements of the actions, engage in networking with media professionals.
11. Publish and support professional materials and books, partly related to the individual program elements.



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# HEALTHY NUTRITION AND FOOD SAFETY

## **Actions to be implemented in 2003-2004**

1. Study dietary and nutritional status on a representative population sample, in collaboration with Ministry of Agriculture and Regional Development and the Hungarian Scientific Society for Food Industry (MÉTE).
2. Finalise, approve and implement food and nutritional policies in alignment with WHO/Euro guidelines and in cooperation with Ministry of Agriculture and Regional Development, Ministry of Education, Prime Minister's Office, the Hungarian Scientific Society for Food Industry (MÉTE)
3. Publish new edition of Nutritional Recommendations in high circulation
4. Provide teaching in healthy dietary habits by dieticians to third and fourth-graders at elementary school. Continue teaching in health dietary habits for fifth graders.
5. Introduce nationwide 'Vegetables, greens and fruits – three servings a day' action in cooperation with the Ministry of Agriculture and Regional Development and Ministry of Education
6. Launch green pyramid action
7. Provide continuing education for catering managers (healthy nutrition, food safety)
8. Introduce dietary counselling in family planning health education
9. Conduct professional consultation with experts of the food industry in order to develop and manufacture foods of a more favourable structure and composition, with the involvement of Ministry of Agriculture and Regional Development and the Ministry of Economic Affairs and Transport, as well as in order to apply food labelling that contains more nutritional information.
10. Involve dieticians, Red Cross volunteers, family protection professionals and health visitors in training teachers of health nutrition in small communities
11. Establish cooperation with the Professional College of Paediatrics in order to disseminate the principles of breastfeeding until the age of 6 months and appropriate weaning practices, as well as implement healthy dietary habits for children aged 1-3 years
12. Review the menu in mass catering and if necessary, offer new menu
13. Increase the number of recipients of child catering services
14. Elaborate draft program to introduce healthy food choice at school cafeterias
15. Increase and make public the food databank, furthermore expand food intolerance and dietary allergy databank
16. Elaborate, widely disseminate and impose food safety policy
17. Inform population at large on food safety (food hygiene) in order to decrease high incidence of food intoxication in the household; elaborate methodological guidelines, control measures and protocols
18. Promote introduction of, and ensure efficient control of HACCP systems; National Public Health and Medical Officers' Service to implement surprise controls simultaneously in the whole country twice a year from 2003.

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## PROMOTING PHYSICAL ACTIVITY

### **Actions to be implemented in 2003-2004**

1. World days of more physical activity (healthcare players, National Public Health and Medical Officers' Service, local decision-makers, local media and population in addition to local professionals)
2. Provide continued support to most appropriate methods for health promoting daily exercise through a multidepartmental grant scheme in the 2003/2004 academic year; develop criteria of health promoting efficiency in wide cooperation; incorporate funding for daily health promoting physical exercise in the 2004 budget
3. 'Do have self-respect'. Create sports clubs for WOMEN, conductors of families' healthy lifestyles, on the model of the existing 20 Walk and run clubs that are scattered across the country.
4. Offer optional actions at workplaces: 'Climb the stairs instead of using the elevator', 'Move without the mouse too', 'Sports Friday at the workplace', 'Physical exercise in suit', 'Moving minutes and moving bodies'
5. 'Health is the strongest weapon' – project of the Ministry of National Defence
6. Organise nationwide 40 minutes' walking at specific days, primarily for elderly population
7. Implement media strategy jointly with the subprograms of the Public Health Program for the Decade of Health
8. Provide education and continuing education in health improvement, but especially to impart knowledge on the importance of regular physical exercise to teacher and health development professionals in the health services.

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# PUBLIC HEALTH AND EPIDEMIOLOGICAL SAFETY

## Actions to be implemented in 2003-2004

### Task 1

1.1. Organise laboratory back-up to measure, diagnose and identify risks related to radiation and chemical exposure, biological contamination. Its infrastructural part is available from Phare-support partly at the National Centre of Public Health and the National Epidemiological Centre, partly at the regional institutes;

1.2. Equip or design a mobile unit (3 specifically transformed and equipped motor vehicles);

#### **1.3. Tasks related to strengthening public health safety**

1.3.1. Organise and provide training to an-call system and chain of alert;

1.3.2. Update structure of NPHMOS (strengthening the Office of the Chief Medical Officer and municipal institutes; ensure rational operation of county institutes and national centres);

1.3.3. Formulate training requirements in the fields of chemical safety, occupational health, environmental health, radiation hygiene, food safety and epidemiological safety for professional education, continuing education and special training courses;

1.3.4. Develop quality control of the healthcare provision system;

1.3.5. Elaborate methodology for efficient control as part of enforcement authority (food safety, environmental health, radiation hygiene, chemical safety); develop agenda for surprise targeted inspections to be carried out simultaneously across the country.

1.4. Tasks related to education and training:

1.4.1. Initiate full-time professional education in labour hygiene (ensured from Phare-support);

1.4.2. Lay foundations of training of food safety inspectors (elaborate program, compile textbooks);

1.4.3. Train environmental health inspectors;

1.4.4. Train radiation hygiene inspectors;

1.4.5. Train sanitary-epidemiological inspectors and infection control specialists;

1.4.6. (Training of chemical safety inspectors was accomplished in 2002.)

