

Hungary: social cohesion for mental well-being in adolescents

Dóra Várnai¹, Gyöngyi Kökönyei¹, Ágnes Németh¹, Bea Pászthy², Anna Aszmann¹.

¹ *National Institute of Child Health, Budapest.*

² *Semmelweis Medical University, Budapest.*

Executive summary

Mental disorders and illnesses represent over 11% of the total disease burden worldwide. In Hungary, 30% of social and economic loss due to all morbidity among people aged 15–44 years is related to mental ill health. Despite this, recent Hungarian data show that the number of patients treated in adult or paediatric psychiatric care institutions and in psychiatric outpatient services has decreased.

According to national epidemiological studies, one fifth of children and adolescents suffer from some kind of emotional or conduct disorder or have psychosomatic complaints. Follow-up studies provide evidence that mental health is one of the most significant background variables for mortality; coping skills and positive self-evaluations established in childhood and adolescence are therefore crucial in promoting good lifelong physical and mental health. Indicators of mental health influence the quality of life, health status and economic status of any given population.

The Hungarian case study firstly describes the mental health and well-being status of adolescents based on 2006 HBSC survey data and some other sources. The following topics are covered in detail: suicide; suicide attempt; risk behaviour (briefly); child abuse and intentional injury; subjective well-being; self-rated health; satisfaction with life; depression; self-esteem; and somatic and psychological complaints. The socioeconomic status of young people with some relevant links to mental health indicators is also analysed.

The study then briefly presents some demographic information and descriptions of characteristics of the mental health care system and the main mental health promotion projects before going on to introduce the “Children – our common treasure” national infant and child health programme, a comprehensive strategy addressing child and adolescent health. Mental health can be affected not only by explicit mental health policies, but also by policies that seem to have no direct link, such as those on housing and education. The national programme is a good example of an approach that takes all these diverse elements into account.

Two live examples are described to illustrate mental health initiatives in practice: the role of primary health care professionals in the prevention of later developmental and mental disorders, and a community psychiatric NGO’s activity to coordinate local welfare services in covering a wide variety of mental health issues.

Finally, some conclusions about the national programme – its strengths, experiences, weaknesses and future directions – are drawn.

About Hungary

Hungary is a republic with a territory of 93 000 km². For administrative purposes, the country is divided into 19 counties and the capital city of Budapest.

In 1990, following changes in the political system, a new independent democratic state was established, with parliamentary democracy based on free elections and a multiparty structure and new legislation eliminating barriers to the development of a market economy. Hungary faced temporary severe economic decline, unemployment and social polarization in the 1990s, but by the end of the decade, development had accelerated.

Currently, Hungary is a member of the United Nations, WHO, the CoE and OECD. It joined the North Atlantic Treaty Organization (NATO) in 1999 and the EU in 2004.

Mental health and well-being among adolescents

Subjective well-being in the 2006 HBSC data

Self-rated health

Most of the students reported their health to be “excellent” (31.4% of boys and 18.7% of girls) or “good” (47.1% of boys and 50.0% of girls). Some of them – 21.5% of boys and 31.2% of girls – considered their health to be “average” or “bad”.

Life satisfaction

Applying the Cantril ladder (the top of the ladder (10) indicates the best possible life, and the bottom (0), the worst possible life), the Hungarian average was 6.96 (SD = 1.94), with no gender difference observable. Life satisfaction decreased with age. Most of the students belonged to the average range or above, although the proportion decreased with age. There was no significant difference from the previous HBSC survey (1).

Depression

Measured with the Child Depression Inventory (CDI, shortened version applied in the seventh, ninth and eleventh grade), the average for the whole sample was 2.36 (SD = 2.47). Boys scored significantly lower than girls, with the difference remaining stable across all age groups. The cut-off point in CDI is considered to be 4 (2); for most students (56.1% of boys and 40.1% of girls), the total score was 0–1, which indicates good general mood and a lack of depressive symptoms. Approximately 25% (24.5% of boys, 27.8% of girls) scored 2–3, indicating disturbed mood, and nearly 30% of girls and 19% of boys had 4 or more points, which might indicate depressive mood.

