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Health care for illegal migrants in Hungary

1. Legal and illegal migration

Nowadays the debate on the immigration policies of developed countries has turned its attention towards illegal migrants. It makes sense to take a hard look at the real economic implications of clandestine migration: Does illegal immigration help the underground economy? Who really benefits from the employment of undocumented migrants? And to what extent does their employment affect the recruitment and wages of nationals? What social security impact do they make?

To answer these questions, it would help to know how illegal immigration is actually defined. The spectrum is very wide. For apart from those who enter countries illegally, many migrants enter a country quite legally but overstay their visas or fail to get their permits renewed. Also in this group are the seasonal workers who fail to return home when their contracts expire and rejected asylum seekers.

Where illegal migration begins and ends is a matter for each sovereign state to define. And it is through the rule of law – with its gaps – that the state imposes restrictions on entering and leaving a country, and establishes the legal conditions governing access to the labour market. In countries that remain broadly open to immigration, like Australia, the United States and Canada, illegal entry appears as one option to would-be immigrants. Where countries are more restrictive – as in Europe today – it is the only option, except for those applying for asylum or family reunification.

Length of stay plays a defining role too. A migrant may be legal one day and illegal the next. For many migrants, illegality may just be a provisional situation on the way to achieving legal status. But illegality may be a permanent status too, either because authorisation has not been obtained or because when it was granted, as has recently been the case in countries like Greece, Italy, Portugal and Spain, it was done so on a one-off, non-renewable basis.[2]

In the early 1990s, the German philosopher Dieter Hoffmann-Axthelm asserted that the paradigmatic scene of the modern era is that of the immigration officer examining a

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[2] http://www.oecdobserver.org/news/fullstory.php/aid=190 (Downloaded: July 17, 2009)

passport.[3] The movement of people across borders is not specific to the modern era, but it is the border policies and immigration laws of nation states that have created the paradigmatic scene and one of its consequences, „illegal" immigrants. The proliferation of undocumented migrants and human 'smuggling' is associated with the state's „loss of control", „national security", and organized criminality. Many of the states –especially in Europe – are seized by „security panic" about illegal migration.

This is a study of illegal migration and health care rights, which focuses on the process of unauthorized migration.

The status of illegal immigrant is only possible because a person is seen to be in violation of rules of residence and citizenship. This status is produced not only by the institutions of the police and immigration authorities, but also by other officials in education, health, and housing, as well as by private persons who as employers or landlords verify immigrant documents.

Due to the nature of the subject in most countries there are no exact figures on the number of undocumented migrants. Most statistical data on 'illegal' migrants are estimates, usually based on border arrests, court records, and deportations. However, there are some widely accepted estimates in several countries.

Smuggling human beings is today a global problem[4] and a matter of great concern for states in the West. The movement of people from the poorer countries to the richer is increasingly taking place outside the regular immigration channels. Smuggling refugees and immigrants often makes use of the same channels as those used by narcotics and weapons smugglers. The well organized „smuggler groups" work in complex networks which stretch from countries of origin, via 'transit' countries, to the countries of destination.

Profits from trafficking in people are estimated to be comparable to the profits of international drugs and weapons smuggling. Due to the fact that the penalty for smuggling people is much less severe than for smuggling narcotics, many criminal groups abandon the latter in favour of the former[5]. The emergence of new destinations and routes has shaped a new geography of transnational migration. The majority of studies of undocumented migrants in Europe has largely been left to governmental institutions, journalism, criminology, and legal studies. These studies tend to focus on the issue of travelling, i.e. how people get to their destinations. The living conditions – including social security rights – of these people are often overlooked.

Being an „illegal" immigrant in almost every country entails exclusion from a range of societal institutions, including education, health care, welfare systems, and the protection of the law. The everyday life of undocumented migrants means living under the constant threat of deportation. Yet, mostly, „illegal" immigrants are invisible except in cases of tragic incidents. e.g. suicide, traumatic deportations, or attempts to receive an „amnesty" after having been misled by smugglers.

The undocumented migrants are pre-eminently labour (economic) migrants.

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[3] HOFFMANN – AXTHELM, DIETER.: Identity and Reality: The end of the philosophical immigration officer, In: LASH, S. and FRIEDMAN, J. (eds.): *Modernity and Identity*, Blackwell, London 1992 p. 196.

[4] KYLE, DAVID and KOSLOWSKI, REY: *Global Human Smuggling*. Baltimore: The Johns Hopkins University Press. 2001 p. 1.

[5] SMITH, P. JAMES: *Chinese Migrant Trafficking: A Global Challenge*. In: Smith, P.James (ed.): *Human Smuggling: Chinese Migrant Trafficking and the Challenge to America's Immigration Tradition*, Washington, D.C.: The Center for Strategic & International Studies (CSIS), 1997. p. 12.