### Task 2

In connection with radiation and chemical safety:

2.1. Develop, disseminate widely and ensure acceptance of policy;

2.2. Update country profile of chemical safety; elaborate national chemical safety action program taking into account the recommendations of IFCS (Intergovernmental Forum on Chemical Safety); launch implementation of program;

2.3. Establish a special sampling unit that is a prerequisite for the rapid identification of, and taking necessary actions with regard to hazardous materials and radiation sources which entered the country illegally and were confiscated or banned;

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2.4. Ensure that the staff manning mobile radiation and chemical safety units and the personnel at relevant authorities get familiar with the specific requirements of procedures related to radiation protection and chemical safety.

### **Task 3**

In connection with epidemiological safety:

- 3.1. Develop, disseminate widely and ensure acceptance of policy;
- 3.2. Develop laboratory and IT background to serve the surveillance system ensuring epidemiological rapid response capacities; introduce and impose new knowledge and methods;
- 3.3. Elaborate mid-term and long-term vaccination strategy;
- 3.4. Develop state-of-the-art laboratory diagnosis of new and dangerous infectious diseases, together with an appropriate safety laboratory and reference laboratory background;
- 3.5. Launch a new data collection system of nosocomial infections
- 3.6. Introduce Directly Observed Treatment (DOT) in 5 counties;

### **Task 4**

Occupational health preparations:

- 4.1. Draft legislation on mandatory comprehensive reporting of occupational diseases;
- 4.2. Elaborate country profile in occupational health;
- 4.3. Implement those parts of the National Program of Occupational Safety that are assigned to occupational health services.

### **Task 5**

In connection with environmental health safety:

- 5.1. Develop, disseminate widely and ensure acceptance of policy;
- 5.2. Develop and publish methodological guideline on the rapid assessment of the hazards and risks of industrial sites,
- 5.3. Perform annual surprise inspections to check out environmental health havaria plans.

### **Task 6**

In connection with IT developments at the National Public Health and Medical Officers' Service (NPHMO):

- 6.1. Launch IT system and infrastructure covering central and regional institutes of the NPHMOS which ensures the Service's rapid reaction capability at all levels (national, regional, county, municipal) and at all areas of public health, and which contains structured and valid databases and enable rapid risk assessment and information;
- 6.2. Establish databases to support strengthening of the coordination of surveillance in chemical, food, epidemiological, radiation and occupational safety as well as environmental health, which will ultimately improve the supervision and enforcement ability of the Service;
- 6.3. Establish connection systems promoting up-to-date and rapid information flow with authorities interested in the institutionalisation of public health safety;
- 6.4. Make the chemical Safety Information System (KBIR) operational.

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# NATIONAL ENVIRONMENTAL HEALTH ACTION PROGRAM

## Actions to be implemented in 2003-2004

1. Study two selected areas in the initial stage of soil pollution investigations.
2. Assess waste disposal sites and their environmental pollution impacts.
3. Carry out on-site sampling in building containing asbestos insulation and determine type of asbestos; carry out indoor air background measurements in rooms in buildings containing asbestos; carry out leakage and purity efficiency measurement during demolition of asbestos in buildings.
4. Determine 1,200 dioxin and dioxin toxicity chemical compounds per year.
5. Initiate population information efforts to advance human adaptation.
6. Establish regular data provision with curative institutions in order promote planning for emergency care provision related to extreme weather conditions.
7. Call for killing ragweed: organise annual RAGWEED-KILLING WEEK (last week of June).
8. Urge land owners and tenants to continuously engage in weed killing in the frames of calls, leaflets and information presentations, with the involvement of the county ragweed coordinators of the NPHMOS.
9. Forward information rapidly and frequently, forecast current and expected status of pollen situation and publish such forecasts in the written and electronic media as part of the meteorological report.
10. Expand regular forms of information to doctors, local governments and other authorities in the ragweed season.
11. Develop the Aerobiological Network of the NPHMOS with additional pollen traps; provide training and professional continuing education for future staff at stations ready to operate, as part of the criteria for installation
12. Assess turnover of patients with allergy regularly
13. Investigate factors influencing microbiological pollution levels in natural baths: study the impact of precipitation penetration and the polluting effect of water birds.
14. Carry out hygienic and quality assurance development related to the use of mineral waters and therapeutic waters.
15. Implement methodological developments in the field of virus identification and protozoological methods.
16. Study the allergization and skin irritation effect of blue algae at times of algal bloom in bathers
17. Investigate Cryptosporidium and Giardia protozoones in natural and pool bathing waters.
18. Establish continuous information for the population at large about the microbiological quality of recreational waters.
19. Implement national data collection on electromagnetic apparatus getting into the environment.
20. Elaborate piloting and validating procedures.

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21. Start uploading database.
  22. Elaborate most appropriate method for drawing up radon map of Hungary.
  23. Approach organisations and individuals who may be involved in data collection.
  24. Edit form required to administer representative survey of activity concentration of radon in the indoor environment.
  25. Elaborate appropriate measurement method.
  26. Implement representative survey of a limited area in order to test the methods designed and tools.
  27. Elaborate a grant scheme and provide funds for the grants to ensure elaboration of local environmental health action plans in the frames of multilateral agreement between line ministries (Ministry of Environment and Water Management; Ministry of the Interior, Ministry of Health, Social and Family Affairs, Ministry of Agriculture and Regional Development).

