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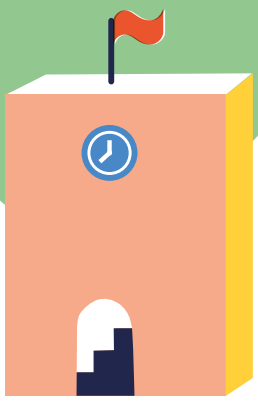

A PLACE TO CALL HOME

SOCIAL INTEGRATION OF REFUGEES IN HUNGARY

MENEDÉK
MIGRÁNSOKAT SEGÍTŐ EGYESÜLET

András Kováts
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DIFFICULTIES IN ACCESSING HEALTHCARE AND PEOPLE IN NEED OF INTERNATIONAL PROTECTION IN HUNGARY

1. Introduction

People in need of international protection are exposed to significant physical and psychological stress in their search for safety, often for long periods, and therefore require health care and assistance from the moment they cross the border. However, health care workers (and social workers) have received very little training on (public) health care for people in need of international protection. Therefore, providing them with some kind of procedural protocol could improve access to care, improve treatment and thus indirectly help the health and integration of people in need of international protection. This is the reason I created the *Refugee Health Procedures Protocol* (MEP). This paper presents the arguments and explanations in favour of the introduction of MEP, but it first discusses the data gap, the current regulation, its positioning in health care policy, professional concerns and relevant WHO recommendations.

2. Specificities of refugee health

What are the specific health needs of refugees and (forced) migrants, i.e. people in need of international protection? Many of them do not have access to health services, and thus have to do without, inter alia, medical treatment and care, including mental health services (especially services for post-traumatic stress disorder).

Women have limited access to gynaecological, obstetric and reproductive health services and face particular threats to their rights, even though they are most vulnerable to sexual violence and other gender-based abuse, as well as to trafficking. Patients and professionals involved in refugee health care may face the following problems, among others:

- mobility can lead to a lack of regular access to vaccinations and medicines and medical supplies, which can lead to antimicrobial resistance; lack of access to integrated health services despite their particular vulnerability to HIV infection and tuberculosis;
- food insecurity and nutritional problems (including malnutrition, including micronutrient deficiencies linked to the unavailability of disease prevention services) can be a serious problems;

- if they come from areas where communicable diseases are present, they pose a risk of infection to the host and transit populations;
- they may be at risk of communicable diseases (food and water-borne) due to the dangers during travelling, poor living and working conditions in the host country and lack of access to basic health services;
- a high proportion of people in need of international protection are disabled, elderly and children. They may seriously lack paediatric care, treatment appropriate to their condition, assistive devices and palliative care;

Displaced persons make up 3.4 per cent of the world's population, totalling 82.5 million (2020). This number is not evenly distributed around the world (for example, 73 per cent of them flee to countries closest to them).[369] This raises an important question: should they be cared for as part of the general health care system, or in isolation and based on international cooperation if a (host) country cannot provide care on its own. The former was advocated in the UN Declaration adopted in 2016,[370] drawing on good practices and experiences of WHO, UNHCR, IOM, as health care is an essential part of both aiding refugees and good governance.

The WHO Programme for Action 2019-2023 has identified six target areas and priorities:[371]

- promoting the health status of refugees and migrants through a combination of short and long-term public health interventions (e.g. vaccination of children and adults; treatment of acute, chronic and communicable diseases, injuries, mental and behavioural disorders; and provision of sexual and reproductive health services to promote health promotion, disease prevention, timely diagnosis and treatment, rehabilitation services and palliative care, especially in humanitarian crises;
- promoting the continuity and quality of basic health care, while developing, strengthening and implementing occupational health and safety measures;
- integrating health care for refugees and migrants into global, regional and national strategies. This is crucial to promoting refugee and migrant sensitive health care policies, as well as legal and social protection (including gender equality; intersectoral, intergovernmental and inter-agency coordination; capacity building in the health care sector; reducing communication barriers; and training health care professionals in culturally sensitive service provision);
- for health care to cover the entire global population (coverage), the training, recruitment and regulation of (international) health care professionals working with refugees must be organised;
- health care monitoring and information systems must be strengthened, which require standardised and comparable registers at global, regional and national levels. Policymakers need to develop evidence-based policies with an understanding of the health risks. The information system is also necessary for the development of portable health records and health cards, including the introduction of health cards for people on the move to ensure continuity of care;
- evidence-based health care communication, tackling misconceptions about refugee health, as the host population is not sufficiently informed about migration and refugees nor the impact on local communities and the health care systems,[372] which makes advocacy, public communication and education within the health care sector difficult.

This is in line with the priority objectives of health care set out in the UN's Global Compact on Refugees.[373] Resources and expertise must be provided in accordance with national health care legislation, policies and plans, and at the request of the host country. This could expand the health care system and improve the quality of care, thus improving the situation of refugees and host countries, in particular for women and girls, children, adolescents and young people, the elderly and people with chronic diseases (tuberculosis and HIV). Furthermore, it would assist survivors of trafficking, torture, trauma or violence, including people with disabilities and victims of sexual and gender-based violence. Assistance can take the form of financial or technical support to build or equip health care facilities or to strengthen service provision (capacity building). Equally important is training for health care professionals working with refugees, including the fields of

369 www.unhcr.org/refugee-statistics (23 October 2021)

370 UN General Assembly resolution on refugees and migrants 71/1 (2016)

371 WHO, SEVENTY-SECOND WORLD HEALTH ASSEMBLY A72/25 Promoting the health of refugees and migrants. draft global action plan, 2019-2023

372 Especially if there is a directive on public television that instead of the word refugee, only migrant can be used, even for recognised refugees, and instead of refugee camp, only reception camp can be said, i.e. in the world according to MTVA there are no refugees at all, just as there is no realistic picture of the pandemic. The M1 journalists have been exposed, they had to paint a false picture of the pandemic. *Index*, 11 Nov 2020.

373 Global Compact on Refugees, United Nations, New York, 2018, pp. 72-73.

mental health and psycho-social care. The main target areas are disease prevention, immunisation and health promotion activities, including participation in physical activities and exercise. Furthermore, access to adequate supplies of affordable medication, medical equipment, vaccines, diagnostic tools and preventive tools must be ensured.

The reception of irregular migrants (i.e. the majority of applicants for international protection) and the processing of their applications can cause public health (mainly epidemiological and occupational health) problems.[374] They may bring in diseases with a long incubation period, often preventable by vaccination, because their epidemiological profile is different from that of the host countries (HIV/AIDS, tuberculosis, hepatitis B/C). At the same time, the EU as a whole is struggling with the differences in vaccination policies between Member States. There is a high turnover of asylum seekers, and the time available for recording the data required for asylum applications is minimal, placing a huge burden on health care staff to carry out health screening and examinations in reception centres/alien policing centres. It is a contradiction that the relevant national legislation requires the identification of persons suffering from certain diseases when examining asylum applications. In other words, in addition to the immigration aspects, the required screening tests to establish the health status of the asylum seeker and cooperation in any therapy are essential for granting a status. If an applicant carrying a potential pathogenic condition refuses treatment, his/her asylum application might be rejected. However, lack of screening data can also be a problem, as screening (blood sample, stool sample collection and lung screening) requires applicants to attend different health facilities, i.e. cooperation is necessary.[375] (As an example, the highest screening rate among asylum seekers was 76%, while the lowest was in 2014 when only 6% of asylum seekers had a blood sample taken. The data on the bacterial carrier conditions of syphilis, bacteriophyphoid and paratyphoid are lacking even more if the asylum seeker leaves for an unknown destination before the screening result is in or, in the case of a positive test result, while on drug therapy.) It is clear, therefore, that adherence to screening protocols is almost impossible and that the cumbersome reporting process, the long time between placement and the screening test being carried out, and the onward journey/disappearance of asylum seekers are obstacles to effectively addressing the health care challenges associated with migration. Also, it is clear from the literature on screening and care of people living with HIV[376] that high latency is a problem and that those who are already confirmed infected often do not have access to health care services.

According to the Code of Ethics of the Hungarian Medical Chamber,[377] sin the case of serious or incurable diseases, gradual provision of information is desirable, provided that it is in the patient's best interest. Information on HIV infection is usually not provided gradually, so it can often trigger a suicidal mental state. The Code also states that it is unethical to justify financial decisions that restrict patient care on medical-technical grounds,[378]i.e. a doctor must not give the impression that the patient is receiving optimal care despite financial constraints.[379] However, patients do not necessarily disclose their infection to their doctors, according to a survey of people living with HIV.[380] More than half of respondents did not even tell their GP that they were infected. Most people do not talk about their HIV status for fear that others will find out, or to avoid being stigmatised or denied care. One in ten respondents had been refused specialist care because of their HIV status, and one in four hospitalised patients had experienced discrimination. There were several cases of people not having their sensitive data handled properly, for example writing HIV in large red letters on their medical chart or medical staff talking about their HIV status in a way that others could hear. The dignity of several respondents was violated by being placed in isolation and unnecessary precautions were taken, such as being approached by nurses wearing a mouth mask or rubber gloves. There is no evidence that the situation has changed.

There is a high turnover of asylum seekers (a significant proportion leave the country or their first accommodation before the decision on their case) and the timeframe for collecting the data required for an asylum application is inherently minimal. Therefore, the medical examinations and screening to be carried out in reception centres/detention centres place a barely manageable burden on their health care staff. When assessing asylum applications, the legislation on mandatory screening requires the performance

374 Zoltán Katz: The health status of asylum seekers in the light of mandatory screening tests – Facts, conclusions, recommendations. In. Gyula Gaál, Zoltán Hautzinger (eds.), 2016, Pécs, 253-261.

375 For example, between 2007 and 2014, a total of 3727 blood samples were taken at the Debrecen Reception Centre, but only 1687 asylum seekers appeared for screening, while between 2012 and 2014, 1072 stool samples were taken, see Decree 32/2007 (27.VI.) of the Ministry of Health on diseases endangering public health related to the stay of persons with the right of free movement and residence and third-country nationals in Hungary.