Compared with legal migrants, the undocumented aliens work very long hours and receive lower wages. Today's trafficking in human beings as labour force is similar to the many thousands years of the parents had decided that they would follow their children and relatives who had moved to a new country. Essentially what we saw taking place was a movement toward family re-unification. Its unique distinguishing feature is that the father who had once come as a young guest worker was not followed by a wife and children, as is customary in Western European patterns, but instead the nuclear family had immigrated together, and the elderly relatives followed suit later[6]. The motivations may have included the fact that if the elderly parent comes to live in Hungary they are easier to look after, if need, than if there is a distance of several hundred kilometres. If the immigrating parents were ill, they were able to expect a higher standard of health service than at the place they had left behind. And if they were healthy they could give the money from selling their property in the country of origin and from gaining Hungarian pension to the younger generation as a sign of inter-generational solidarity, alongside offering use of their activity itself.

Obviously, parents following their children are not the only pattern for old age immigration – there must be others. A second significant section of old age immigrants consists of persons who had once emigrated from Hungary and wish to return to their roots. A third significant layer of elderly immigrants is that of foreigners with no Hungarian background who are seeking for the more pleasant side of life here.

In sum, international elderly immigration has emerged since the mid 1990s in Hungary. While the aging process was becoming accelerated in Hungary, the share of old people among foreign immigrant stock in this country was also rising. At the time of the millennium they reached roughly a 10% proportion, which means that one in ten immigrants staying in Hungary is of sixty years of age or older. From the demographic point of view, the increasing proportion of old persons among immigrants can be retraced to two factors. One is the natural aging of earlier immigrants themselves in the destination area. The other comes from the effect of the immigration of increasingly older persons. A third factor could be the low mortality rate of old age immigrants, which arises from their extremely good state of health. For lack of specific research on this question, however, this can only be formulated as a hypothesis.

As a main feature, in Hungary there is virtually no sociological, legal or ethnographic research into the situation of „illegal" immigrants. However, there are some exceptional studies.[7]

[6] DWYER, PETER: *Welfare rights and responsibilities.* The Policy Press, Bristol, 2000 p. 163.

[7] SALT, J. and HOGARTH, J.: *Migrant Trafficking and Human Smuggling in Europe.* In: Migrant Trafficking and Human Smuggling in Europe: a review of evidence with case studies from Hungary, Poland, and Ukraine, Geneva: International Organization for Migration (IOM), 2000 pp. 23–25.

2. Health care as human rights

2.1. Health care as a human rights: affirmative approach

Human rights are about our basic needs as human beings. They capture the core rights we are all entitled to so that we may develop our potential and live our lives in dignity and respect.[8]

There is another approach: human rights are „basic rights to humane dignified treatment and things I should have access to simply because of the fact I am a human being".

They were first defined by the international community in the Universal Declaration of Human Rights adopted by the United Nations in 1948 as a response to the events of the Second World War. These events were a stark reminder of what may happen when states treat, or allow others to treat, some people as *less human than others*. The Universal Declaration of Human Rights proclaimed that „everyone has the right to a standard of living adequate for the health and well-being of oneself and one's family, including food, clothing, housing, and medical care."

There are many different human rights reflecting the basic needs across different areas of the human beings' lives. For example, the need for *physical and mental* well-being is reflected in the right to life, the right not to be tortured or degraded, and the rights to food and shelter. The need for *social* well-being in families, communities and wider society is reflected in the right to respect for private and family life, the right to hold and express one's beliefs, and the right to participate in the cultural life of the community.

The more the human rights are respected, protected and fulfilled, the more humanity or 'what makes us human' is fulfilled. Human rights are not only about the protection of particular groups and individuals in society. They are about providing a practical framework to protect the rights of everyone.

2.2. Human rights – the core principles

A good way to understand human rights is to see them as a vehicle for making principles such as dignity, equality, respect, fairness and autonomy central to our lived experience as human beings. These core principles are brought to life by a range of different human rights that make them real.

For example, the principle of dignity is what lies beneath the right not to be tortured or treated in an inhuman or degrading way, while the principle of autonomy informs the right to respect for private and family life. Human rights can give these principles real meaning in people's lives.

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[8] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_0734 74.pdf (Downloaded: July 17, 2009)

Table 1

Human rights, their key principles and links to healthcare

PRINCIPLE	HUMAN RIGHT	EXAMPLE POLICY OR PRACTICE
Dignity	Right not to be tortured or treated in an inhuman or degrading way.	Ensuring there are sufficient staff to promptly and properly act to reduce the risk of people suffering degrading treatment.
Equality	Right not to be discriminated against in the enjoyment of other human rights.	Committing to improving health services for people from black and minority ethnic groups. Ensuring that people are not denied treatment solely on the basis of their age.
Respect	Right to respect for family and private life.	Respecting all diverse families e.g. same sex couples with children. Not denying those detained or in residential care access to family without good reason.
Fairness	Right to fair trial.	Ensuring that there is a robust and fair process for removing a doctor or dentist or other health worker from the Performers List.
Autonomy	Right to respect for private life.	Involving people in decisions made about their treatment and care.