Self-esteem

The average of the whole sample was 28.49 (SD = 4.92), measured with the Rosenberg Self-Esteem Scale (a ten-item scale ranging from 10 to 40 in measuring global self-esteem). Boys scored significantly higher than girls, and this difference remained stable across all age groups. This was similar to the previous study results, as the ninth grade girls had less-favourable measures on self-esteem and depressive mood (1).

Somatic and psychological symptoms

The average of the symptom checklist (a nine-item standard symptom checklist with five frequency options, ranging from 9 to 45) of the whole sample was 20.43 (SD = 7.36). Girls scored significantly higher (mean = 21.80, SD = 7.56, boys' mean = 19.12, SD = 6.92) and reported symptoms more frequently. The gender difference remained stable across all grades. There was a significant difference between age groups in girls.

For both genders in all grades, there was a high occurrence of irritability and feeling low (both prevalences were higher among older girls), nervousness and feeling tired at least weekly (approximately 30% in the fifth grade and above 40% in boys and above 55% in girls in eleventh grade).

A significantly higher rate of girls reported experiencing headache, stomach ache and backache regularly. In the ninth and eleventh grade, one third of the girls experienced frequent headache and a quarter complained about frequent stomach ache and backache. For boys, the frequent occurrence of these symptoms never exceeded 15% in any grade. Difficulties in getting to sleep were more common for girls, especially with increasing age, while it declined to under 10% for eleventh grade boys.

A high rate of students reported having two or more symptoms at a time. More than one fifth of the seventh, ninth and eleventh grade girls experienced at least two symptoms several times a week.

Approximately 15% of the fifth to eleventh graders indicated having some chronic disease requiring regular medical follow-up.

The socioeconomic status of young people

According to the 2006 HBSC data, 82.3% of the young people's fathers and 72.2% of their mothers were employed; 10.8% of fathers and 25.8% of mothers did not have a job. Both parents were unemployed in 5.9% of families; this group was considered to be at high risk of mental health problems. There were just under 11% of families in which both parents belonged to the high SES category and who probably lived in very good material circumstances. When taking both fathers' and mothers' financial situations into account (applying the four-category FAS), 6.4% of the families belonged to the low category and were lacking financial resources. Just over 43% of the young people belonged to the low–middle category and 43.2% to the high–middle FAS groups. According to this scale, 7.3% of the families could be considered to be in the most well off range.

Based on subjective categorization, 13% of students considered their families very well off, 25.4% quite well off, 54.9% average, 4.3% not very well off and 1.4% not at all well off.

Differences by FAS

Means of depressive mood scores are shown in Table 1.

When comparing means of depressive mood scores, there was a significant difference between the low and low–middle groups ($F = 5.95^*$, $t = 5.29^{**}$)¹ and between the low–middle group and high–middle group ($F = 30.67^{**}$, $t = 5.96^{**}$), but no meaningful difference between high–middle and high groups ($F = 0.52$, $t = 0.99$).

Table 1

Means of depressive mood scores

FAS group	Depressive mood		Symptom checklist		Life satisfaction	
	Mean	SD	Mean	SD	Mean	SD
FAS low	3.54	2.79	21.88	8.27	5.83	2.20
FAS low–middle	2.57	2.53	20.67	7.28	6.59	1.94
FAS high–middle	2.00	2.27	19.98	7.28	7.33	1.78
FAS high	1.83	2.20	20.31	6.98	7.88	1.64

There was a significant difference in the symptom checklist between low and low–middle FAS category ($F = 10.18^{**}$, $t = 2.69^{**}$) and low–middle and high–middle groups ($F = 1.15$, $t = 3.14^{**}$), but no difference between high–middle and high categories ($F = 0.52$, $t = -0.80$) and no difference between low–middle and the high group ($F = 1.82$, $t = 0.89$).

In relation to life satisfaction, there was a meaningful difference between low and low–middle groups ($F = 6.91^{**}$, $t = -6.52^{**}$), low–middle and high–middle categories ($F = 24.71^{**}$, $t = -13.21^{**}$), and high–middle and high groups ($F = 8.15^{**}$, $t = -5.67^{**}$).