376 Judit Tóth: HIV and AIDS in the international migration regulation. Hungarian Law, 1994/12: 730-734; Judit Tóth: The Role of HIV Status in Alien Policing. In HIV/AIDS and Human Rights in Hungary. Szerk: Csernus Eszter. Társaság a Szabadságjogokokért, Budapest, 2003, pp.87-109.

377 II. point 5(7)

378 II. point 14(1)

379 Máté Julesz:HIV/AIDS and the law in Hungary. Medical Weekly, 2016/47: 1884-1890.

380 www.tasz.hu/cikkek/hiv-vel-elok-tapasztalatai-az-egeszsegugyben-1

of screening tests for specific diseases, pathogen-carrying conditions, health conditions and the subsequent treatment of the patient. The cooperation of the applicant is essential, but without thorough information, interpretation and knowledge of their place of accommodation, this is hardly possible.

The lack of data is also due to the fact that in recent years irregular migrants have been pushed back at the Greek or Hungarian borders in an informal procedure, and there are frequent cases of abuse, and hindering entry to the country with violence.[381] The cornerstone of the international protection system is the obligation for the state not to expel or return a person to a territory where his or her life, safety or freedom could be at risk. The prohibition of torture in Europe is an absolute rule, allowing no derogation, exception or restriction[382] even when migrants arrive en masse at borders or when there is a health emergency such as the Covid-19 pandemic. Therefore, the LIBE Committee of the European Parliament has proposed a draft regulation[383] to establish a uniform regime for pre-checks at borders, i.e. the identification, registration and fingerprinting of persons in need of international protection and for conducting security and health checks at the EU's external borders. This proposal requires a quick decision: the migrant either must return to the border crossing or for applicants for international protection, a normal, an accelerated or an asylum procedure is launched. The aim is to create a new "independent mechanism for monitoring fundamental rights" to ensure that they are treated in accordance with EU and international law, as similar monitoring mechanisms are already in place for the forced return of migrants (expulsion, deportation), including the swift and appropriate handling of their complaints. In case of evidence of push-back, national judicial authorities must investigate the violation of fundamental rights, identify the responsible actors and provide compensation to victims. Judicial proceedings in various EU Member States (e.g. Italy and Slovenia) highlight how judges assess responsibility and provide both criminal and civil remedies to third-country nationals affected by push-back. This procedure, if implemented, would also provide for medical measures and data collection.

381 Setting the right priorities: is the new Pact on Migration and Asylum addressing the issue of pushbacks at EU external borders? Forum on the new EU Pact on Migration and Asylum in light of the UN GCR Contribution by Marco Stefan and Roberto Cortinovis (CEPS, Brussels, 25 November 2020)

382 Non-refoulement principle: based on Article 33(1) of the 1951 Refugee Convention and Article 3 of the 1984 UN Convention against Torture, Articles 2-3 of the European Convention on Human Rights

383 Proposal for a Regulation of the European Parliament and of the Council introducing a screening of third-country nationals at the external borders and amending Regulations (EC) No 767/2008, (EU) 2017/2226, (EU) 2018/1240 and (EU) 2019/817, COM/2020/612 final

The WHO is also addressing the issue of migrant and refugee health,[384] to which the International Centre for Travel Health and Vaccines within the National Centre for Epidemiology should respond more strongly. The slow response may be explained by the lack of significant practice in travel health before 2004, which includes not only assistance medical services (medical care and repatriation of tourists abroad) but also health care for asylum seekers and beneficiaries of international protection. Finally, an amendment to the Health Act (§ 74/A), which entered into force on 28th October 2015, empowered the Chief Medical Officer of Hungary to order screening of asylum seekers in the time of mass immigration or other health crises. People in transit zones had to prove that they had taken the necessary samples for the screening test to be allowed to enter Hungary. The public health authority (district government office) communicates the screening test result to the asylum authority, but the result cannot serve as a basis for rejecting the asylum application unless the asylum seeker is not cooperative.

The association of paediatricians has declared:[385] refugee children and young people need special physical and mental support. To this end, age assessment is essential to determine eligibility. However, there is no objective and culturally accurate method for age assessment. Therefore, paediatricians and other health professionals must be involved in planning the reception of these children and young people and in implementing clinical and public health programmes and protocols. Physical, mental and social assistance must take into account the traumas they may have experienced in their country of origin or during their flight. Upon arrival in a place of safety, their physical and mental condition must be assessed to ensure that they receive the curative-preventive care appropriate to their needs, identifying those in need of urgent care, assessing risks and protective factors, including a non-stigmatising assessment of family members or any other accompanying persons. They must be provided with a full range of primary care and locally available specialist care. The main objective of the assessment of developmental and behavioural status is to ensure that the placement is appropriate to their needs. Interpreters must also comply with health care rules.

UNHCR's regional office has urged that refugees in Central Europe should have easier access to health care services.[386] Although the EU Qualification Directive (2011/95/EU)

384 Éva Kereszty – Máté Julesz: Migrants in Hungary – Some legal and public health considerations. Hungarian Science 2016/4:438-451

385 Budapest Declaration on the Rights, Health and Well-being of Refugee Children and Young People. International Society of Social Pediatrics and Child Health Conference, Budapest, October 2017

386 UNHCR Regional Representation for Central Europe, Budapest, 2009.

provides that refugees have access to health care under the same eligibility conditions as nationals, it does not necessarily cover the full range of services, often limited to basic and emergency care. Experience in the EU shows that refugees are often not familiar with the health care systems of their host countries. Without basic language skills or interpretation and translation services, they are often unable to communicate with medical professionals; they are often not referred for appropriate treatment. Health care providers may not be familiar with the forms used to prove refugees' eligibility for health insurance and thus refuse to treat them or refer them to specialists. In Member States where participation in integration programmes (e.g. language training) is compulsory, refugees with special needs who are unable to attend the course (elderly or survivors of torture and trauma) may lose their health insurance eligibility, even though they are the ones who need medical care the most. Furthermore, there are significant regional, municipal and social disparities in the EU in terms of health care. There is a need for a health care comprehensive policy that includes measures specifically targeting vulnerable groups (people living in poverty, disadvantaged migrants and ethnic minorities, people with disabilities, older elderly people), as this affects their fundamental rights.[387]

In 2016, the WHO Regional Commission for Europe published a situation analysis on migration health in Hungary, prepared jointly by the Ministry of Human Capacities and with the involvement of international and civil society organisations working in Hungary.[388] In 2015, at least 400,000 irregular migrants arrived in Hungary, but only 161,000 sought asylum and only 30,000 were screened, while the government requested WHO's assistance in providing public health facilities for refugees. The report is based on an onsite investigation that took place in October 2015, as well as in-depth interviews and discussions with stakeholders. The report highlights that many vulnerable refugees, suffering from chronic illness or acute infections (victims of human trafficking, victims of torture, post-natal women, infants) would have needed suitable care within realistic timeframes, proper documentation of care, and follow-up. However, Hungary did use its emergency (disaster) plan in 2015-2016. Although the police and ambulance service had set up mobile screening stations, there was no strategy for screening, psychiatric care, child care or treatment of infectious diseases in place. There were no means of communication to inform the general population and refugees, no interpretation, no professional platform of specialists to deal with cultural conflicts and no comprehensive centralised communication with refugees concerning infections. This was particularly the case due to the high number of decentralised places of care (transit zones, reception centres, detention centres, civil and religious institutions, health care services) and the lack of coordination between central authorities. The lack of relevant training for health care professionals also became a source of problems. The national public health (crisis) plan and, especially at the frontline (at the border, at primary entry points and shelters), the emergency plan, the data collection plan on refugees and the communication plan were not implemented at all.

In the field of occupational health and safety, frontline border guards and police officers on the receiving side were not fully prepared to deal with migrants and prevent health risks.[389] In 2009, the level of preparedness along the EU's eastern Schengen borders (Poland, Slovakia and Hungary) was assessed focusing in particular on public health safety and the specific health problems of migrants,[390] but by 2015-16 the situation had only improved little.[391]

3. Availability and lack of accurate data

For decades, health care data collection has been based on the statistics on diseases and interventions and their financing units (ICD and HDG).[392] Therefore, the statistics do not show the number and nature of doctor-patient visits, nor the actual need of patients, as it is mainly health interventions that the health insurance finances.

387 The relationship between health and solidarity is discussed in several institutional communications. See COM (2009) 567 final: Solidarity in health: reducing health inequalities in the European Union. On the above-mentioned communication, see the opinion of the Committee of the Regions (2010/C-000/01) and the opinion of the European Economic and Social Committee (2011/C-18/13).

388 Hungary: Assessing health system capacity to manage sudden, large influxes of migrants. A joint report on a mission of the Hungarian Ministry of Human Capacities and WHO Regional Office for Europe. 2016.

389 István Szilárd – Árpád Baráth: Migration and health security: new occupational health challenges. Pécs, Pécs Border Guard Scientific Publications, 2011, 269-278.

390 For example, in most of the interview rooms where migrants are strip-searched, there were no hand-washing facilities; medical examiners meeting health standards were only available in the guarded accommodation; the uniforms of police officers who go to the green border or interview and search applicants with unknown health backgrounds and potential infections are washed at home with the rest of the family's clothes.

391 Gábor Éberhardt: The possible public policy implications of overload migration. PhD thesis, Budapest, National University of Public Service, Doctoral School, 2021.

392 The WHO introduced the BNO (The International Statistical Classification of Diseases and Related Health Problems) code system, so that the diagnosis of a person who has fallen ill or sustained an injury in any country can be classified according to a uniform code system. Based on the standard coding used by the OEP, the various statistics and country reports can be collated according to a uniform coding. The homogeneous disease groups (HBCSs) are used in the financing of inpatient care, classifying active hospital cases with a similar performance value in terms of size, i.e. with almost the same professional-technical input requirements, into a financing group, and the classification is medically acceptable. The classification is primarily determined by the diseases justifying the care and the medical interventions prioritised for the classification. The system of homogeneous disease groups is not only used to classify hospital cases, but also those that can be treated without the patient having to stay in hospital all day.