Source: The British Institute for Human Rights, http://www.dh.gov.uk/prod_consum_dh/groups /dh_digitalassets/@dh/@en/documents/digitalasset/dh_073474.pdf (Downloaded: July 10, 2009)

2.3. How are rights made real?

There are two main ways in which human rights are made real in people's lives:

a) The state respecting, protecting and fulfilling human rights

The state is the core „duty bearer" in relation to human rights. It has duties to respect, protect and fulfil the human rights of all those within its jurisdiction. This means that state bodies, such as health providers, must respect people's human rights, and refrain from interfering with them without good reason. For example, a person's s right to freedom of speech may be interfered with where this is necessary to protect the rights of others or the interests of the wider community. However this needs to be properly justified.

b) People claiming or raising their human rights

Human rights belong to all human beings, all the time, regardless of whether they are aware of their rights and regardless of whether they are actively invoking or claiming them. In other words, human beings are all 'rights holders'. In this way, at the minimum, human rights serve as a safety net for all people.

When they are not being respected, protected or fulfilled, people should be able to activate or claim them. For example, everyone has the right not to be treated in an inhuman and degrading way, but for most of the people, most of the time, there is no need to raise this. However, at some stage in life they may become more dependent on the actions or care of others, for example staff in hospital or carers at home. In other words, human rights are not given or awarded on the basis of need.

However, it is important to remember that people most at risk of human rights abuses, for example because they are socially excluded, are less likely to have access to information and resources about their human rights, and therefore are less likely to claim or raise their rights.[9]

2.4. Health care as a human right: negative approach

The Tavistock Group has invited comments on its document on shared ethical principles. I would challenge its first major principle – that health care is a human right.[10]

According to Philip Barlow, human right is a moral right of paramount importance applicable to every human being. However, there are several reasons why health care should not be considered a human right.

Firstly, health care is difficult to define. It clearly encompasses preventive care (for example, immunisation), public health measures, health promotion, and medical and surgical treatment of established illnesses. Is the so-called human right to health care a right to basic provision of clean water and adequate food, or does everyone in the world have a right to organ transplantation, cosmetic surgery, infertility treatment, and the most expensive medicine? For something to count as a human right the minimum requirement should surely be that the right in question is capable of definition.

Secondly, all rights possessed by an individual imply a duty on the part of others. Thus the right to a fair trial imposes a duty on the prosecuting authority to be fair. On whom does the duty to provide health care to all the world's citizens fall? Is it a duty on individual doctors, or hospital authorities, or governments, or only rich governments? It is difficult to see how any provision of benefits can be termed a human right (as opposed to a legal entitlement) when to meet such a requirement would impose an intolerable burden on others.

Thirdly, the philosophical basis of all human rights has always been shaky. Liberalism and humanism, the dominant philosophies of Western democracies, require human rights. Most people can see some advantage in maintaining the concept of civil and political rights, but it is difficult to find any rational or utilitarian basis for viewing health care in the same way.

To propose that health care be considered a human right is not only wrong headed, it is unhelpful. Mature debate on the rationing and sharing of limited resources can hardly take place when citizens start from the premise that health care is their right, like a fair trial or the right to vote. Barlow suspects that the proponents of the notion think that to

[9] www.feantsa.org/files/Health.../HUN_health_report.doc (downloaded: July 17, 2009)

[10] BARLOW P.: Health care is not a human right British Medical Journal 1999; pp. 319–321. http://www.bmj.com/cgi/content/full/319/7205/321 (downloaded: July 31, 2009)

claim health care as a human right adds some kind of weight or authority to the idea that health care, and by extension healthcare professionals, is important. A more humble approach would achieve more in the long run.[11]

Doctors, among all those whose work is based on the scientific method, must guard most against taking apparently logical arguments too far. Barlow's rejection of the proposal that health care is a human right is such a case.[12] He bases this rejection on three points: 1) that health care is difficult to define; 2) that it is not clear whose duty it is to provide health care; and 3) that „it is difficult to find any rational or utilitarian basis" for viewing health care as a human right. The value and justification of human rights is not that they can be derived from abstract principles but that they represent a consensus view of what all of us owe to each other. In this way human interdependence has a chance of producing positive rather than negative outcomes. The Universal Declaration of Human Rights of 1948 is the most widely accepted expression of this consensus and has been signed up to by many nations whose people would not agree on religious or social principles.