Differences by SES

Differences between the highest and lowest by SES are shown in Table 2.

In depressive mood and life satisfaction, there were significant differences between the highest and lowest maternal SES groups ($t = -3.00^*$ and $t = 4.52^{**}$). Students reported fewer depressive symptoms and higher life satisfaction in the highest maternal SES group. There was no difference between the two groups in the symptoms checklist ($t = -1.43$, ns.).

¹ $F = F$ -probe, $t = t$ -probe, * $p < .05$, ** $p < .01$

Table 2

Differences by SES

Maternal SES	Depressive mood		Symptom checklist		Life satisfaction	
	Mean	SD	Mean	SD	Mean	SD
Highest	1.758	2.232	20.343	6.914	7.48	1.763
Lowest	2.703	2.659	21.532	8.153	6.56	2.040

Dissemination of health data among decision-makers

The Hungarian Government has been made aware of the above-mentioned data. HBSC national reports are disseminated across different ministries, research centres, public health institutions, welfare institutions, education services and participatory schools. They are also published on the web site of the National Institute of Child Health and a press conference is organized to mark the release of the national and international reports. The international report is sent out to a narrower governmental and professional circle. In addition, fact sheets, journal articles, conference presentations and posters on HBSC and related topics are prepared. HBSC data were considered in the relevant topics when the National Infant and Child Health Programme was being designed.

Some other mental health indicators

Suicide

Suicide rates are higher for boys. The number of deaths due to suicide in 2004 was 1.6/100 000 for boys in the age group 10–14 (girls were 0.7/100 000), and 5.8/100 000 for boys in the age group 15–17 (girls: 3.3/100 000).

The ratio of suicide in the child population between 1996 and 2004 shows that the number of suicides for both age groups was significantly lower for girls. For boys, the suicide rate is decreasing after a temporary increase, and for girls there is a slight increase between the ages of 10 and 14. A decrease for boys and no change for girls can be observed in the older group (3).

Attempted suicide

Exact statistical data regarding attempted suicide are not available, but it is known that the rate is significantly higher than for executed suicides. Girls produced more suicide attempts than boys and the rate of attempted suicide has increased since 1996 for both genders in the 10–14 age group. The attempted suicide rate in the 15–17 age group has gradually increased after a sudden decrease in 1997 for both genders (3).

Risk behaviour

According to the 2006 HBSC data, 42.9% of the sample (38.5% of girls and 47.2% of boys aged 11–18 years) had been drunk at least once in their lifetime.

Data on cannabis use showed that 26.6% of boys and 18.7% of girls (aged 15–18) had smoked cannabis at least once. A so-called “heavy user” is considered to be someone who has smoked cannabis 40 times or more; the rate of heavy users by this criterion was 3.8% for boys and 1.3% for girls. The lifetime prevalence of “ecstasy” use was 6.6% for boys and 5.6% for girls, and 0.8% of boys and 0.7% of girls had consumed opiates.

Child abuse, intentional injury

It is very difficult to capture or measure the phenomenon of child abuse within the family. In Hungary, approximately 30 children die every year in cases considered to be homicide, including infant murders and deaths due to severe neglect, but

most cases remain undiscovered (4). Regarding bullying in Hungary, 2006 HBSC data show that 61.9% of young people were not involved in bullying at all, 12.9% were considered to be “bullies-victims” (that is, children and young people who were bullies and the victims of bullies simultaneously), 12.9% were victims and 14.9% were bullies. There were significant gender differences, with more boys among bullies and bullies-victims and more girls among victims.

The current situation in mental health care

Child and adolescent mental health care

Resolving mental health problems in children is a complex task requiring close cooperation among health care, welfare, education and child protection services. It is evident that the current care-provision network in Hungary is unable to cope with the scope of the problem. The network (paediatric outpatient psychiatry, outpatient psychology and counselling services, child protection network, organizations involved in crime prevention, NGOs and inpatient facilities) is so widely separated and areas of competence are so indistinct that care is often provided in a haphazard manner.