To optimise expenditure on health insurance, from 2004 onwards, a maximum level of performance volume was set for health care providers (i.e. the number of interventions in a given period), and financing is only available within this limit. Consequently, the statistics only show the interventions actually performed (and not those claimed). This led to a capacity shortage and waiting lists[393] (active state capacity planning instead of responding to needs or the market) because only the reserved specialised care capacity is subject to a financing agreement.

The weekly/annual statistics of the National Health Insurance Fund (NEAK), also provide information on communicable diseases, deaths, hospital occupancy and expenditure. However, none of the data sets are disaggregated by age, sex, nationality or legal status.

With the creation of the National eHealth Infrastructure (EESZT),[394] the data gap could in principle at least partially be closed. Public health care must be recorded in the health profile since 2018 and private health care from the second half of 2020, creating a large database with a wide range of data. For example:

- the type and value of the personal identity card (social security number) of the patient. However, only a small proportion of asylum seekers and people in need of international protection have this, i.e. they are not included in this register,
- for primary care, the reimbursement category is listed, which would allow collection of data on financing (the patient, the health insurance or the national budget),

  for emergency (ambulance) care, the nationality of the patient, the referral and the patient's further medical history,
- the information to be uploaded to the health profile for the patient includes:

  - name of the vaccination, date of vaccination for the immunity (disease),
  - the dates of closed or inactive medical problems, previous surgeries and interventions,
  - current medical problems/diagnoses, therapeutic suggestions,
  - current medication,
  - description of a disability,
  - lifestyle factors,
  - pregnancy,
  - the medical documentation (final hospital report, outpatient form, surgery report, ambulance form) and the report on the laboratory tests.

This wealth of information would help to obtain partial statistics only if there was no obstacle to only allowing the querying of the EESZT database based on the social security number and the data on the general practitioner service[395]. In connection with inpatient care, only care provision can be financed that are recorded in the EESZT, i.e. not all treatment events are recorded there, but only those that are financially relevant.

The health insurance register is kept by the health insurance body designated to manage the Health Insurance Fund. The personal data contained in the register may not be deleted for 30 years after the death of the natural person concerned. In principle, certain statistical data could be collected ex post from this database.

The NIEM health care data types[396] (indicators) overlap and are closely linked to the indicators related to social benefits, so it would be important to know the proportion of people receiving health care based on social need and the proportion of people receiving health care based on their social security status. However, this is also not available because the database is based on the Social Insurance Identification Number (hereinafter: SID).

393 NEAK's national waiting list register, which shows how many patients are waiting for priority operations in each hospital and what the waiting times are, the number of patients waiting and the waiting times in each region and country

394 Chapter III/A of Act XLVII of 1997 on the management and protection of personal data related to health and related personal data and the annexes of EMMI Decree 39/2016 (XII. 21.) on the detailed rules related to the Electronic Health Service Space define the continuity of on-call, emergency patient care and rescue tasks, while the provisions of Act No.47/2004. (V. 11.) Ministerial Decree on certain organisational issues of the continuous operation of health care and the detailed rules for the financing of health services from the Health Insurance Fund are defined in accordance with Government Decree 154/2020 (IV. 27.) amending Government Decree 43/1999 (III. 3.) on certain organisational issues of the continuous operation of health care and the detailed rules for the financing of health services from the Health Insurance Fund.

395 The purpose of the relationship check is that all publicly-funded healthcare providers, in compliance with legal obligations, check online at each doctor-patient appointment whether the patient is registered with the health insurance company. But the check based on the social security number/other personal identification data is not the same as a relationship check. The notification of the absence of a relationship will be given to the patient by the provider if the patient does not have a relationship. The notification is not part of the patient's documentation (under Article 12/B of Government Decree 217/1997 (XII. 1.) on the implementation of Act LXXXIII of 1997 on the benefits of compulsory health insurance.)

396 Indicators: procedure for health care needs of asylum seekers, beneficiaries of international protection; identification by groups (asylum sekker, refugee, beneficiaries of international protection, long-term resident, resettled refugee, family member) on the basis of residence permits (temporary and permanent access, family reunification); access to health care (as foreigners or as Hungarian citizens); administrative barriers to access (waiting, documentation...); involvement in the health care system; extent of health care coverage (emergency only, life-saving only, primary care...); access to health care when special needs arise (child/infant care, antenatal care, maternity care, psychiatric and mental health care, elderly care, victims of torture, trauma); information to health care providers on entitlements/eligibility (authorities/providers regularly inform their staff); information on entitlements and use of health services (institutional or individual); unmet needs; free/easy access to interpretation services (institutional or individual); average integration of beneficiaries of international protection in the health system (how refugees are included in ministerial policies, monitoring of health care for refugees, regular review of refugee legislation); health budget (proportions), cooperation of authorities, municipalities in health care for beneficiaries of international protection (if any, how), partnership with health professional NGOs (if any, how).

Beneficiaries of international protection are becoming a hidden population, as no data on them can be extracted from statistics. This in turn makes their social representation, acceptance and integration more difficult. There are hardly any asylum seekers and beneficiaries of international protection in Hungary,[397] and statistics (whether microcensus, decennial census or by social security number)[398] include only a fraction of people in need of international protection (for example, due to undercounting, optional responses or migration abroad or lack of social security number) and no statistics whatsoever on asylum seekers.

Overall: the data underlying the common European research (Baseline: age, gender, vulnerability – single parent, disabled, unaccompanied minors, victims of torture) and other data disaggregation are not available in Hungary, even for the asylum procedure and for the assessment of vulnerability. At most, only partial data are available on health care expenditure for certain groups.[399] As the Hungarian data collection system is also structurally different from the NIEM indicators, basic data relevant for health care are missing for the usefulness of the indicators. Health statistics are not collected separately for asylum seekers and beneficiaries of international protection (by legal status or vulnerability groups), so only partial and sporadic data will be available. With the proposed introduction of the Asylum Health care Procedures Protocol MEP, data could be generated in Hungary on people subject to an asylum procedure and subsequently receiving health care services.

397 According to HCSO, 73 people applied for asylum in Hungary between January and March 2020, and only 22 between April and June. In the summer, the transit zones in Röszke and Tompa were closed, and the 300 or so people staying there were transferred to reception centres in the interior of the country. In other words, the maintenance of the crisis caused by mass immigration (until 7 March 2021) is legally unfounded, because it is not justified either by the number of applicants or by the situation at the border, especially if asylum applications can be lodged under a preliminary procedure at Hungarian embassies outside the EU (see the procedure under Act LVIII of 2020 and Government Decree 292/2020 (17 June 2020) on the declaration of intent to lodge an asylum application, which will apply from 18 June 2020).

398 Anna Sára Ligeti: Circular migration in Hungary. *Statistical Review*, 2019/4:327-346.

399 For example, the Ministry of the Interior paid the OEP 72.2 million for the medical care of refugees in reception centres in Hungary in 2015 and 15.2 million for the care of refugees until 31 August 2016. From January 2015 to August 2016, the Hungarian state spent a total of 87.4 million forints on medical care for refugees, while one and a half times this amount was spent on publishing anti-refugee referendum posters in a government newspaper during the same period. By September, the total advertising campaign had reached HUF 20 billion (see We paid one and a half times as much for migrant care in Magyar Idek alone as for refugee care. Zsolt Kerner, 24.hu, 23 September 2016)

4. Policies

To apply the legal obligations and international standards on refugee health care in Hungary, it is not sufficient to incorporate them into legislation, but they must be incorporated into various public health programmes and health care action plans.

Over the past decade, a plan to save the health care sector has been drafted[400] however, it does not even mention people in need of international protection. The aim of the document, which is addressed to the medical profession and the health industry, is to ensure that health care is available to all citizens based on their needs, in proportion to the performance of the economy, social realities, public spending and the principle of solidarity. Self-financing is complementary and patients could pay to jump the waiting lists. Respect for human dignity and patients' rights (such as freedom of choice of doctor) is a means to other objectives. The essence of the reform is IT development and institutional concentration (consolidation into national centres and university clinics) to save money. Although it would have been an improvement in terms of legal protection for people in need of international protection, the proposed National Centre for Patients' Rights was not created, despite the fact that the former insurance oversight and complaints handling body has been dismantled.[401]

In 2015, a short paragraph of the reform to strengthen primary care states that primary care should be made fully available to asylum seekers, refugees and beneficiaries of subsidiary protection within the period allowed by the Act on Asylum (i.e. during the procedure and for up to six months afterwards).[402] The concept states that the eligibility to primary health care services is regulated by various levels of legislation (general practitioners, dentists and public health nurses) and that "the provision of services is not uniform across all regions and creates problems of interpretation. As the resolution of this situation is important for the protection of the persons concerned and the general public, clear access and eligibility to primary care for these persons should be

400 Semmelweis Plan to save health care. Professional Concept, State Secretariat for Health of the Ministry of National Resources, October 2010, page 64.

401 The Health Insurance Supervisory Authority 2010. Its general successor is the Ministry of National Resources, its partial successors and partly exercising its former competences are: the National Office of the Chief Medical Officer of the State Public Health and Veterinary Service, the former regional institutes of the State Public Health and Veterinary Service, and currently the public health administration bodies of the regional government offices, the National Health Insurance Fund. The OBDK, which investigates patient complaints, was integrated into the Ministry in 2017.

402 The 2015 Act CXXIII of 2015 on primary health care finally passed does not cover refugees

established as soon as possible."[403] In other words, it is not urging the development of basic services from a constitutional or human rights point of view, but from a perspective of enforcement of the law.