Article 25 of the universal declaration states: "Everyone has the right to ... medical care." On the basis of this, health care is a human right. It is this that makes tackling the difficulties of deciding appropriate and affordable levels of care so urgent, not just for doctors but for politicians, economists, and the rest of everyone.[13]

3. Introduction to the Hungarian health care system

3.1. The right to health approach in the Hungarian Constitution

In Hungary, the Constitution (Act 20 of 1949) declares the right of everybody living in the territory of Hungary „to the highest possible level of physical and mental health." [Section 70/D Paragraph (1)] In addition, citizens have a right to social security, which involves an entitlement to benefits guaranteeing income for old people, widows, orphans and unemployed who lost their jobs due to reasons other than their own fault, or in the event of ill health and disability [Section 70/E Paragraph (1)]. The state satisfies this obligation through social security and social institutions [Section 70/E Paragraph (2)]. The Constitution sets a task for the Government to define the public system of social and health care, and to arrange for funding for these services [Section 35 Paragraph (1) subparagraph g)].

The above principles were integrated into the Constitution when it was modified on 23 October 1989, representing one of the important stations of the change of the system. Hungarian health services were available for all citizens universally since 1972 as of right, but at the time of the change of régime, the services were made subject to insurance relationship based on contribution payment obligation ('it was put on an

[11] SMITH R., HIATT H., BERWICK D.: Shared ethical principles for everybody in health care: a working draft from the Tavistock Group. British Medical Journal, 1999 pp. 318 and 248–251.

[12] BARLOW P.: *Health care is not a human right.* British Medical Journal 1999;July 31; pp. 319–321. http://www.bmj.com/cgi/content/full/ (downloaded: July 19, 2009)

[13] WEIR, D. J. G.: *Human rights are based on consensus.* British Medical Journal, 1999 October 30; p. 1203. http://www.bmj.com/cgi/content/full/ (downloaded: July 31, 2009)

insurance basis'), from which large social groups (pensioners, unemployed, etc.) were excluded and there were some groups which were simply left out. The exceptions from contribution payment obligation were gradually reduced, and since 1996 practically almost all Hungarian citizens have been insured.[14]

3.2. The role of the state in the health care sector

Prior to the political and economic changes in 1989/90, the government managed all aspects of the country's health care sector. The Local Government Act (1990) transferred the responsibility for the ownership, management and provision of health/social services to local governments. Major capital investments are financed by the owners (local governments in most cases) or co-financed with the Ministry of Health (MOH). All recurring expenditures are financed and administered by the National Health Insurance Fund (hereinafter: NHIF). The Fund is controlled through the Ministry of Finance and the MOH.

Public health responsibilities are carried out by the National Public Health and Medical Officer's Service (NPHMOS) in conjunction with local governments. The NPHMOS is charged with overseeing public health and disease prevention activities, which are carried out at both national and local levels. NPHMOS stations are responsible for disease surveillance and reporting, control of communicable diseases, monitoring of environmental health, food hygiene, health education and preventive medicine. Many stations have microbiological and immunological laboratories and each provides clinical testing for local hospitals lacking their own services.

The NHIF was established in 1993 and is designed to be self-sustaining, based on compulsory payroll contributions from both employers and employees and a very limited investment portfolio. However, without special support from the central budget via the Treasury, the Fund would have been unable to run the system for the last few years as actual contributions have lagged behind health expenditures.

3.3. The Hungarian Health Act

The principal piece of legislation in the health sector is the Health Act setting out the most important framework rules of health care (Act 154 of 1997), which replaced its predecessor, which had been effective for 25 years, but became obsolete (Act 2 of 1972). Its scope covers all health service providers operating and health activities pursued in the territory of Hungary, defines the rights and obligations of patients and health care employees, and the state's responsibility for the health status of the population, the system of health services, the professional requirements of the services, and organisational and management system in the health sector, The Health Act also defines medical research conducted on humans, special procedures involving human reproduction, research with embryos and spermatozoon, basic rules of sterilisation, treatment and care of psychiatry patients, organ and tissue transplants, sets out rules relating to corpses, it also deals with blood supply and emergency health care, medical expert activities, natural medicinal factors, spas and climatic therapeutical institutes and

[14] http://www.llrx.com/features/hungarian.htm (downloaded: July 19, 2009)

treatment facilities.[15]

The Health Act specifies the obligation of health employees to provide services, and it also introduces the concept of health service providers with an obligation to provide services in a particular area, including also the main rules of on-call and on-duty services. In the process of the change of the system, the Act on Local Governments (Act 65 of 1990) made local governments responsible for arranging for the delivery of health care services. The local governments are mandated to arrange for the provision of primary health care services. Specialist health care, exceeding the tasks of primary care, is an optional task. Pursuant to the provisions of this act, it is a mandatory task of county governments to provide specialist health care above the primary health care level. Local governments can fulfil their obligation to provide these services not only as owners of outpatient and inpatient specialist institutions, but also in the framework of contracts concluded with the owners of such institutions.