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# REDUCING MORBIDITY AND MORTALITY DUE TO CORONARY ARTERY DISEASES AND CEREBROVASCULAR DISEASES

## Actions to be implemented in 2003-2004

1. Collect epidemiological data on hypertension, blood cholesterol levels, obesity, decreased glucose tolerance and diabetes.
2. Ensure that hypertension, smoking and obesity are detected at each doctor-patient encounter.
3. Use cardio-vascular risk tables in family practices.
4. Organise further clinical workup of patients with multiple risks at stroke or cardio-vascular outpatient clinics (Doppler ultrasonography, TCD investigation)
5. Develop and expand register.
6. Establish a network of patients' clubs and provide support to the existing ones.
7. Popularise on-day events (eg. Our Heart's Day, Hypertension Day) and ensure countrywide expansion thereof.
8. Edit informative newsletter covering this topic and disseminate it to the media.
9. Organise continuing medical education and series of conferences in the relevant topics (hypertension, obesity, diabetes).
10. Elaborate specific screening and prevention strategies for target population groups, relying on the existing databases.
11. Implement unified stroke treatment guidelines across the country; standardise patient trajectories.
12. Place information posters on ambulance cars and public transportation vehicles with a list of symptoms of heart attack and stroke and the phone number of the emergency ambulance service.
13. Prevent cardio-vascular diseases in adults in childhood and adolescence.
14. Provide blood pressure measurement opportunities (e.g. automated blood pressure meters) in retail pharmacies, shopping malls, banks, and public offices.
15. Draw up development plan to address the creation of appropriate conditions for the establishment of interventional cardiology centres and interventional vascular neurology.



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# REDUCING MORBIDITY AND MORTALITY DUE TO NEOPLASMS

## **Actions to be implemented in 2003-2004**

1. Develop unified concept and elaborate professional documents to support oncological activities on the primary healthcare level.
2. Advance the data provision system in oncological services.
3. Elaborate curriculum for unified undergraduate and postgraduate education.
4. Establish county Oncology Centres.

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# STRENGTHENING MENTAL HEALTH

## Actions to be implemented in 2003-2004

1. Organise and launch unified epidemiological surveys.
2. Incorporate education for health into different subjects (biology, chemistry, history, physical education, ethics, etc.); expand number of teachers having mental health knowledge (currently 1,000 teachers).
3. Engage in network and community development of NGOs, churches and operational professional communities; establish register of professionals working for mental health.
4. Make reporting attempted suicide mandatory.
5. Elaborate operating conditions of crisis management units.
6. Design crisis intervention protocols, stabilise their organisational structure and make payment criteria more unified.
7. Organise continuing education for healthcare workers and interested teachers in relation to the early detection of suicide risk.
8. Set up, train and support self-help groups of teachers.
9. Ensure, in the long run, operational conditions for emergency phone numbers.
10. Elaborate transformation of psychiatric institutional system into community psychiatry.
11. Develop community psychiatry in relation to paediatric psychiatry.
12. Create operating conditions for consultation liaison psychiatry services on the country level
13. Develop and expand psychotherapy outpatient clinics
14. Increase the number of paediatric psychology continuing care facilities and develop ambulatory care facilities
15. Implement programs of sensitisation for primary health care workers
  - a) Introduce efficient teaching of psychiatry into training of residents in family practice
  - b) Organise accredited continuing education courses for primary health care workers (family practitioners, family paediatricians, health visitors, graduate nurses, social workers)
  - c) Organise accredited continuing education courses for the occupational health network, military surgeons' network, school health network and social workers.
  - d) Establish group practices with psychological services.
16. Elaborate ways of advancing community rehabilitation
17. Elaborate protocols for programs in occupational rehabilitation; revisit and expand the functions of County Rehabilitation Committees; revise their system of norms and mode of operation.
18. Design prevention projects (two main settings: the family and the school).
  - a) Elaborate preparation programs for families
  - b) Develop family assistance centres, train professionals
  - c) Incorporate education for health into teacher's training
  - d) Incorporate mental health knowledge into teacher's training
  - e) Implement accredited continuing education courses in health promotion and mental health. Draw up list of recommended training courses.
19. Develop background institutions in the social welfare and educational areas.
20. Establish consultative paediatric psychiatry in children's hospitals.

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# REDUCING MORBIDITY DUE TO LOCOMOTOR DISEASES

## **Actions to be implemented in 2003-2004**

1. Launch targeted locomotor screening, prevention and rehabilitation programs; establish the necessary network and infrastructure in all the three target population groups.
2. Assess deterioration in quality of life due to locomotor diseases.
3. Organise teaching, continuing education and patient education concerning locomotor diseases.
4. Pilot with model of care provision to patients with locomotor diseases in primary health care.
5. Prepare feasibility study of locomotor register and implement a limited pilot.
6. Relying on the involvement of faculty at schools of physical education who are qualified and certified to teach spine gymnastics, continue training of physical education teachers; control and help implementation.
7. Elaborate screening protocol and model for locomotor diseases in childhood, primarily spine disorders, that are effective and cost-efficient and may be documented.

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## PREVENTING AIDS

### **Actions to be implemented in 2003-2004**

1. Design primary prevention programs for elementary and secondary schools. Launch continuing education for health educators and teachers. Introduce model for schools.
2. Offer prevention programs to high-risk communities. Involve NGOs and individual members of these communities into program implementation (gay communities, prostitutes, injection drug users).
3. Implement annual media campaigns for the public at large on HIV infection prevention, on changed AIDS disease; demystify the disease and decrease discrimination and segregation.
4. Strengthen enforcement of legally required regular medical check-ups of prostitutes, including HIV-tests.
5. Expand monitoring the HIV/AIDS epidemics among intravenous drug users.
6. Support the work, and extend the activities, of the Anonymous AIDS Counselling Service; operate AIDS phone-in helpline, develop home page on the internet.
7. Organise continuing education courses for family practitioners and family paediatricians, as well as doctors, and dentists who might get into contact with HIV-patients; implement five courses.
8. Elaborate social care provision system for socially severely disadvantageous HIV-infected persons.