The Health Care Sectoral Strategy for 2014-2020, and the Public Health Strategy to be developed on its basis, do not take into account the foreign patient population, except for health tourism. It can be highlighted that the need to promote targeted actions to improve universal access to public health services, systems and their standards was also urged for 2017-2018.[404] Based on the conclusions of international indicators, this could help to examine health care inequalities and the effectiveness of care. The selection of the statistical data set could contribute to the use of some of the common European Core Health Indicators (ECHI)[405] for monitoring improvements. The introduction of EESZT has slightly improved patient data security, but the potential of the cloud-based system is not fully exploited in daily practice. There is a need for the development of professional registers that would also point health care policy planners at the necessary intervention areas. Any development can only be based on reliable data, and although there is extensive data collection at all levels of the care system, its reliability is questionable. The National Strategy for Health Informatics (NES)[406] aims to apply the tools of informatics, digitalisation and artificial intelligence to the Hungarian health care sector to improve the effectiveness of care. The professional coordination of the implementation of the NES system is carried out by the National eHealth Board, whose members include representatives of the Ministry of Interior, Ministry of Human Capacities, Ministry of Innovation and Technology and the Prime Minister's Office. The NES is mainly funded by the European Union, but the actual sub-objectives and expenditures are not public and are only reported annually. The National Public Health Strategy (2017-2026) is subject to a limited public debate.[407] In 2019 it was communicated that it aims to strengthen outpatient and primary care, promote broader collaboration through tenders, develop a community of practice, and also care close to the population through the network of Health Promotion Offices (HPEs). Although 116 of

403 The concept of strengthening primary health care. State Secretariat for Health, April 2015, Health Care for Asylum Seekers, Refugees and Protected Persons, p. 36.

404 1886/2016 (XII. 28.) Government Decision on the Action Plan of the "Healthy Hungary 2014-2020" - Health Sector Strategy for 2017-2018

405 The ECHI is essentially a public health oriented indicator system: out of a total of 88 indicators (for which sub-disaggregations are available in several cases, so that in total there are several sub-indicators), about 20 relate to the description of the operational levels of the health care system beyond the public health system (e.g. primary care, hospital care)

406 Government Decision 1455/2021.(VII. 13.) on the National Health Informatics Strategy

407 Budapest, 4 April 2017., www.parlament.hu/irom40/14478/14478-0001.pdf

these are operational on paper, some of them have not adapted to the needs of the population, and there is no standard or methodology for this, which will be provided by the National Centre for Public Health. Stakeholders have been critical,[408] of this Strategy, stressing that patient pathways should be shortened (which would also simplify access to appropriate care for people in need of international protection).

Another problem is that development strategies and reform plans in the health care sector are not prepared in accordance with legislation. Since 2011, legislation can only be presented after an impact assessment,[409] and since 2012, it has been mandatory to prepare strategic planning documents for all policies (country forecast, national 5-9 year medium-term strategy, ministerial programme, institutional work plan, 10-15 year long-term concept, white paper, and based on these, policy strategy, policy programme, institutional strategy and green paper).[410] These can be adopted by the government and then by the parliament after an intensive public debate and after the disclosure of public information. As a result, refugee health would certainly not be left out of the professional strategies.

It is not clear from these documents, therefore, whether people in need of international protection are not mentioned in the past documents or current strategies because they are treated in the same way as the general population or because separate, specialised care solutions and institutions would be created for them. Policy has long been in arrears in developing a concept of development in one direction or another for the needs and care of people in need of international protection.

Until then, we have to make do with the sub-targets of improving overall access to care and data management. However, the reduction of inequalities, its universal nature and the necessary steps should be emphasised, in connection with the most common situations of discrimination. Examples include facilitating access to contraceptive methods, significantly improving emergency care (e.g. clear demarcation of competences and responsibilities, alignment of geographically appropriate emergency care with operational conditions), increasing the capacity of patient transport, drug prevention, significant improvements in community care for people with mental disorders, support for people discharged from psychiatric treatment, and strengthening patients' rights by

408 Orsolya Tarcza's report on the Medicina Forum, Medical Online, 9 October 2019.

409 1144/2010 (VII. 7.) Korm. h. (part of the Government's Rules of Procedure), KIM Decree 24/2011 (VIII.9.) on the preliminary and ex-post boundary assessment, and the MvM Decree 12/2016 (IV. 29.) on the preliminary and ex-post impact assessment

410 Government Decree 38/2012 (III. 12.) on strategic government management

introducing an effective and transparent complaints handling system. All this would be essential for those in need of international protection.[411] However, as long as the system is wasteful, the government will not provide more resources for health care, as the real issue is that health care is simply not a priority for the government.

5. The legal environment

The legislation includes universal, regional and national sources of law on health care.

The 1951 UN Refugees Convention provides that refugees who are legally resident in a country must have the same rights as nationals in accessing social security benefits (Article 24).[412]This includes care in case of accidents at work, occupational diseases, pregnancy, sickness, incapacity for work, old age, death, unemployment and maintenance obligations under national law. The United Nations Covenant on Economic, Social and Cultural Rights (1966) aims to guarantee social security and access to social security to everyone (Article 9) and the right to the highest attainable standard of physical and mental health, including health care and medical treatment (Article 12).[413]. The right to human dignity and protection of children, including the right to health care, is enshrined in other international conventions (e.g. UN Convention on the Protection of the Rights of All Migrant Workers and their Families, Convention on the Rights of the Child), even for irregularly working refugees.[414]

The United Nations Convention on the Rights of the Child (1989)[415] gives all children under the age of 18 the right to medical care, including prenatal care and infant care, in the best interests of their health (Article 24), protection against all forms of violence, abandonment and neglect (Article 19), and even a state guarantee of family reunification for refugee children (Article 22).

Under Article 168 of the Treaty on the Functioning of the EU (TFEU), public health is a shared competence between the European Union and the Member States. This means

411 The Society for Civil Liberties has expressed its concerns about the "Healthy Hungary 2014-2020" health sector strategy and the amendment of health-related legislation, see: www.tasz.hu/files/tasz/imce/2015/tasz_allasfoglalas_eustrat2015.pdf

412 Promulgated by the 15. tvr. 1989

413 Promulgated by the 9. tvr. of 1989

414 Bell, Mark: Irregular Migrants: Beyond the Limits of Solidarity. In Malcolm Ross - Youri Borgmann-Prebil (ed.) Promoting Solidarity in the European Union. Oxford, Oxford University Press, 2010, p. 164.

415 Promulgated by Act LXIV of 1991

that EU actions are complementary to national policies and that the EU is primarily intended to support actions taken by Member States, for example, monitoring, early signalling and tackling serious cross-border threats to health. Member States coordinate policies and programmes among themselves in the public health area covered by EU actions. In the wake of the Covid-19 pandemic, the Commission has stressed the need for rapid and strong coordination and information exchange to strengthen key areas of preparedness and response, and a commitment to implement these measures where they fall within national competence.[416] For example, the EU may adopt binding health care rules, for example on serious cross-border threats to public health (Decision 1082/2013/EU of 22 October 2013), which also applies to communicable diseases, on the grounds of protecting public health. This Decision lays down rules for epidemiological surveillance, monitoring, early warning and response to serious cross-border threats to public health, including preparedness and response planning for these activities, in order to coordinate and complement national policies. Member States are also required to coordinate their Covid-19 pandemic response in the so-called EU Health Security Committee, chaired by the Commission and composed of national health ministers. The EU Commission can take all initiatives to promote the coordination of Member States' policies and programmes, in particular by developing guidelines and indicators and organising the exchange of best practices.[417]

Under the EU's Common Asylum System, beyond the rules of the Charter of Fundamental Rights (2000),[418] when residing in Hungary

- asylum seekers have the right to appropriate health care, i.e. at least emergency care, including medical treatment and substantive treatment for mental illness, while asylum seekers with special needs must be provided with reception and psychiatric treatment appropriate to their needs, including rehabilitation for child victims;
- beneficiaries of international protection (i.e. independently from the category of their status, until the end of their status) must be provided access to health care under the same conditions as nationals and in an appropriate manner, including

416 Communication from the Commission to the European Parliament, the Council, The European Economic and Social Committee and the Committee of the Regions on Short-term EU health preparedness for COVID-19 outbreaks

417 Friedery, Réka: Free Movement of Persons versus COVID-19: National Restrictions and EU Law. MTA Law Working Papers, 2020/38.

418 Dir. 2011/95/EU on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted, Art.30; (Qualification Directive) Dir. 2013/33/EU laying down standards for the reception of applicants for international protection, Art.19 and 23 (Reception Directive)

psychiatric care, prenatal care, care for people with disabilities, treatment for victims of violence, torture, exploitation and armed conflict, taking into account their specific needs.

Health care in Hungary has been publicly funded since 1992, but it is insurance-based. Under compulsory health insurance, which is a sub-system of social security, beneficiaries can be divided into two main groups: the insured (persons who pay contributions to obtain all health insurance benefits, including health services and cash benefits) and social beneficiaries of health care services (persons who pay no contributions or fees and their care is paid for by the central budget through transfers to the Health Insurance Fund).

Applicants for international protection can fall into both groups and their eligibility to health care[419] are summarised in Table 1, including benefits based on social need,[420] insurance status[421] and nationality.[422]

419 Metv. 5. § (2) d.); 10.§ (4) b.); 22.§ (2) c.); 26.§ (1); 27.§, 29.§, 29/A.§, 30.§ (4), 31/A. § (8)(10), 31/F § (2), 32.§ (1a)(2); 301/2007. (XI.9).) Government Decree § 3-4, § 4/A, § 15-16, § 26-28, § 32-36, § 44, Act CLIV of 1997, § 142, Government Decree 43/1999 (III. 3.), Act CXXII of 2019, Act III of 1993

420 It is established by the district or district body of the Government Office dealing with social affairs, upon application and by issuing a certificate, for persons whose monthly income per person in their family is 120 per cent (HUF 34,200) of the current minimum amount of the old-age pension (HUF 28,500) or who live alone and whose income does not exceed 150 per cent (HUF 42,750) of the current minimum amount of the old-age pension and whose family has no assets. III. law of 1993.