3.4. Health care financing

The most important operational principle of the Hungarian health system is solidarity, which means that the insured do not pay risk proportionate insurance premium but an income proportionate contribution pursuant to the main rule. It can be treated generally as social insurance because of the contribution payment instead of insurance premium payment, which, in addition to the insurance element, also executes a considerable income redistribution too from those with a higher income towards those with a lower income, from the active towards the inactive (pensioners and young people), from the employed towards the unemployed, etc.

In accordance with the effective legislation, the health sector is currently a diverse, multi-actor system, containing local governments, the state, which is present both as a regulator and an owner, a licensing and supervisory authority operated by the state, the National Public Health and Medical Officer's Service (NPHMOS) and the financing agency, National Health Insurance Fund.

The financing system operates on the basis of the principle that current (operating) expenses are covered from the National Health Insurance Fund, while capital expenditure (refurbishment, development, etc.) is covered by the owners (local governments and the state through various public administration agencies, e.g. ministries). This two-channel or dual financing system stops the involvement of enterprises into health services, because enterprises can recover their costs only through to the sale of services.[16]

Following the pattern of West European industrialized countries, Hungary has opted to retain a predominantly publicly funded health system with an increasing degree of private services. Privatization of health services has proceeded most rapidly in the pharmaceutical, dentistry and family physician (GP) areas. Private sector development has been faster for ambulatory and diagnostic services, and negligible for outpatient and hospital care, areas where both costs and reimbursement mechanisms have thus far remained largely within the public sector. However, new mechanisms have been established to allow private physicians to act as independent contractors to health

[15] http://www.orvosilapok.hu/magyar-fogorvos/glosszak-az-egeszsegugyi-torveny-margojara-3-resz (downloaded: July 19, 2009)

[16] http://mighealth.net/hu/index.php/3. (downloaded: July 15, 2009)

agencies and private companies are now providing many former in-patient services through home care services. The production and distribution of health aid products has also been fully privatized.[17]

The Hungarian health care system operates on the basis of dual financing. Major investments like equipment purchases and construction/maintenance are financed by the owner (in most cases the municipalities) or co-financed with the MOH from the central budget. All recurring expenditures of the daily operations, including salaries of health care professionals, are financed by the NHIF on diagnosis-related groups (DRG) basis.

The role of private medical insurance in Hungary has not yet been clearly defined. While the concept of supplemental health insurance has been accepted as a matter of policy, the structure for such insurance programs has yet to be worked out.

3.5. The structure of the Hungarian health care services

The Hungarian health care system provides general services to all Hungarian nationals and to the majority of EU citizens.[18] Except for such „non-essential" services as cosmetic surgery and private hospital rooms, the health insurance system guarantees free access to all necessary medical care. Partly due to this accessibility, utilization of health services in Hungary is fairly high.

3.5.1. Primary care family physicians/nurses

In 1992, the Minister of Welfare's Decree created the Family Physician Service. Previously, the system of „panel physicians" required citizens to seek medical treatment only from designated district doctors. Now individuals have the freedom to choose their own family physician. These general practitioners are the first points of contact for sick people/patients. Family doctors refer patients requiring more sophisticated interventions to hospitals, outpatient clinics and/or diagnostic centers and labs for examinations and testing. They have an important gate-keeper position.

Family doctors are remunerated on performance-based capitation (i.e., their incomes are determined according to the number of individuals registered with them), taking into consideration the age of the patients and the doctor's level of expertise. Higher points are awarded for treating infants, young children and older people. Family physicians have "district nurses" on staff who assist in the clinics during business hours and provide minor follow-up in-home health services (take blood pressure, provide shots, etc.).

[17] http://www.factbook.net/countryreports/hu/HuHealthCare_mkt.htm (downloaded: July 15, 2009)

[18] The status of the EU citizens varies according to their labour market situation. If they are employed according to the Hungarian legislation, they will be covered by the Hungarian social insurance scheme. It means that they are entitled equally to the Hungarian citizens. If they are treated under EHIC (European Health Insurance Card), their rights to health care are limited, according to the provisions of the EU social security co-ordination.

3.5.2. Hospital care

Hungary's previous health care system relied on institutional care. Emphasis was placed on the development of large hospitals (with 1,500-2,000 beds) and university clinics. That has changed along with other major health care reforms and most owned by the local governments. The national institutes (for cardiology, oncology, pulmonology, etc.) and rehabilitation centers belong directly to the MOH and the four medical schools own five clinics. About twenty institutions belong directly to other owners/ministries (the Hungarian Army, Ministry of Interior, Hungarian Railways and church/charity organizations); however, their operational costs are covered by the NHIF as well. There are only few private hospitals that operate without any NHIF financing.