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## PUBLIC HEALTH SCREENINGS

### **Actions to be implemented in 2003-2004**

1. Install and test run the final IT software that covers all three screening modalities (starting from January 2003.).
2. Settle reserves related to Social Insurance Number with National Health Insurance Fund and the ombudsman on data protection in order to ensure better patient pathways follow-up and quality assurance at appropriate levels.
3. Organised population-based screening of cervical and colon cancer; set up technical and professional bases thereto.
4. Launch gynaecological-oncological screening including cytohistology for women aged 25-65 years.
5. Evaluate first round of breast cancer screening; draw theoretical and practical conclusions; make appropriate decisions and prepare for second two-year round.
6. Guarantee professional staffing requirement of population screening; primarily restore training of cytology pre-screening technicians and arrange for background capacities in pathology.

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## IMPROVING THE PROVISION OF CARE

### **Actions to be implemented in 2003-2004**

1. Document distortion of patient pathways by disciplines and types of institutions, in a specific way and supported by statistical, IT, sociological, social medical etc. analyses, especially in the case of cardio-vascular diseases, neoplasms, renal failure.
2. Conduct complex health sociological study to identify the situation, approach and behaviour of those working at different levels of care; analyse the situation in order to identify points of intervention.
3. Identify (or train) players in the system who can be charged with 'preventive' tasks within the care provision system.
4. Launch training to create pool of professionals doing risk assessment and counselling in addition to the family practitioner
5. Identify communication problems between levels of care provision and elaborate proposals for financing.
6. Prepare and disseminate information materials targeted at the different professional levels.
7. Discussion forums to advance communication and coordination.
8. Develop consensus in guidelines for developing the care provision network, capacity regulation, criteria of accommodating a service for reimbursement and the algorithm of allocating development funds.
9. Map out health/disease consciousness in relation to patients' movements within the healthcare system.

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## RESOURCE DEVELOPMENT

### **Actions to be implemented in 2003-2004**

1. Prepare comprehensive study on current organisational structure and possible future developments of public health
2. Expand Internet access of public health personnel through grant scheme
3. Launch public health portal.
4. Establish civil consortium.
5. Plan and implement public health distance education infrastructure.
6. Design distance education modules in public health.
7. Prepare methodological program of training public health managers.
8. Make nationwide survey of PhD research in public health and elaborate reporting system.
9. Advance public health professionals' skills of surfing the net via distance education.
10. Set up monitoring system for grants within the Public Health Program and make it available for those concerned
11. Implement central planning of PhD programs to be launched in the field of public health
12. Systematise funds for research in public health (Ministry of Health, Social and Family Affairs, Ministry of Education)



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# MONITORING – INFORMATION TECHNOLOGY

## **Actions to be implemented in 2003-2004**

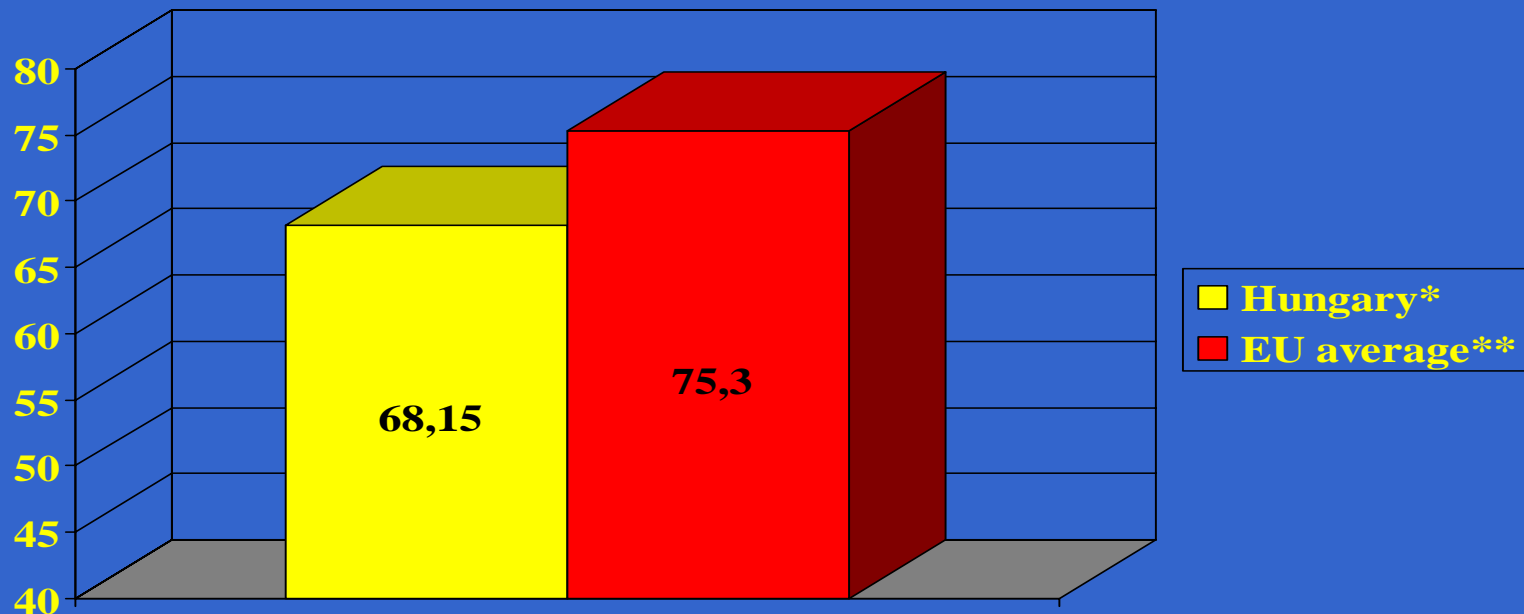
1. Draw up budget of Program monitoring in annual breakdown
2. As part of the annual report, present the progress and achievements of the Program.
3. Compile definitions and structure of the whole system of health and social welfare indicators in the form of a handbook and internet application.