421 The compulsory health insurance (Act LXXXIII of 1997) has been tightened, from 1 July 2020 it is no longer possible to settle the outstanding health insurance service contribution (HUF 7710/month for nationals, based on the minimum wage for other people) after three months, i.e. the patient must pay the service and the monthly premium if he/she has been treated, but emergency care must still be provided.

422 Hungarian: a Hungarian citizen with a registered place of residence in the territory of Hungary pursuant to Act LXVI of 1992 on the Registration of Personal Data and Addresses of Citizens, a person with immigrant or settled status, a person recognised as a refugee or a person granted protection, and a stateless person.

Table 1.

Who is entitled to health care under national law and what kind of health care?

<table>
<tr><th>Applicant</th><th>Person in asylum detention centre</th><th>Refugee</th><th>Beneficiary of subsidiary protection</th><th>Tolerated status</th><th>Beneficiary of temporary protection</th></tr>
<tr><td colspan="2">eligible to: screening, vaccinations, treatments prescribed by the authorities, epidemiological care, primary care, emergency care, including specialised outpatient/inpatient care, medical aids and medicines, dental care, prenatal care, obstetric care, post-mortem examinations, emergency health care, patient transport, rehabilitation, psychological and clinical psychological care, as well as psychotherapeutic treatment, for people with special needs</td><td colspan="4">eligibility: screening, vaccinations, treatments ordered by the authorities</td></tr>
<tr><td colspan="2" rowspan="3"></td><td colspan="2">eligibility: for 6 months after the status is finally granted, if the person is in need of primary care and general medical care, specialised care, medicines, emergency care, patient transport, obstetric care, prenatal care</td><td>after the status has been validly granted, if the person is in need, for general medical care, ambulance, emergency care, post-mortem and emergency care</td><td>eligibility. after the status has been validly granted, if the person is in need of primary care and emergency care, patient transport</td></tr>
<tr><td colspan="2">eligibility:0-18 years old (minor), if resident or staying in Hungary, entitled to full health care
if the person socially deprived and have a registered place of residence, if the person is entitled to full health care[423]
full-time student (over 18) entitled to full health care
homeless (as a user of a social assistance institution) entitled to full health care</td><td colspan="2">Eligibility: 0-18 years (minor) if the person has a place of residence in Hungary, they are eligible for comprehensive healthcare</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td></tr>
</table>

423 It is established by the district or district body of the Government Office dealing with social affairs, upon application, by issuing a certificate to a person whose monthly income per person in his/her family is 120 per cent (HUF 34,200) of the minimum old-age pension (HUF 28,500) or who lives alone and whose income does not exceed 150 per cent (HUF 42,750) of the minimum old-age pension and whose family has no assets. III. law of 1993.

Applicant	Person in asylum detention centre	Refugee	Beneficiary of subsidiary protection	Tolerated status	Beneficiary of temporary protection
		the right of a resident[424] to health care for up to 45 days after the termination of his/her employment (passive right under social security)			
eligibility: rescue					
Eligibility to health care for other categories of persons:					
a foreign minor temporarily placed or taken into care by a Hungarian authority under the Act on the Protection of Children and Guardianship Administration is entitled to full health care					
a third-country national who is placed in a community shelter or transit zone or who is a victim of trafficking in human beings is entitled to epidemiological, rescue, emergency care, post-mortem examination, emergency health care, including medical aid, medication, and compulsory vaccination as provided for by specific legislation (a refugee who is a victim of trafficking in human beings can prove this with a humanitarian residence permit or a temporary residence certificate)					
as a detainee, the person is entitled to full medical care (specifically: prison doctor/central prison hospital as primary care, specialised care and inpatient care)					
those who are insured (through work, business, regardless of nationality)[425] are entitled to full health care					

Source: own ed.

This table shows the general trend: blue refers to care paid ex-post by the asylum authority, pink the care funded from the national budget and green the care available through social security contributions. It is due to the fact that several pieces of legislation apply simultaneously, without clearly referring back to other eligibility.

Laboratory screening tests are compulsory in the context of the stay of third-country nationals in Hungary to identify diseases and pathogen-carrying conditions that pose a risk to public health:[426] such as tuberculosis (TBC), HIV infection, lues, paratyphoid fever, hepatitis B. Therefore, screening is paid for by the national budget/health insurance. Covid-19 screening is not listed, but would be a justified to add to the list.

424 Hungarian: a Hungarian citizen with a registered place of residence in the territory of Hungary pursuant to Act LXVI of 1992 on the Registration of Personal Data and Addresses of Citizens, a person with immigrant or settled status, a person recognised as a refugee or a person granted protection, and a stateless person.

425 From 1 July 2020, it will no longer be possible to settle a claim after three months by paying the unpaid health insurance service contribution (HUF 7710/month for nationals and the minimum wage for non-residents), meaning that the patient will have to pay the service and then the monthly premium if he/she has been treated, but emergency care will still be provided.

426 Decree 32/2007 (VI. 27.) of the Ministry of the Economy

The list of life-threatening conditions and illnesses covered by urgent care is set out in a decree,[427] which lists 31 cases (e.g. childbirth, kidney attack, electric shock, infectious disease, amputation). According to the definition, all health care activities that must be carried out in the context of in-patient care from the time of diagnosis until the first treatment of a condition in order to provide medical care for life-threatening conditions and diseases and to prevent lasting harmful effects until the patient's condition is stabilised, or in the context of in-patient care, from the time of diagnosis until the first medical treatment of a condition in order to provide medical care and to prevent lasting harmful effects. This is quite a considerable discretion for medical practitioners when emergency care is included in a piece of legislation.

Specialised healthcare can be provided by a health service provider with an obligation of territorial coverage. The health care provider reports the provided service to NEAK on a form provided for the reporting and accounting of the care in question, as prescribed by the legislation on the detailed rules for the financing of health care services from the Health Insurance Fund. The report, broken down by health services, are sent monthly by NEAK to the asylum authority, which then reimburses them.

In the case of prescription medicines, the healthcare provider can claim back the cost of the treatment by presenting a receipt showing the applicant's (humanitarian) residence permit number and a summary invoice issued to the attention of the asylum authority as the purchaser, stating the name, price and quantity of the medicine. The prescription and the invoice must be forwarded by the healthcare provider to NEAK.

If the health care service is not covered by the Fund or the national budget, it is provided by the health care provider against payment of a fee set by a specific law. This is where the medical staff's understanding of what constitutes an emergency service and what is covered by primary care becomes relevant. People with no valid social security number due to failing to pay social security can only receive not urgent medical care after paying the bill in advance. Emergency care used to be free for everyone, but now people with no valid social security number must pay for emergency care. The bill can be paid after the procedure, but the patient or a family member must be informed of the expected costs before the procedure. Hospitals can charge as much as they would receive from NEAK for the treatment, up to a maximum of HUF 750 000. In other words, the treating doctor cannot provide the patient with medical care from public funds in the absence

427 Decree No 52/2006 (XII. 28.) of the Ministry of Economic Affairs and Labour

of a social security number.[428] Part of the legal environment is that quality control is neither general nor specific to foreigners (the social insurance supervision body has been abolished), and to protect patients' rights, complaints can be submitted to the maintainer, or to the patient advocate,[429] who suggests mediation[430], or mediates himself, investigates complaints and tries to prevent lawsuits. Hungarian law has not established a specific liability regime for compensation issues related to health care providers, but judicial practice takes into account the specific nature of the legal relationship between doctor and patient, in particular concerning liability.[431] Although there is no legal practice in connection with beneficiaries of international protection claimants in relation to liability for damages against a medical service provider, it would serve to prevent litigation if medical staff and institutional managers were made aware that this practice could be established with the provision of adequate legal advice. In particular, because the care provider is not prepared to meet the needs of this particular group of patients. The conditions for proper communication and the use of informed consent are lacking, medical mediation is not helpful (as is the case with other forms of out-of-court settlement), and the lack of preparation of the necessary medical documentation constitutes a breach of the duty of care in both form and substance.

The Hungarian legislation has three main features of concern for people in need of international protection:

1. The main feature of existing national health legislation is that it is not specific, because it does not regulate health care provision based on diseases or life situations, but according to forms of care and eligibility. Asylum legislation is not sufficiently detailed as regards health status, accommodation conditions and individual life paths, because it is linked to certain stages of the procedure (asylum seeker, detained, person placed in a reception centre, acquisition of status). It is therefore doubtful whether the European standards have actually been transposed.

2. The lack of a specific application rule for people in need of international protection is an obstacle to equal access. For example, the regulation on termination of pregnancy does not take into account how the public health nurse receives the refugee woman's application, whether the refugee woman is seen twice by the Family Protection Service and how she could communicate there, whether she is informed of her rights, whether it is discussed with her in which institution she wants to have the intervention. Similar problems exist in the system of care for pregnant women in need of international protection in the absence of specific rules.[432] The right to access these services does not guarantee access and equal treatment.

3. Regulatory deficiencies also hinders effective access as required by EU directives, because either the living situation (e.g. homeless) or the status (e.g. refugee, beneficiary of subsidiary protection) or both (e.g. immigrant minor) is required by law, while a refugee can be homeless or a full-time student or even a person in need. This regulatory technique, based on single/main criteria, makes it difficult to apply the law because it is not clear what the legal objective is: to address certain life situations or to distribute rights between people with different statuses; it does not provide an answer to what should happen to cases that can be classified in more than one category. Therefore, there is no priority given to those who need special attention and care (e.g. persons requiring a different placement due to psychiatric and psychological need, therapy, physical and psychological rehabilitation, disability, old age or traumatisation). This is further limited by a lack of knowledge and communication difficulties, on the part of both providers and recipients.

428 28/2020 (VIII. 19.) EMMI Decree on certain rules of health care for persons residing in Hungary who are not entitled to health care services under social security and on certain rules of agreements on the provision of health care services. The new rule could have unforeseen consequences. It is possible that the person who goes to the emergency room with a stroke, or a relative, will simply not seek care after hearing the cost of the intervention because they know they cannot afford it. The new social security law will come into force in July 2020, and the six months after that are already being monitored by the tax office. Anyone who accumulates six months of arrears – the first possible date is January 1, 2021 – will have their social security number cancelled by the NEAK.