Under the previous system hospital budgets were determined by bed occupancy rates. Therefore, there was no incentive to release patients on a medically timely basis. In 1993 new methods of paying health facilities were introduced. For in-patient care payment is based on the DRG system as in the United States, while a German-style „point" system is used for determining payment for out-patient care based on the relative tariff fee-for-service schedule. Accordingly, hospitals receive funding from the NHIF on the basis of patient volume and types of treatment offered, regardless of the length of time of patient stays. Thus physicians are encouraged to shorten in-patient stays. This has created a growing need for out-patient and in-home health care services.

3.5.3. Out-patient care

Outpatient clinics are affiliated with hospitals and perform one-day surgeries, while more serious cases are referred directly to hospitals. Following the privatization of the family doctor services, the outpatient services will be privatized in stages. Doctors will be offered the opportunity of purchasing specialist consultation rooms under closely specified conditions.[19]

4. Health care for foreigners in Hungary

4.1. Personal scope of the Hungarian health system

Foreign nationals may stay in Hungary temporarily, or live permanently in the country. In the latter case, the foreign national has moved his/her residence to Hungary for the purpose of taking up employment, or as an old-age pensioner, or for the purpose of pursuing studies, or as the dependent of a Hungarian worker (insured person), or having a refugee, asylum seeker or admitted status. From the point of view of health insurance, entitlement to health care differs by specific groups of foreigners.

Foreigners qualifying as insured must prove entitlement to benefits of the Hungarian health insurance scheme by the form „Certificate of entitlement to healthcare benefit", or in other cases, in keeping with the relevant agreements (e.g. by their passports).

[19] http://www.factbook.net/countryreports/hu/HuHealthCare_mkt.htm (downloaded: July 19, 2009)

A natural person who does not qualify as a national shall be deemed a foreigner (for social insurance purposes). The following persons qualify as nationals (for social insurance purposes):

a) Hungarian nationals residing on the territory of the Republic of Hungary,
b) Immigrants, holding an immigration permit,
c) holders of permanent residence permit (residents),
d) persons recognized as refugees,
e) EEA citizens (citizens of European Economic Area member states),
f) family members of EEA citizens (provided they are holders of EEA residence permit issued by the Hungarian alien policing authority),
g) citizens of third countries who enjoy identical status with citizens of EEA states, provided they are in possession of a residence permit and
h) stateless persons.

On the basis of specific agreements, State Parties to such agreements provide for entitlement to a range of health care services on a mutual basis for their citizens during their stay in each other's countries. Nationals of State Parties to such agreements who are not insured in Hungary are entitled to health care benefits free of charge (with expenses borne by the health insurance fund on the basis of different methods of accounting) during their stay in Hungary, to the extent such care is necessary due to an acute illness episode or urgent need, upon production of their passport. The benefits include basic health services, outpatient care and inpatient (hospital) treatment.[20]

The Republic of Hungary has bilateral agreements in effect with Angola, Bulgaria, North Korea, Iraq, Jordan, Serbia-Montenegro, Cuba, Kuwait, Mongolia, Romania, and the legal successor states of the former Soviet Union except the Baltic States.

With the Member States of the European Union Hungary applies European Community Law, namely Regulation 1408/71/EEC on the coordination of social security schemes. With Croatia, as from 1 March 2006 a new agreement entered into force which applies the same principles as those in Regulation 1408/71 /EEC and 883/2004 from May 1 of 2010.[21]

In keeping with the general rule, foreign nationals who come to Hungary with the aim of taking up employment shall qualify as insured from the beginning of their employment relationship with an employer deemed a national in Hungary and the employer is required to make contribution to the insurance fund on behalf of these workers. By virtue of the contributions made on their behalf, these workers shall acquire entitlement to all benefits of the health insurance scheme.

The Social Insurance Identification Number (in Hungarian: TAJ-szám) and the entitlement of foreigners who are entitled to health care in Hungary are certified by the form „Certificate of entitlement to health care in Hungary", on which the employer certifies entitlement to use health services (or rather, the payment of contribution every 3 months) by affixing its stamp onto it. Upon termination of the employment relationship, the employer withdraws the certificate.

[20] www.oep.hu (downloaded: July 17, 2009)

[21] http://www.eum.hu/english/social-security-of/beneficiaries-of Beneficiaries of healthcare in Hungary with special regard on foreigners (downloaded: July 19, 2009)

In the case of foreigners studying in Hungary, entitlement to health care services in Hungary is restricted to foreign nationals who pursue full-time studies at an institution of secondary or higher education and whose student status is based on an international agreement or a fellowship granted by the Hungarian Ministry of Education.