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# Selected demographic data

A comparison of averages in Hungary  
and the European Union

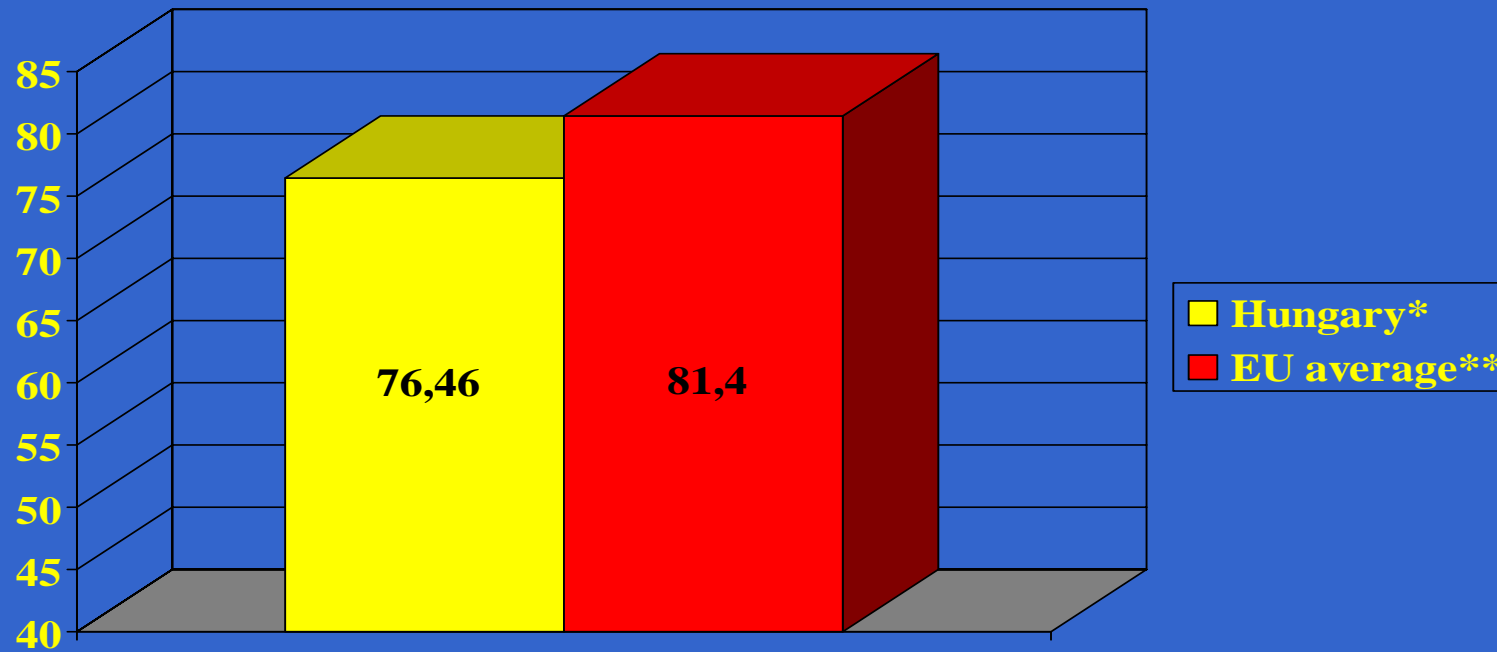
## Average Life Expectancy at Birth I. Males



Sources: \* CSO data for 2001

\*\* Statistics in Focus: Population & Social Condtion (Theme 3-17/2002);  
First results of the demographic data collection for 2001 in Europe