429 381/2016 (XII.2.) Government Decree on the Integrated Legal Defence Service

430 2000.évi CXVI.tv. on the health mediation procedure

431 András Pethő: Difficulties in the liability of a healthcare provider. *State and Law*, 2019/2:50-62.

432 32/1992 (XII.23.) NM Decree on the application of Act LXXIX of 1992 on the protection of foetal life, 26/2014 (IV.8.) EMMI Decree on prenatal care

6. Lessons learnt from the pandemic

It is not yet possible to take full stock of how the restrictions imposed by the Covid-19 pandemic have affected access to care, border entry and exit, infection prevention and patient treatment specifically for those in need of international protection.

The starting point is that epidemiological measures are universal. For example, "chain tracing" is the task of the epidemiological authority: in the case of a specific disease, requiring the patient to name the persons from whom he or she may have contracted the disease. Therefore, the epidemiological authority also cooperates with the WHO, which has a prominent role in international cooperation on epidemiology, as regulated by the International Health Regulations (2005)[433]. The WHO Regulations aim to prevent the international spread of communicable diseases without unnecessary disruption of international traffic and trade. Thus, they include the obligation of States Parties of notification (surveillance) and authorise the WHO Director-General to decide whether an international public health emergency exists, to issue interim and permanent recommendations for epidemiological measures. It is determined whether an event constitutes a public health emergency of international concern on the basis of the information received, in particular from the State Party on whose territory the event occurs.[434] For example, if the public health impact of the event is severe, i.e. the population at risk is particularly vulnerable (e.g. refugees, people with low immunity, children, elderly, people with low immunity, malnourished). But there is no indication that there are (practised) measures in the Hungarian regulatory framework for public health emergencies in relation to people in need of international protection.

According to the secretary of the Hungarian Medical Chamber, the weakness of the pandemic management has highlighted the fact that the National Public Health Centre, the capacities of which were reduced by a tenth in 2017, cannot perform its basic functions, such as contact research. Professional control has been lost due to lack of capacities and, with the issuance of mandatory official licences, it is questionable whether they will be regularly monitored. Their working group named Redesign has proposed in vain to renew the minimum conditions of care and then to monitor them rigorously. The Chamber is not invited to engage in the work on health care reform. The Boston Consulting Group was commissioned by the government to draw up a restructuring concept but it is not public. The Chamber has no insight into the details of the reform plans, because the government does not seek consensus concerning policy decisions; there is no cooperation with professional platforms. Consequently, there can be no social consensus on health care reform. The pandemic has set back reform.[435]

According to Eurostat's August 2020 analysis, Hungary is below the EU average in both treatable and preventable mortality; and its mortality rate for treatable diseases is almost twice the EU average. Preventable mortality, i.e. mortality that can be avoided through a conscious, healthy lifestyle, is the worst among the EU countries, i.e. unhealthiness is a safety risk, but the National Safety Strategy[436] does not cover the challenges of health care, in spite the destroyed epidemiological care system, inadequate public communication and a shattered health care system.[437] In addressing the epidemiological risk, the Strategy states in paragraph 169: 'Health security, which includes operational and regulatory response capacity to public health and epidemiological challenges, natural or manmade, in addition to a high level of health care, must be a priority. In extreme cases, it must be ready to deploy military forces to prevent an epidemiological crisis (in evacuations and quarantine, control of movements of persons, control of migration and crime, operation of military hospitals)." So, it seems, health and public health care is at most a military matter, but not a security or strategic one.

People without a social security number, in particular asylum seekers, refugees, beneficiaries of subsidiary protection, people with tolerated status and their family members (with different legal statuses) perceived that they were treated differently in the measures against Covid-19. They[438] did not have access to vaccinations and free screening/testing was only available to them in quarantine and under official obligation. This changed after 17 months:[439] From May 2021, foreigners living in Hungary (and Hungarians living abroad without a social security number and Hungarian minorities living outside Hungary) could finally register for vaccination at www.vakcinainfo.gov.hu.

433 Promulgated by Act XCI of 2009

434 Marianna Fazekas: Health policy. National University of Public Service, Institute of Management and Continuing Education, Budapest, 2014.

435 Orsolya Tarcza: A conscious communication silence surrounds the transformation of the health sector. MedicalOnline, 2021. 09.11.

436 Secure Hungary in a volatile world. 1163/2020 (IV. 21.) Government Resolution on Hungary's National Security Strategy

437 Tamás Csiki Varga – Péter Tálas: On Hungary's new national security strategy. Nation and Security 2020/3: 89-112.

438 It is in vain that Americans living in Hungary ask for vaccination. Index, 26 April 2021..

439 Government Decree No 221/2021 (3 May) amending Government Decree No 479/2020 (3 November) on additional protection measures to be applied in times of emergency

7. Opinions and recommendations

The consultations, interviews and debates organised as part of the project have revealed the following views that served as a basis for recommendations, and indicating what is missing in the provision of care.

Refugees in Hungary generally refrain from using the health care system because even if they know they are eligible for benefits, it may turn out that their employer did not register them legally, and does not pay their contributions, and therefore would not receive free care. If possible, they prefer to choose a dentist from a private practice. Those who have had their own experience with Hungarian health care had good rather than bad impressions, but they did mention that their statements (e.g. I am cold, hungry) were not taken seriously, either for language reasons or because of work overload. It is depressing that it is unclear for them who and where would provide them with medical care, meaning that access is often difficult.

Hungarian health care staff have argued that as long as their work is socially and financially not recognised, the level of empathy of health care workers will not be high. If the health service is adequately staffed and paid, refugees will not encounter doctors and nurses who are overworked and spend little time with patients. On the other hand, as long as the propaganda frightens the population with refugees and the diseases they bring, people will remain hostile to refugees. There was no epidemic risk in Europe during the 2015 refugee wave, but still, there is fear-mongering communication, which seriously hinders and even blocks the integration of refugees. Communication with patients is a common problem, which makes it impossible to learn about the symptoms, the condition, the medical history, which means that treatment is nearly impossible. If there were a list of available and trained interpreters who were properly paid (by the authorities or the Health Insurance Fund), a large part of the related problems could be addressed. Professional interpreters are also excellent on the phone, most of them are refugees integrated into Hungarian society.

According to doctors there is an urgent need to find a way to ensure that the care of asylum seekers and refugees is not linked to their social security number. The pandemic has drawn attention to the fact that an increasing number of Hungarian citizens and foreigners are unable to do Covid-19 tests, because they do not have a social security number, even though the general practitioner is responsible for the epidemiological measures. As refugees and asylum seekers frequently change their place of residence, it would be of vital to include them in the EESZT (cloud-based data service) with their own ID, as the change of residence and without access to their medical records, their care will be inefficient, and generating unnecessary additional administrative work, too. It would be particularly important to have at least their immunological data accessible in a cloud-based database (vaccination data, for example). The age of the patient and, in this context, the suitable of treatment is of particular importance. Age determination is not a law enforcement task, but health care competence, which requires well-established professional cooperation involving endocrinologists, psychologists, paediatricians and cultural anthropologists. Standards developed to determine the age of an average American young person cannot be applied to people from other parts of the world, because of their different lifestyles and diets. As this is a time-consuming and complex task, time must be devoted to it. A suitable procedure should be developed for age determination. If an adult patient appears not to know his way around a strange environment and exhibits understanding at the level of a child, health professionals need guidance and training on how to communicate with him.

According to social workers, there is an urgent need to fill absolute health care gaps, such as adult and child psychiatric care. It is difficult to identify progressive and territorial jurisdiction of care, which is a double disadvantage in cases requiring rapid assistance.

Based on the above, a number of proposals can be formulated, according to the European, national and institutional levels, without rigidly defining the lines of response between them.

At European level:

- there is a need for further action in the EU to address the health needs of vulnerable social groups, especially with public health cross-border relevance. Member State authorities need institutional cooperation to promote health screening, access to services, preventive care for migrants, ethnic minorities and other vulnerable groups, through the identification and exchange of good practices of the health care system. The ways in which the Fundamental Rights Agency can collect information on vulnerable groups should be examined, and the extent to which they suffer from health inequalities in the EU. Sensitisation and exchange of good practices should be initiated in cooperation with

Member States to improve access to and adequacy of health services and to prevent the lack of care for vulnerable groups;

- the EU should harmonise the existing testing protocols in each Member State and create an interoperable eHealth IT system. The Hungarian institutional system's electronic record system and database could be adapted to this, so that it could be used for the planning of separate care, prevention and research based on the health data of asylum seekers and beneficiaries of international protection. In other words, there is no need to standardise care for all foreigners, but specific epidemiological profiles must be taken into account;
- cooperation between Member States' authorities should be strengthened, particularly in the field of primary care and the admittance of people in need of international protection and vulnerable groups, to ensure patient-centred, compassionate care that responds to the health needs of refugees. More research on gaps is needed. This is also how appropriate training materials can be developed.[440] These should also be made available to Hungarian GPs, for example.[441]

At national level:

- a strong coordination mechanism should be established between the actors of the decentralised care system, including a rationalised system of administrative channels, financial and professional data exchange (e.g. updated website, non-stop telephone service, regular forums);

  the health care of beneficiaries of international protection should not only be remunerated by the provider on the basis of the standard ICD code, but also by a multiplier/allowance that could be included in the legislation and budget to take into account the additional skills and time needed to provide care;
- the list of competent institutions providing care and their services should be regularly updated on their websites, a database of rules and procedures should be set up, and a 24/7 telephone helpline should be set up, accessible to anyone, in foreign languages (for refugees, ambulances, social services, police, civil helpers);

440 For example, under Horizon 2020, in 2016, the Consumer, Health, Food and Agriculture Executive Agency (CHAFEA), under the supervision of the European Commission, funded a survey in seven countries in the EUR-HUMAN project.