Non-national students who fail to meet the above-mentioned requirements may become entitled to health care services only if they sign an „Agreement" with the Health Insurance Fund.

The Act on entitlement to social insurance benefits takes out certain categories of non- national workers from the scope of the main rule on the insured. The statutory health insurance scheme does not cover non-national employees at diplomatic representations, in other words, diplomats, non-national members of the staff at diplomatic representations and non-national spouses and children living together with them.

Only nationals and assimilated groups are entitled to health care services. According to Act 80 of 1997 on Social insurance general issues, the persons who are in one of the types of legal relationship listed below only will become entitled to using healthcare services if they qualify as nationals (Hungarian or any of the EU and EEA Member States), in addition to meeting other entitlement criteria:

a) Beneficiaries of sick-pay, maternity benefit, child-care allowance, accident sick-pay or accident annuity and their dependent close relative and common law partner;
b) Beneficiaries of pension of own right, or survivor's pension benefit and their dependent close relative and common law partner;
c) Beneficiaries of old-age, work incapacity or survivor's annuity, of old-age, work incapacity or survivor's annuity of an increased amount, temporary annuity, regular social welfare annuity, health impairment annuity, disability support or disability annuity and their dependent close relative and common law partner;
d) Beneficiaries of war veteran's allowance and their dependent close relative and common law partner;
e) Beneficiaries of miners' wage supplement and their dependent close relative and common law partner;
f) Beneficiaries of child-care allowance and their dependent close relative and common law partner;
g) Beneficiaries of child raising support and their dependent close relative and common law partner;
h) Beneficiaries of pension from churches or religious denominations registered in Hungary and their dependent close relative and common law partner;
i) Beneficiaries of regular social welfare assistance and their dependent close relative and common law partner;
j) Beneficiaries of elders' annuity and their dependent close relative and common law partner;
k) Beneficiaries of carers' allowance and their dependent close relative and common law partner;
l) Beneficiaries of income replacement support of the unemployed [the unemployment benefit scheme changed as of 1 November 2005, and the support

scheme of job seekers was introduced] and their dependent close relative and common law partner;
m) Socially indigent persons whose entitlement to health care services is certified by the mayor of the local self-government by means of an official certificate;
n) Persons engaged in activities as foster parents.

4.2. Health care coverage of illegal persons

According to the health insurance legislation in force, foreigners in Hungary are provided with health care as follows:

a) for free (on basis of international agreements and bilateral agreements between states – e.g. within EU)
b) without a direct payment on the basis of statutory health insurance (compulsory health insurance) – EU and Council of Europe (European Social Charter) or
c) by direct payment (e.g. foreigners from states out of EU).

The foreigners without permanent reside in Hungary have two options:

1. Foreigners without the permanent residence status who are employed in Hungary are insured by the employer who has its residence in Hungary (principle of *lex loci laboris*). The insurance is paid by the employer and employee, and the insurance lasts only for the employment period.
2. Foreigners without permanent residence in Hungary who are not employed there cannot be participants of the statutory health insurance system but they can sign a contractual health insurance contract with the regional health insurance agency.[22]

Problems can appear only in the case of people who are not insured at all (for example: foreigners of the third group) and who become sick or disabled. In that case they must pay for health care directly. Therefore, the most problematic group in this sense is the group of foreigners living illegally in Hungary. Some of them have insurance in their countries which is not valid in Hungary. Often; they are not informed properly about the administrative necessities. Another problem is the quite high price of insurance and the condition to pay for several months (six months) in advance in case of concluding an agreement with the Hungarian Health Insurance Fund Administration. Illegal immigrants are also afraid that the health insurance fund would deny accepting them as clients. And last but not least – some of them are afraid of the interconnection of the health insurance fund administration and the police – they are afraid of being exposed and expatriated by the police. Therefore such people go to the doctor only in very urgent cases and they pay the care in cash in advance. Often they look for a doctor from their community even if such a doctor does not have the licence to be able to provide care in Hungary.