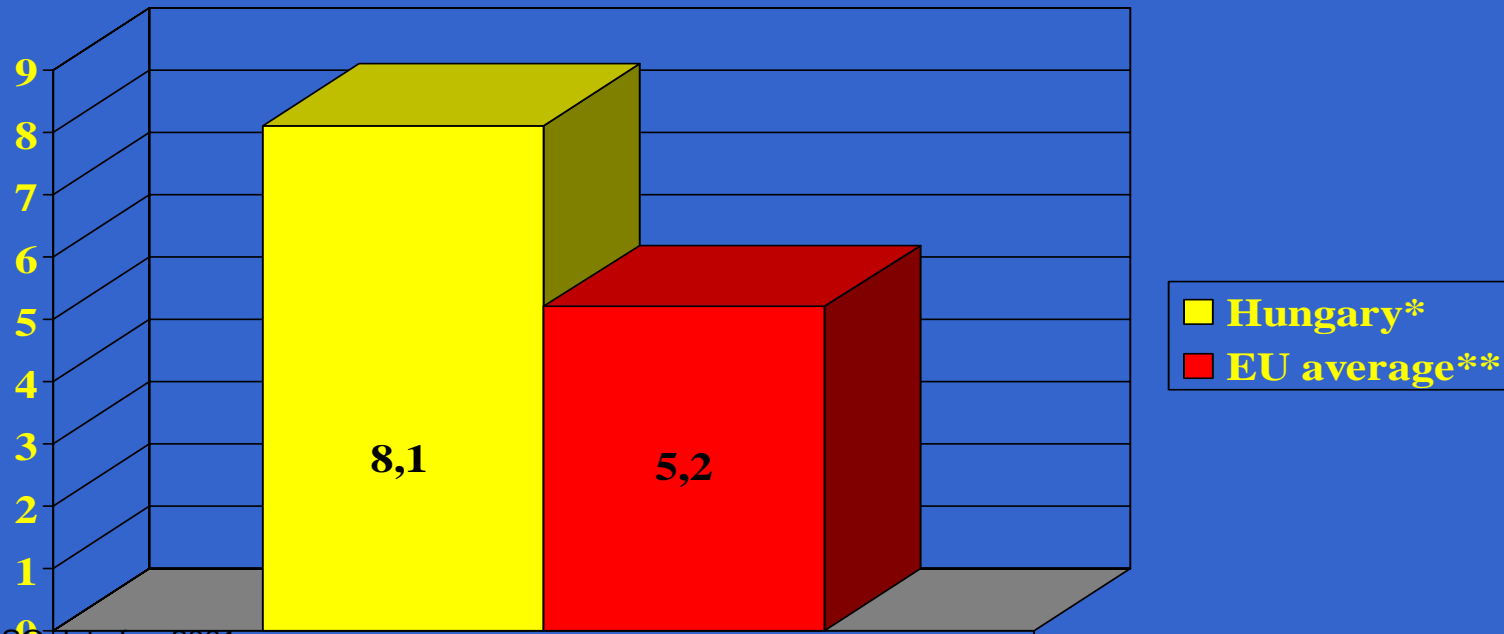
## Average Life Expectancy at Birth II. Females



Sources: \* CSO data for 2001

\*\* Statistics in Focus: Population & Social Condition (Theme 3-17/2002);  
First results of the demographic data collection for 2001 in Europe

## Infant Mortality (Rate per 1,000 liveborn)



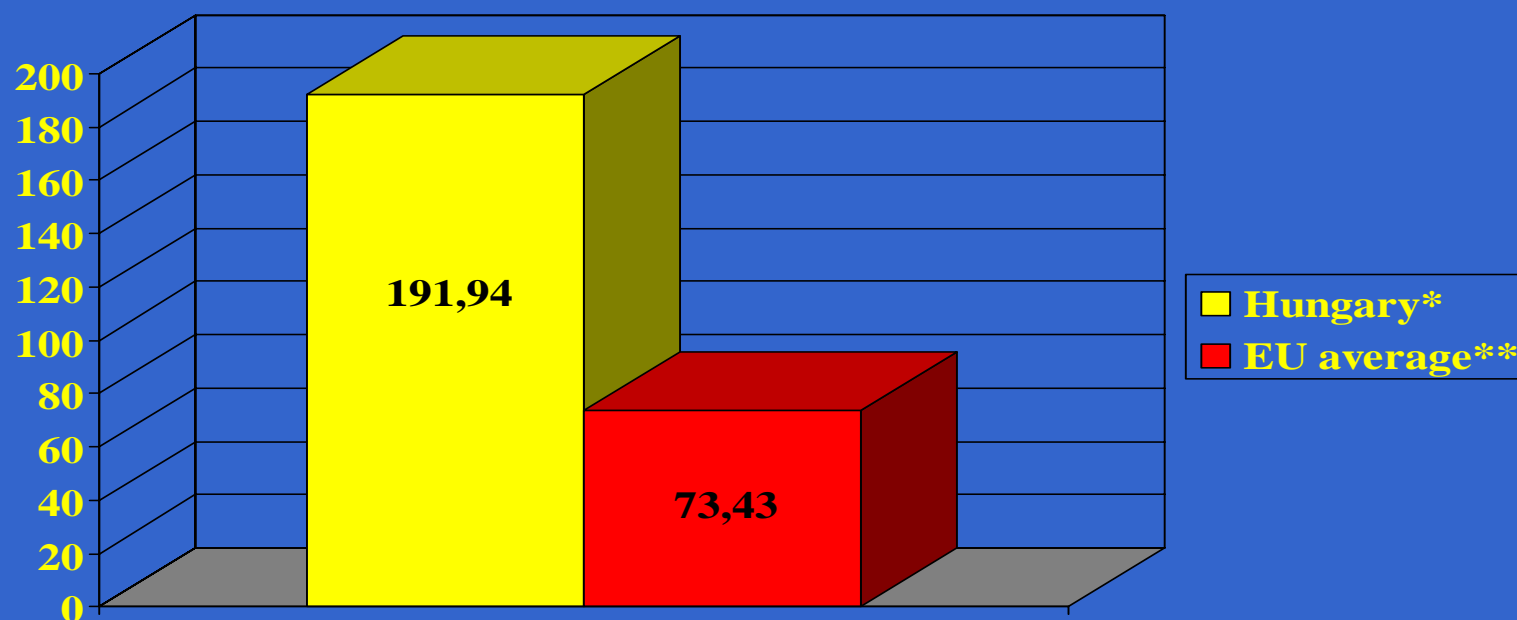
Sources: \* CSO data for 2001

\*\* Statistics in Focus: Population & Social Condtion (Theme 3-17/2002);  
First results of the demographic data collection for 2001 in Europe Data for  
the year 1998