The 36 child and adolescent psychiatry centres are the backbone of outpatient psychiatry care for children and adolescents. Their access to equipment and professional staff differs sharply across the country. Existing early development centres that focus on children over the age of one year who have been identified as having pathological symptoms and/or cognitive development difficulties do not have sufficient capacity. Centres focused on seeking out and treating young drug addicts have been established to reflect rising drug problems in society. The emphasis in the past 10 years has shifted towards offering care for 16–18-year-old patients, but the challenge of providing appropriate treatment to those under 16 years remains unresolved.

Day sanatorium/hospital care facilities (a total of 51 places) have been established in three sites in the country. There are currently six inpatient facilities, unevenly distributed throughout the country. There is a complete shortage of child psychiatry intensive rehabilitation beds. In all wards, parents may be admitted with their children. There are two paediatric neuropsychology wards in operation, in addition to the child and adolescent psychiatry wards. Rehabilitation is available in four wards nationwide. There is no separate paediatric rehabilitation ward.

For 44 years, child and adolescent psychiatry training was available only to medical doctors who had specialized in psychiatry; consequently, in order to become a child and adolescent psychiatrist, one had first to have specialized in adult psychiatry. The training system has changed, with child and adolescent psychiatry training being available to doctors immediately after they complete medical training, and they can now practise child and adolescent psychiatry as a basic medical profession. The main mental health promoting projects introduced in public education are shown in Table 3.

Currently, there are a number of projects and policies under way that are related to this case study:

- National Strategy for Drug Prevention;
- National Strategy and Action Plan for Crime Prevention;
- National Programme Countering Child Poverty (this programme has merged into the “Won’t give up on anyone” National Equal Opportunities Programme);
- National Programme for Mental Health;
- National Public Health Programme;
- National Environmental Health Action Programme;
- Injury Prevention Programme;
- Health Development Policy Concept; and
- Human Resource Strategy.

Table 3

Main mental health promoting projects introduced in public education

Project's name	Focus	Target group	Project management
"Healthy life" complex health promotion	Healthy nutrition, environment, personal hygiene, family life and peer relations, alcohol, smoking and substance use	5th–8th graders	National Institute of Health Development
Life-skills and health knowledge	Self-development, healthy and safe life, risk factors, personal safety and responsibility	From nursery school to 14 years	Private initiative
Shapiro programme	Nutrition and health, sexuality, HIV, conflict management and communication, smoking, alcohol and drug prevention, environmental health	Age 10–18 years	Soros Foundation
In healthy body and soul	Personal development, drug and alcohol prevention programme	Age 5–18 years	Canada–Hungary Educational Foundation (CHEF), with the support of Soros Foundation
DADA project	Tobacco smoking, alcohol, drug, HIV prevention programme	Age 6–14 years	National Police Headquarters (ORFK)
UNICRI project	Drug and alcohol integrated prevention programme	Elementary and secondary school students	United Nations Crime and Justice Research Institute's project
Training in conflict management	Self-management, communication and cooperation skills, constructive problem solving and conflict management	Elementary and secondary school students, adults	ENCORE Hungarian Conflict-pedagogy Foundation

“Children – our common treasure” – National Infant and Child Health Programme

Background and objectives

The National Infant and Child Health Programme (NICHP) is based on the principle that the period of life from conception to 18 years is crucial in preserving health and preventing disease during the entire lifespan. The programme was adopted in November 2005 by the Prime Minister.

The main objectives of the NICHP are to:

- focus on child and adolescent health and on the related components of the health care system;
- analyse the current situation related to the state of child and adolescent health and health care and identify the main improvement goals, with a particular focus on equity;
- mobilize society, involving all concerned parties and seeking their support for successful implementation; and
- identify a framework for monitoring and regularly reviewing implementation.

Development and implementation of the NICHP

Building ownership and ensuring coordination

Following the adoption of the NICHP, a programme council with 27 representatives from social and professional organizations and government departments was established. The council contacted representatives of national programmes and the institutions and organizations that would play a key role in NICHP's implementation. The process of developing the NICHP has been participatory, which seems to have contributed to building sound awareness in society and within the government about the importance of investing in child and adolescent health.