441 Imre Rurik et al: Refugees, migrants in primary care. What can we learn from the results of the EUR-HUMAN project? Medical Weekly, 2018/35, 1414-1422.

it would be necessary to organise the translation of medical documents of persons in need of international protection into Hungarian and foreign languages. A central on-line database of appropriately trained interpreters should be set up. Translation services should available free of charge to health care providers; this should be covered by NEAK funds; professional interpreters are also excellent on the phone, most of them are refugees integrated into Hungarian society, and thus able to assist in other ways in the medical work;

- screening tests of beneficiaries of international protection should be ordered immediately upon launching the administrative procedure, including their medical assessment and access to emergency care (epidemiological, gynaecological, addiction and mental health assessment and treatment at least);
- doctor(s) should be present in accommodation facilities (reception centre, detention centre) at all times, depending on the capacity and the number of asylum seekers and their state of health. The aim should be to promote small, home-like accommodation facilities, which would also improve the mental health of residents, so that the mass accommodation would be temporary;
- the assessment and testing of the vaccination status of adult asylum seekers and the individual assessment of need of vaccination should be developed, as one of the main public health risks, according to the WHO, is the re-emergence of vaccine-preventable diseases;
- medical needs assessment should take into account the physical and mental health state of beneficiaries of international protection and the psychological stress of integration, and therefore provide for greater capacity in emergency care, primary care with flexibility in the provision of adequate professional and infrastructural conditions (e.g. mobile medical units, adult and child psychiatric care);
- the basis of trust between the patient and the caregiver is a two-way information provision on health status and treatment, which requires basic training, data protection, information materials in foreign languages and confidence-building measures, especially in the context of HIV testing, treatment and other health care for people living with HIV;

health care provision should take into account linguistic, cultural and ethnic backgrounds, ensure informed consent and participation in medical decisions, as well as the trauma they experienced;

- professionals working with refugee children need specific language and cultural training (e.g. how to work with interpreters). Paediatricians and child health organisations should work with major international organisations (UNICEF, WHO, UNHCR, International Organisation for Migration) and regional and national organisations, as age assessment and safe care for children requires a holistic approach and careful consideration. A comprehensive "Child Health Action Plan for Refugee Children and Adolescents" should be jointly developed with the IPA (International Paediatric Association): to provide clinical care for refugee children in a non-discriminatory and non-judgemental manner, regardless of their legal status, within a publicly funded high-quality service, protecting their human dignity. Health policies should ensure that refugee children and young people receive equitable care, and that paediatricians and other child health care professionals work according to evidence-based protocols and guidelines. This requires inter-professional cooperation, and the use of trauma-mitigating methods in medical-psychological care, with continuous evaluation and development of programmes, and the integration of children's rights.

At institutional level:

- migration and refugee health should be made part of medical training,[442] just as public education should pay attention to the various cultures within the society;
- the performance of border and asylum tasks requires specially trained and qualified staff and safe working conditions, stress management and mental health services, which need to be ensured and monitored at the ministerial and institutional level;
- information materials, preferably video/visual materials, should be produced, published in all reasonable places and disseminated in foreign languages to persons in need of international protection;

442 For example, at the University of Szeged it was introduced into the foreign language training programme from 2012, and at the University of Pécs six modules were added to the Master's degree in migration health in 2011: (1) public health and applied epidemiology, infectology; (2) social and behavioural aspects of migration; multicultural aspects and their role in medical and social care; (3) applied fields of occupational health; (4) economics of integration; (5) mental health and psychosomatic care of migrants; community-based health promotion programmes; human rights of migrants; (6) 'Migrant-friendly' health and social care systems and related systems management skills and tasks.

- forums should be organised to help train health care staff, prepare and disseminate educational materials on what it means to provide health care, screening, treatment and communication to beneficiaries of international protection.

8. Procedural proposals similar to the Refugee Health Procedures Protocol

Based on the joint experience of the EU and IOM, a set of procedures for the medical examination of refugees and asylum seekers has been developed.[443] It proposes the recording of a personal data and the use of ICD codes (e.g. A15-19, B20-24), which can be stored in an electronic database. The proposed procedure consists of four main elements:

- medical history, including vaccinations (with appropriate questionnaire, assuming the lack of vaccinations);
- assessment based on physical examination, recommendation for tests, further travel, treatment, vaccinations for under 18s and adults separately; this may include assistance with daily living (e.g. bathing, feeding, fitting prostheses, whether assistance is needed with toileting based on sphincter condition), regularly/regularly/regularly/regularly;
- mental assessment (e.g. dementia screening, early childhood development assesment for children aged 0-5 years);
- suggesting laboratory tests, controls or treatments and immunisations, and informing the patient of these, as documented. This will also avoid duplication, chaos, damage to public health, the spread of infections and worsening of conditions.

The Council of Europe and the United Nations High Commissioner for Refugees (UNHCR) recommend the involvement of refugees in health care provision. This could serve a dual purpose.

On the one hand, it encourages states to make use of refugee health professionals to keep national health systems functioning.[444] There are people in Europe in need of international

443 Health assessment of refugees and migrants in the EU/EEA. European Commission, Directorate-General for Health and Food Safety – IOM, 2015, Brussels

444 www.coe.int/en/web/education/recognition-of-refugees-qualifications

protection who have the appropriate medical training and experience and are willing to help. As most health professions are strictly regulated, the competent national health authorities must authorise refugees to work. To facilitate this, in the Council of Europe launched a pilot project in 2017 and developed a European *Qualification Passport for Refugees (EQPR)*[445] or refugees with medical qualifications. Ten Qualification Recognition Centres have been set up and, with their help, the first five hundred refugees in these countries could be employed in 2019.[446] The EQPR does not replace the necessary professional certificates and licences, but it helps authorities to speed up the licensing process by carrying out certain procedures and obtaining documents. To fill the shortage of national health workers, interpreters and mediators, it would be useful to assess the availability of qualified refugee health professionals using the EQPR. Knowing their data and numbers, health and asylum authorities could plan to employ these people, or at least to involve them as volunteers. Drawing on UNHCR's experience, innovative methods could be used to ensure access to refugee communities, to identify health professionals who could be recruited as volunteers or employees, and to assess their skills and qualifications.

On the other hand, the paid or voluntary involvement of beneficiaries of international protection in the care and treatment of their community, their fellow citizens, also helps them to integrate and to improve their self-esteem.

9. Refugee Health Procedures Protocol (MEP)

In order to make complex use of the requirements, criticisms, shortcomings and suggestions described in detail, I have created a protocol called *"Refugee Health Procedures Protocol" (MEP)*. My aim is to work through it to define a set of procedural steps for health care staff (authorities and carer givers) in relation to people in need of international protection, to promote their safety and integration, as well as the protection of public health. It is not my aim to undermine the protocol for preventive health care or to influence the content of preventive health care work through any professional forum. I merely intend to develop a procedural guide that could, for example, be published and promoted by a medical association or primary care institution to standardise procedures.

445 Use refugees in healthcare, Legal World, 15 April 2020

446 Armenia, Bosnia and Herzegovina, Canada, France, Germany, Greece, Italy, Monaco, Norway, Belgium

The procedure can be divided into 12 units or tasks, as summarised in Table 2:

- The *first step* is to be able to identify the patient in some form, not specifically instead of the authority responsible for this task, but actually to be able to assign to them certain personal data in the healthcare system and care activities in the NEHP. The most important information is that as a rule of thumb asylum-seekers and beneficiaries of international protection do not have an SSN/SS card (except if the social worker requests it for those living in reception facilities, or their employer requests it for them when they start working). Therefore, they can be identified based on the number and data of their currently valid (and from time to time replaced) residence permit. They rarely have other documents and their naming is different from what is used in Hungary. In the light of these circumstances the SSN used as a healthcare personal identification number should be issued in a much more simple, automatic manner and not depending on the eligibility for care as in emergency care and ambulance care the identification of the individual has a great role when there is a medical intervention (e.g. to be aware of allergy, blood type, acute illnesses). In the long run the creation of a separate healthcare identification number (using a random number generator) is suggested in the NEHP for the health care administration of asylum-seekers and beneficiaries of international protection which can be entered into a common electronic refugee database (European electronic database for Healthcare of refugees) in the EU also resolving the portability and accessibility of data this way, since complying with the GDPR is mandatory in each member state. It is relevant to: authority, National Health Insurance Fund, legislator, healthcare workers doing patient admission.
- The *second step* is the verification of the financing of care, which requires substantial legal knowledge. The starting point is that care for people who have no SSN/SS card as an applicant or beneficiary of international protection shall be financed from budgetary sources (based on legal regulations or a decision based on social eligibility) or with the support of civil organisations or rarely the person covers the costs from their own funds, and there is a difference in who the invoice is issued to (reporting to OEP/NEAK,[447] Ministry of the Interior, or directly to the financing entity). During invoicing we did not specifically mention the application of ICD/HDGs codes and the rules on local fees, because

447 NEAK receives a report on emergency care from the health care provider see

these are explained in detail in the financial rules of hospitals, specialist clinics, although these documents often provide insufficient suggestions specifically on how to compensate for the lack of data, documents and communication related to beneficiaries of international protection, which do not follow the changing legal regulations and merge certain personal categories.[448] It is relevant to: personnel conducting patient admission.

- The *third step* is the verification of the existence and content of healthcare data accumulated so far about the patient. In case of asylum-seekers it rarely happens that a GP would follow their life, which means they meet different staff and care providers and they are even moved within the country. On the other hand, the health status of asylum seekers changes between the date of leaving and arrival and even during the asylum procedure. Finally, it rarely happens that refugees have treatment (outpatient) records, documents from countries they have transited through. For this reason, greater attention must be devoted to whether they have any historical data or healthcare documentation. If they do, or it can be obtained through cooperation among care providers and can be replaced, obviously some of the following phases can be skipped. It is relevant to: doctors providing primary care, personnel involved in patient admission.