# Standardised Mortality due to Diseases of the Circulatory System I.

(Rate per 100,000 population; age-group 0-64 years)

Males



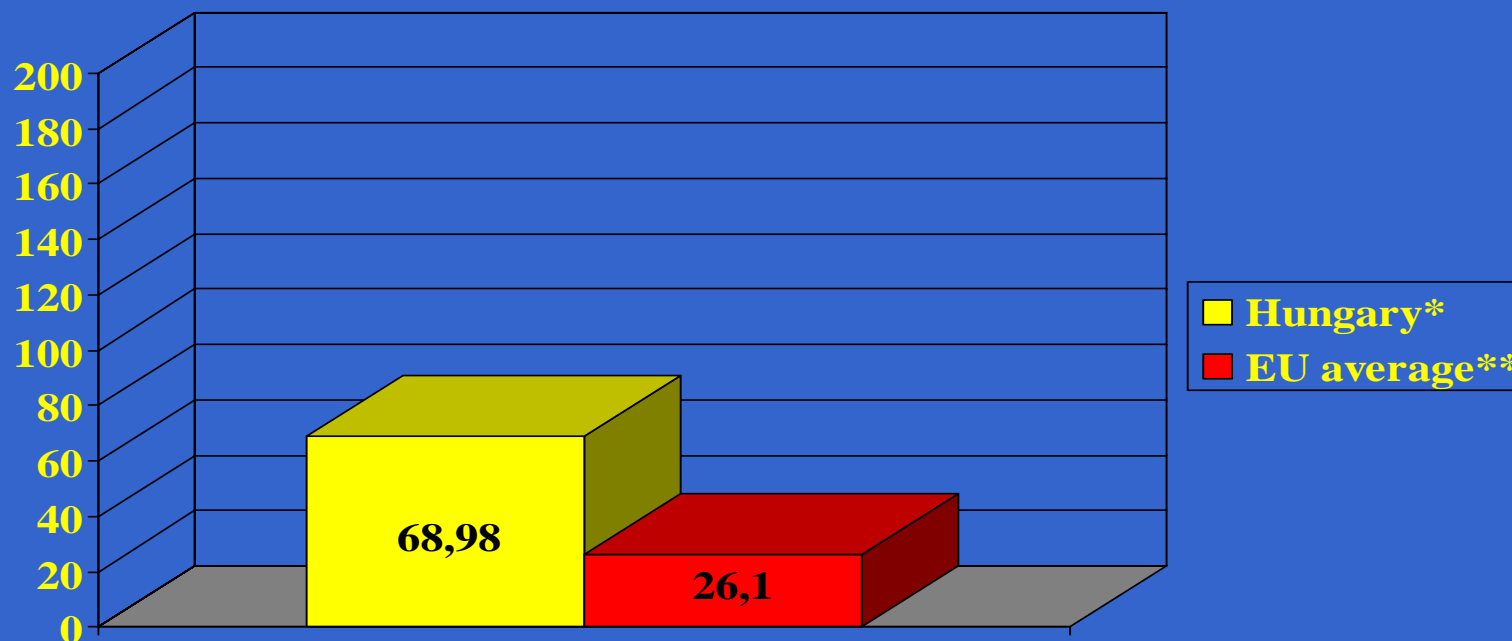
Sources: \* CSO data for 2001

\*\* Statistics in Focus: Population & Social Condon (Theme 3-17/2002);  
First results of the demographic data collection for 2001 in Europe Data for  
the year 1998

# Standardised Mortality due to Diseases of the Circulatory System I.

(Rate per 100,000 population; age-group 0-64 years)