Situation analysis

The NICHP identifies priority problems in health status and in health service delivery. These have been defined as: newborn health, nutrition, communicable diseases, injuries and violence, physical environment, adolescent health, psychosocial and mental health, noncommunicable diseases, and disability.

The NICHP recognizes that equal opportunity is not fully existent in the care system. In socially disadvantaged regions, principles of equality operate in a limited manner, if at all. This particularly affects the country's largest ethnic minority, the Roma population. Only about 70–75% of children are offered primary health care in any form, which means that marked differences in available professional services exist across regions. Small communities and economically disadvantaged regions of the country are particularly hit by regional inequalities. In these areas, paediatric health care posts and regional paediatric home visitor positions are often vacant.

Strategy development

As in other European countries, Hungary faces the problem of updating a system that was conceived in times when infectious diseases were the main problem in child health. The prevailing hospital-centred approach of Hungarian paediatric care is not coherent with new needs. So, in addition to restructuring superfluous hospital capacity, the focus is on developing and extending primary health care competencies (see example in Box 1) and creating specialist outpatient care services attached to inpatient settings. Eleven of the thirteen goals of the NICHP are devoted to these “two pillars” of the health care sector, and it is hoped that most of them will be achieved during 2008.

Box 1. Example: the primary paediatric health care system's (home visitors and paediatricians) role in the prevention of developmental disorders.

The health visitors' network has a ninety-year tradition in the area of prevention (5). On the basis of the principle of equity, each community has its own local health visitor. Each and every resident may therefore contact his or her local health visitor *in his or her own environment* on the basis of an established relationship built on first-hand experience and trust. Health visitors are present at the most important stages of family life – pregnancy and childbirth, the shaping of family life, when the child goes to kindergarten/school, and when young people are preparing for family life.

District health visitors provide regular care for expectant mothers, newborns, infants and kindergarten-age children. School health visitors take part in preventive school health initiatives in primary and secondary schools. The most important school health care tasks are carrying out prescribed tests, screening examinations and health promotion activities. Hospital health visitors contribute to caring for expectant and confined mothers and newborns, supporting the mother-child attachment and teaching mothers child care techniques and breastfeeding.

Health visitors and paediatricians can monitor children's and young people's development and help them to achieve optimal progress. They have to be able to identify developmental delays as soon as possible, to help the family to find proper care and to support the family in taking care of children with special needs.

The National Institute of Child Health, in cooperation with the National Programme Countering Child Poverty and the “Won't give up on anyone” programme, has developed a follow-up study system for health visitors and paediatricians to enable them to monitor somatic, motor, cognitive, psychological and social development. Based on regular contact with the family and awareness of the quality of parent-child attachments, parental expectations and child-rearing practices, it enables the professional to gain a deeper insight into child development. The recommended timing of checkups are the ages of 1, 2, 4, 6, 9, 12, 15 and 18 months, and 2, 3, 4 and 5 years. Evaluation aspects are age specific and include all the important developmental tasks for sensorimotor skills (vision, attention, fine and large movements) social skills, behaviours and parent-child relationships.

Parents are provided with an easy-to-understand “child health book” that enables them to follow up their own baby’s development. It begins with all the important information about the newborn (data about the family, pregnancy, birth, newborn medical checkup data), followed by the regular checkups to the age of five years. Parents are encouraged to check their babies and can add their own observations. Parental experiences can be shared with the health visitor or paediatrician and, if needed, families can be referred to special care centres, early development centres or family counselling centres.

There is a significant compulsory checkup for all children at the age of five years that is carried out by the paediatrician with the support of health visitors. The execution of this psychomotor and medical checkup is regulated by law and is administered approximately one year prior to the School Maturity Test (carried out by the local family counselling service). Children with (or with suspected) developmental delays are again referred to family counselling services.

Within the frame of the “Won’t give up on anyone” programme, it was suggested that screening of children should commence much earlier, as interventions to correct developmental delays are more effective if introduced earlier. Consequently, the initiation of a developmental checklist for children at the age of three years is currently in progress under the National Institute of Child Health. It is expected that tenders for the “Won’t give up on anyone” national equal opportunities programme will be announced soon and the developmental service will be given priority.