  The *fourth step* is determining the age of the patient. As they often do not have any valid documents, their age can only be recorded according to their statement although their age is extremely important for validating several legal guarantees (childhood/ elderly age, single, adolescent pregnancy, victims of abuse before reaching the age of sexual self-determination, the prohibition on child labour and child military). If the age is not known, it must be clarified with the right examinations based on the available instruments with the best possible approximation except if age has no significance in the independent action, self-determination and treatment of the person. It is relevant to: personnel conducting patient admission, treating physician, authority, relatives.

- The *fifth step* is to clarify whether the patient belongs to any vulnerable group (unaccompanied minor, victim of torture, violence, traumatised person, very elderly, living with disabilities). This is not necessarily revealed at the first meeting with the doctor, the language-related, psychological reasons and the uncertainty about their age together may justify further inquiries, examinations of the person or their family. Therefore, later at the data recording this question must be revisited. It is relevant to: personnel conducting patient admission, treating physician, authority, relatives.

- The *sixth step* is to record whether and how it is possible to communicate with the patient. Language skills, perception and psychological disorders and the cultural distance altogether can explain communication disruption (for example if the doctor, healthcare professional is not the same gender as the patient, absence of parents, lack of better knowledge of mediating language, lack of trust can be in the background). Therefore, it must be documented, whether the person conducting the examination or treatment can communicate/talk, in what language, with an interpreter or directly with the patient also including the situation when it is visible that the person does not understand medical expressions/terminology. Interpreters, let alone interpreters of tribal languages and sign language, are unfortunately not available, so the request for interpreters and potential communication disturbances must be recorded and knowing about these helps the other people providing treatment in future examinations and meetings with the patient. It is relevant to: personnel conducting patient admission, treating physician, authority, interpreter, relatives.

  The *seventh step* is providing sufficient information to the patient on the healthcare and treatment data pertaining to them. This is important also because only based on this the patient's consent can be obtained for various invasive examinations, interventions and medical treatment. The patient's right to self-determination is not a matter of citizenship, the patient is entitled to it at all times. The information provision greatly depends on what age, physical and mental state the patient is and whether it can be provided independently to them, or only in the presence of a relative, legal representative (parent, guardian, caregiver) and whether their status can be explained and their consent requested for treatment only personally to them or together with others. It is relevant to: treating physician, interpreter.

- The *eighth step*, which can be interchangeable with the previous step, is revealing the medical history, which is the phase preceding the treatment process. Here, we point out that in countries with compulsory vaccination systems, including Hungary, it is important to know which vaccinations the person has

448 For examples see here, here and here.

received (in the absence of documentation, it is assumed that all age-related vaccinations are missing). Furthermore, it is important to clarify what illnesses, operations, injuries the patient has had which is determined by what severe effects have impacted the person before arriving in the country before and during the migration, escape, travel, and after arriving in the country (such as accident, abuse, oppression, torture, pregnancy, rape, STDs, parasites, malnourishment, stress). Who is relevant: treating physician, primary care provider, public authority (epidemiology).

- The *ninth step* is the physical examination of the patient, partly by recording general data and partly by taking a look at his/her current perceptible condition (injuries, infectious diseases, acute health problems and symptoms, pregnancy, emergency and acute treatment as an outpatient/hospital referral). Obviously, a number of laboratory and specialist tests will lead to a diagnosis. It is relevant to: treating physician, primary care provider.
- The *tenth step* is a mental examination of the patient. This includes PTSS and dementia, the identification of addictions, treatment of people who are traumatised, suffer from depression or mental disorder, furthermore examination of infants and toddlers for age-appropriate development, and the early identification of disorders. These should be registered, but the list is not exhaustive. Relevant to: treating doctor (psychiatrist).
- The *eleventh step* – naturally in parallel with the points above – making various recommendations so that the identifiability of the person, the coverage of care and the existing healthcare documentation could be revealed. On the other hand, the professional recommendations for laboratory tests, treatments, control and immunisation required for treatment and diagnosis are also formulated here. At this point it becomes significant what recommendation is made for the person's onward travel/return, transfer in another institution. The former is a recommendation pertaining to the ability to travel (e.g. exclusion of the deterioration of health status, fixed pose, exclusion of air travel, care provided in the receiving country) and for the placement conditions (e.g. tolerability of closed institution, exclusion of detention centre, placement in serviced residence together with family members or isolated placement). At this point the recommendations of must be recorded for what help the patient needs until recovery and how often (e.g. washing, feeding, placement of prosthesis, help with toileting based on the condition of sphincter muscles, daily, occasionally, continuously). It is important to cooperate with the various authorities, because it is legally relevant if someone carries marks from beating or abuse (creating an injury report because of domestic violence or ill-treatment by law enforcement officers), if the patient is a minor (informing the child protection signalling system not the abuse, neglect or if the supervision of the unaccompanied minor is not resolved), or if the patient is suffering from mental disorder (for example their statements in the asylum procedure cannot be assessed, for example due to alcohol or drug abuse, or PTSD, which is important to document and indicate, or the family reunification must be organised for them, because this significantly influences their psychological state and physical). It is relevant to: personnel conducting patient admission, treating physician, authority, interpreter, relatives
- Finally, the *twelfth step* is to ask whether, if the refugee has any medical qualifications and/or experience, this could be put to good use in the community, either as a volunteer or by formally recognising his/her qualifications. So far, this retention and integration force has not been exploited, although it common practice worldwide, and the opinion of a health professionals would be important in this regard. It is relevant to: treating physician, authority.

Schematic structure of the Refugee Health Procedures Protocol (MEP)

1. Does s/he have a social security number?

YES, S/HE HAS

The data available in the registration system and the data declared match ☐

Data don't match ☐ → **Point 11**

NO SOCIAL SECURITY NUMBER

The data available based on the residence permit and the data declared match ☐

Data don't match ☐ → **Point 11**

2. Verification of financing:

financing from budget/public funds ☐

means-tested funding ☐

willing to pay promptly ☐

covered by others ☐

cannot pay ☐ → **Point 11**

3. There is historical data:

YES ☐

NO (has never been examined, not included in EESZT, no file) ☐ → **Point 11**

4. Age determined?

BASED ON EXAMINATION cca: ☐

NO ☐ → **Point 11**

5. Does the patient belong to a vulnerable group?

YES, i.e.: ☐

NO ☐ → **Point 11**

6. Can you communicate with the patient?

Yes, in language: ☐

Only with an interpreter: → **Point 11**

- interpreter provided ☐
- no interpreter ☐

Through a relative, cause: ☐

No, reason: ☐ → **Point 11**

7. Informing the patient

On their health status:

- orally ☐
- with an interpreter ☐
- writing ☐
- via a relative ☐ → **Point 11**
- with legal representative ☐ → **Point 11**
- in part ☐

On the necessary examinations

- orally ☐
- with an interpreter ☐
- writing ☐
- via a relative ☐ → **Point 11**
- with legal representative ☐ → **Point 11**
- in part ☐

On the necessary treatment

- orally ☐
- with an interpreter ☐
- writing ☐
- via a relative ☐ → **Point 11**
- with legal representative ☐ → **Point 11**
- in part ☐

On other recommendations

- orally ☐
- with an interpreter ☐

- with an interpreter ☐
- writing ☐
- via a relative ☐ → **Point 11**
- with legal representative ☐ → **Point 11**
- in par ☐

8. Medical history

illnesses, operations, injuries ☐

vaccinations (assuming their absence): ☐

how long the patient been travelling (from to): ☐

victim of torture? ☐

medication (takes it, has it...):

therapeutic appliances (glasses, crutch...):

number of children, births, pregnancy:

9. .Physical examination

general (weight, height, blood pressure):

immunisation status, communicable disease:

HIV ☐

complaints, symptoms: ☐ → **Point 11**

10. Mental examination

mood, perception memory, concentration, orientation: ☐

addiction, dependence: ☐ → **Point 11**

trauma/PTSS: ☐ → **Point 11**

dementia: (mini-mental state) ☐ → **Point 11**

early childhood development (0-5 years) ☐

11. Recommendations

verification of personal data:

issuing invoice for financing

sending invoices/sending data:

obtaining historical data (where from, what):

specialist medical examinations:

hospital treatment, referrals (emergency):

To determine the order of tests:

- Treatment proposal,
- medicine:
- medical aids:
- lifestyle: (food, exercise, accommodation)

Vulnerable group screening:

- Recommendation for care:
- Periodically:
- Continuously:

Laboratory testing:

Diagnostics:

Recommendation for immunisation:

Which vaccinations:

Check-up:

Notification to authority:

- with special regard to: injury report, guardianship authority/child protection authority,
- how can the asylum authority take into consideration the statements of the patient, other

Travel/relocation proposal:

- If the person can travel, under what circumstances:
- If he/she is to be transferred to another institution, under what conditions:

12. Medical education

THERE IS, and that is: ☐

THERE IS NOT ☐

COULD BE USED ☐
(in which area, under what conditions/proposal)

After the 2015 crisis year, the Hungarian government cut down domestic programmes supporting the social integration of refugees. The European Union's financial support has largely become inaccessible to NGOs dealing with refugees. The creation of transit zones made social work with asylum seekers very difficult. Lodging of asylum applications has hardly been possible since the closure of transit zones. Although formally still in existence, by 2020 the Hungarian asylum system has practically withered.

And yet there are people living in Hungary who started a new life here as refugees or beneficiaries of subsidiary protection. By choice or against their will, with the help of family or friends, with or without the support of Hungarian NGOs, but somehow, they became part of Hungarian society. Their legal status allows them to work, study or raise their children here, but they face many difficulties due to the complete lack of targeted state assistance. How do they find a job? Do they have a place to live? How are they received by the healthcare, social and education institutions? What are their needs and how can they overcome the difficulties?

This volume focuses on various fields related to the situation of refugees in Hungary and outlines some possible proposals. We recommend it to all those who want to gain a more in-depth knowledge of this topic, which is surrounded by many prejudices, and who want to make Hungary a more inclusive place.

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