## Females

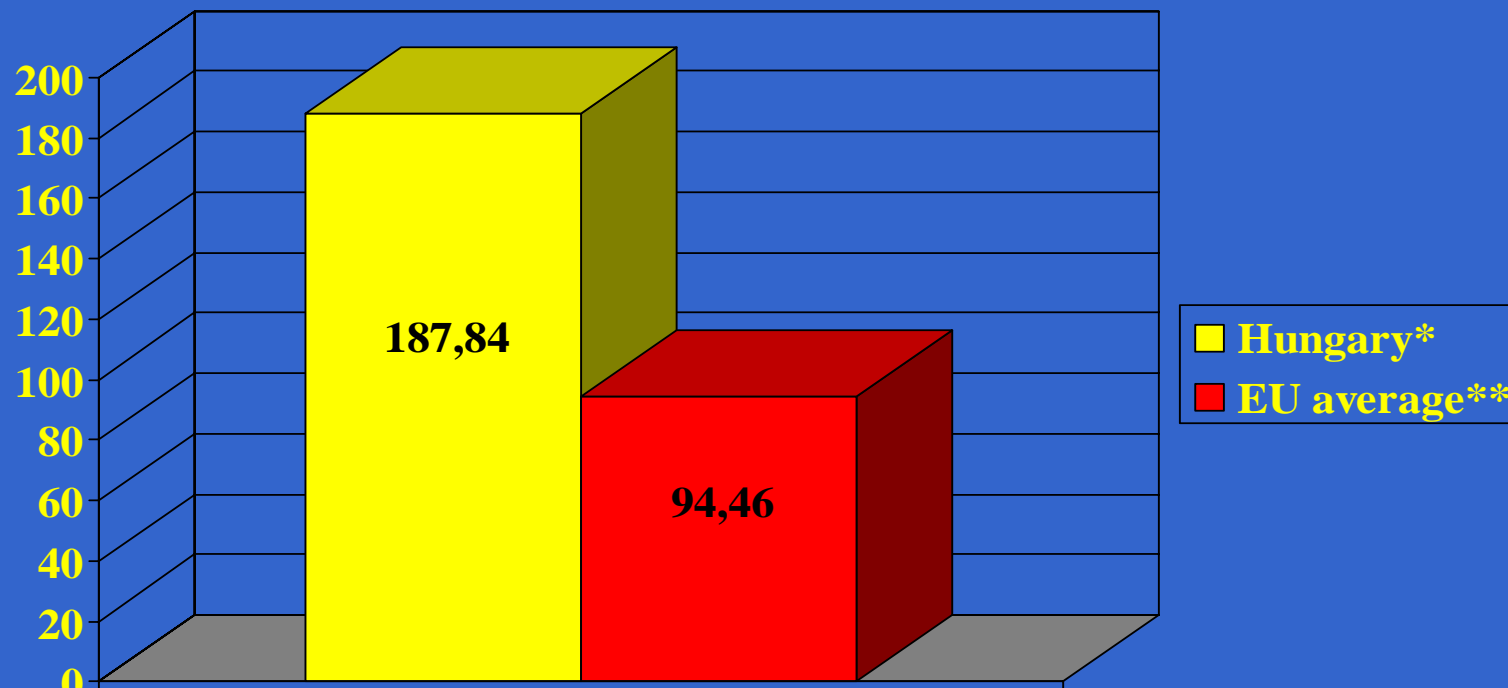


Sources

\* CSO data for 2001

\*\* Statistics in Focus: Population & Social Condotion (Theme 3-17/2002);  
First results of the demographic data collection for 2001 in Europe Data for  
the year 1998

# Standardised Mortality due to Neoplasms I. (Rate per 100,000 population; age-group 0-64 years) Males



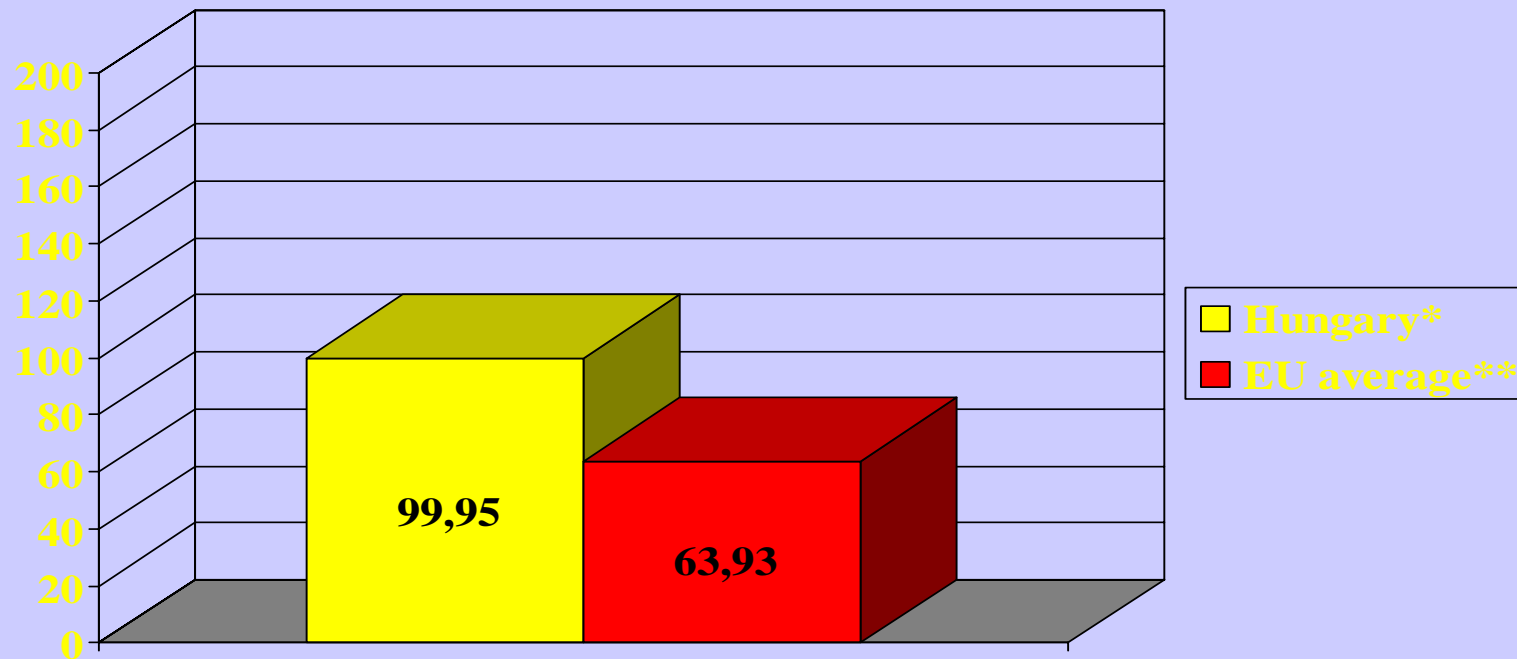
Sources : \* CSO data for 2001

\*\* Statistics in Focus: Population & Social Condition (Theme 3-17/2002);  
First results of the demographic data collection for 2001 in Europe Data for  
the year 1998



# Standardised Mortality due to Neoplasms II.

(Rate per 100,000 population; age-group 0-64 years)  
Females



Sources

\* CSO data for 2001

\*\* Statistics in Focus: Population & Social Condotion (Theme 3-17/2002);  
First results of the demographic data collection for 2001 in Europe Data for  
the year 1998