The NICHP recognizes that several public health issues must be addressed by multisectoral action. In particular, the NICHP goal 13 (“public health tasks requiring multidisciplinary cooperation and the collaboration of several ministries”) is of special interest. These tasks are:

- accident prevention;
- improvement of psychological support at all levels of care to promote psychosocial health and, in particular, to prevent suicide;
- prevention and management of child abuse and bullying;
- design of complex health promotion projects not only in schools, but also at all levels of care;
- joint work with the Public Foundation for Patients’, Care Recipients’ and Children’s Rights Advocacy Groups/NGOs to protect the rights of children;
- cooperation with the National Environmental Health Action Programme to prevent environmental hazards from harming children’s health;
- participation in designing government measures to counter child poverty;
- provision of care for children in disadvantaged situations; and
- joint work with the Interdepartmental Committee for Roma Affairs to reduce the specific types of discrimination to which Roma children are subjected.

Cooperation with education and law enforcement networks is also necessary. Health visitors and paediatricians have developed close cooperation with child protection and custodial services, the Ministry of Youth, Family, Social Affairs and Equal Opportunities and the Public Foundation for Patients’, Care Recipients’, and Children’s Rights Advocacy. The role of the various NGOs and foundations in offering significant help in providing for children, working in close cooperation with the institutes, and in relaying public demands to the health care system, is also stressed.

Integration of child and adolescent health strategy and action plan in sectoral and multisectoral plans

The NICHP complements other government and sectoral programmes and plans already in progress or in a draft form. There is a complex activity net leading jointly to the achievement of the objectives of promotion of health and healthy development of children. The NICHP is seen as a specific set of policies affecting children and as a component of more comprehensive plans relating to health and many other sectors. The “child strategies” of individual ministries and sectors have to be developed and implemented under government coordination, involving many partners from the civil sector and NGOs (see as example Box 2).

Box 2. An example of NGO activity – a community psychiatry centre: the activities of the Awakenings Foundation for comprehensive mental reform

The Awakenings Foundation was established in 1989 by the Semmelweis School of Medicine, Budapest. The foundation operates in the 8th District, one of the most disadvantaged parts of Budapest with a high proportion of Roma inhabitants and people living in extreme poverty. Employees and managers of the foundation are trained in psychiatry, community care and rehabilitation. Evidence-based methods of community psychiatry and supported employment programmes have been developed.

The professionals of this NGO launched a pioneer project in the 8th District with the support of local government. The objective is to develop comprehensive mental health prevention services with a special emphasis on NGO participation. Cooperation among welfare agencies and the development of a common professional paradigm were facilitated. Team-building and assertive-behaviour training were organized for the participants to establish cooperation, and regular meetings are held (members of the district police are regular guests at these meetings; they frequently take part in crime-prevention activities in support of high-risk clients). A guidance manual was published with ongoing supervision for the project partners (38 organizations are currently involved), and supportive services are being extended. Evidence-based methods of prevention are discussed and their everyday application is planned at the foundation's conferences.

As part of this project, a high-risk pregnancy "signal" system has been developed, through which pregnant adolescents will be offered special care and support. The programme takes special interest in the systematic care of families, especially those with multiple disabilities and where more than one family member needs social, medical or other care.

Informal networking among welfare service providers and the development of assertiveness techniques through group work on challenging cases are supported. The groups design and manage projects which, depending on efficiency evaluation results, support the everyday activities of service providers. As an example, a database of service providers (NGOs and other organizations and institutions in the district), which is available on the Internet and in the local newspaper, was created following recommendations from the family issues workgroup.

Volunteers have been recruited to a NGO project called "We help at home". The volunteers provide training and supervision for the Child Welfare Division of the local council. Communication and conflict-management training has been organized for welfare workers who work with aggressive clients, and professionals from schools have participated in a special course focusing on assertive communication skills in childhood.

At the behest of the antidiscrimination workgroup, a roundtable discussion was held for welfare service providers to share experiences of best practices in reducing stigmatization. The Barka Theatre was contacted to promote partnerships with local artists supported by the Roma Parliament. Together with several other NGOs, foundation partners participated in a local health day and carried out alcohol and depression screening. The foundation's most important goal is to make contact with many organizations and welfare service providers and increase the number of volunteers. Participation of NGOs in service provision is acknowledged by local and state governments, but their lack of resources is still an issue.

There is a significant compulsory checkup for all children at the age of five years that is carried out by the paediatrician with the support of health visitors. The execution of this psychomotor and medical checkup is regulated by law and is administered approximately one year prior to the School Maturity Test (carried out by the local family counselling service). Children with (or with suspected) developmental delays are again referred to family counselling services.

Within the frame of the "Won't give up on anyone" programme, it was suggested that screening of children should commence much earlier, as interventions to correct developmental delays are more effective if introduced earlier. Consequently, the initiation of a developmental checklist for children at the age of three years is currently in progress under the National Institute of Child Health. It is expected that tenders for the "Won't give up on anyone" national equal opportunities programme will be announced soon and the developmental service will be given priority.

Lessons learned

Hungary has been among the first countries in Europe to adopt a fully developed national child and adolescent health plan and to seek to harmonize it with the *WHO European strategy for child and adolescent health and development (6)*. The NICHP acknowledges the good results obtained so far with respect to child health in Hungary, but also identifies important issues represented by social and cultural risk conditions, by inadequate provision of health care in underserved areas and for minority population groups, and by emerging health issues.

The NICHP promotes the concept of a restructured health care system based on two pillars (primary child care services provided to all children and a more-focused and efficient hospital and outpatient care system for specialized care). It recognizes the need for a good information system based on selected indicators that are consistent with EU and WHO definitions and recommendations. Both in the process of its development and its contents, the NICHP emphasizes the importance of intersectoral collaboration and participation of all interested parties, including civil society and children and adolescents.

There is a need to examine to a greater extent issues related to ensuring the financial sustainability of NICHP. This would entail examining ways to ensure adequate and sustained resources for:

- improving primary care and specialist services;
- restructuring of child health services; and
- improving the living conditions of the poorest families (correctly seen as a means to improve health outcomes of the entire nation) and increasing investment in children in Hungary's social and economic policies.

All possible options should be carefully considered, particularly in the light of current budgetary constraints.

There is also a need to define more precisely an action plan with roles and responsibilities at various levels (health professionals, health system managers and planners and cross-sectoral action at central and peripheral level) for implementation. Tasks defined in action plans could be framed at regional level according to the subsidiary principle.

Ensuring collaboration and coordination among programmes addressing child and adolescent health issues has proven challenging. This could potentially be remedied through the establishment of a support organization to harmonize the National Public Health Programme and other programmes and to ensure continuous collaboration. This organization could be enabled by the government to coordinate and negotiate with all the ministries that have responsibilities for child and adolescent health, development and social protection. This type of approach could enable programmes and initiatives to serve common objectives in more of a cooperative, and not competitive, manner. Collaboration of NICHP with the National Programme Countering Child Poverty has been established, but both programmes' funding is precarious at the present time, underlining the need for sustained financing mechanisms.

Other issues that need to be addressed include:

- focusing public health approaches and activities, as there is a clear lack of health promotion and prevention;
- amending the process of validating children's rights in health care and supporting the principles of the "Sick Children's Charter";
- developing programme-monitoring and quality-assurance processes;
- involving the public and children and adolescents in planning and implementation; and
- reconsidering the time frame of the action plan and refining criteria for completion of tasks.

In summary, further work should consequently include:

- a costing exercise for the NICHP, defining the financial means that are believed to be necessary as a prerequisite for negotiation with the health sector and the government;
- the precise identification of the coordinating body for the NICHP implementation and definition of its mandate vis-à-vis related programmes and government agencies;

- the shared formulation of a feasible and financially sound action plan which includes priorities along a multiyear time frame; and
- action involving all interested parties at community level to further build awareness of the importance of investing in children and of the contribution to the health and development of the nation that can derive from a well-developed public health approach to child and adolescent health.

The last action in the list above should include a communication strategy based on selected health indicators and estimates of cost of action and inaction to the public as well as to political leaders.

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