[22] http://www.eum.hu/enelish/social-security-of/beneficiaries-of Beneficiaries of healthcare in Hungary with special regard on foreigners (downloaded: July 19, 2009)

In sum, illegal immigrants must pay the care directly and when they do not have money, the medical staff can even deny treating them. A doctor, however, cannot deny treatment in case of urgent need (injury, acute illness or a delivery). For such a treatment the doctor cannot require a payment.[23]

5. Issues for reconsideration

5.1. Culturally sensitive medical care

Multicultural issues in many countries have become a part of formal education in primary and secondary schools for the last few years. As far as multicultural issues in the field of health care and nursing education are concerned, they also became a part of the curricula quite recently (around the year 2000) in many countries where intensive migration became visuable. They are still implemented only in some institutes, even if these issues have been analysed and their importance was well-known already in the 50s of 20th century.[24]

The knowledge of cultural issues helps doctors and nurses to plan and implement a suitable treatment regime. In practice, medical staff often misses practical tools for collecting information about a concrete patient. A model of Giger and Davidhizar[25] can facilitate assessment of cultural factors and their influence on the behaviour of a human being. This model offers systematic procedure for assessment of six basic cultural factors: (1) communication; (2) space; (3) social inclusion; (4) time conception; (5) influence of environment and education; (6) biological differences. All of these factors are present in the cultures: they differ by their content. If we consider them while working with the patients, we will be able to assess and approach individually.

Assessment procedure. There is a recommendation for medical staff how to assess the patients with a different cultural background: 1. Find out if the client has been culturally assimilated or if s/he keeps his/her original cultural habits. 2. Insert the following data to the plan of medical staff care: A. Invite a client for a common dialogue on cultural differences; people from other cultures can help nurses to gain a new point of view on many things. B. Try to accept and make use of the clients' way of communication. C. Respect the client's personal space (territory). D. Respect the right of the client to worship the Almighty according to his/her belief. E. Eventually contact a priest (a divine) of the client. F. Find out how religious habits influence the health and life of the client, his/her quality of life etc. (e.g. Jehovah's Witnesses do not accept blood and its derivates; some clients demand only kosher meals etc.) G. Find out what the client is interested in, especially if you are going to take care of him/her for a longer time – e.g. during rehabilitation etc. H. Respect the orientation of the client towards time and values. Provide comfort and pacification, if necessary. I. Ensure the privacy

[23] http://www. menedek.hosting1.deja.hu/.../06KovatsAndrasszocialpolitikaiesmigracio.doc (downloaded: July 19, 2009)

[24] Madeleine Leininger and Marilyn McFarland: Transcultural Nursing: Concepts, Theories, Research and Practice, New York, 2002 p. 34.

[25] JOYCE NEWMAN GIGER and RUTH DAVIDHIZAR: *The Giger and Davidhizar Transcultural Assessment Model.* Journal of Transcultural Nursing, 2002, Vol. 13, No. 3, pp. 185–188.

adequate to the client's needs and his/her health condition. J. Take notice of treatment procedures in the scope of the client's culture: 1. identify and support effective folk procedures 2. identify dysfunctional procedures and inform the client about their dysfunction 3. identify neutral procedures and consider if they can have a negative influence in the long-term perspective. K. Take notice of the eating habits: 1. ensure the food according to the client's wishes as much as his/her health and long-term perspective allows.

5.2. Migrants' access to health care services

Equal access to health care for those in equal need of health care is one of the main characteristics of equity in health. Three components of „access" can be distinguished: 1) the right to help, 2) ability to come in contact with the caregiver and 3) effectiveness of help. Usually, legal migrants who have been granted work and residence permit are entitled to the same basket of health treatments as nationals. For obvious reasons, research on the health of illegal immigrants is in general neglected. Anyway, illegal migrants have no rights to use health care services in Hungary except emergency service.

5.3. Main barriers in accessing health care services by migrants in general

There are, at least, three groups of factors that can explain why legal migrants may experience unequal access to health care:

a) requirements for obtaining permanent status can be very stringent,
b) literacy, language and cultural differences and,
c) administrative and bureaucratic factors, lack of knowledge of the system and mistrust of health providers.

In addition, there are two more barriers:

a) patient related barriers (such as lack of language competences, beliefs concerning health and treatment, mistrust to the health care system of the hosting country) and
b) system related barriers (legislation, lack of provision of information) can be distinguished.
c)

5.4. Main barriers in Hungary

There are, at least, three main barriers in accessing health care services by new labour migrants in Hungary: 1) lack of information, 2) lack of language competences and 3) economic factors.

a) Lack of information

In contemporary society information becomes a kind of an immaterial commodity, which is sometimes much more valuable than material goods. Accordingly, lack of provision of information can cause the marginalization of particular social groups. All people have equal rights to get the information they need because the state authorities are obliged to use all the possible resources to provide and support the equality in social, cultural, political and economic spheres between minority groups and the majority. In the age of globalization, the state still plays an important political role. Unfortunately, it seems to be difficult for many governments – including Hungary as well – „to construct new forms of interaction with their citizens". Instead of making that effort, they rely on existing communication channels. Migrants have the right to know what kind of medical help they are entitled for, what health care services are available and how to get the help they need. However, it looks like migrants with low education will become more and more disadvantaged and marginalized in the information/network society. Many have insufficient digital skills and many of them lack dominant language competence.

Undoubtedly, advances in information and communication technologies somehow influence the type of information people can get access to and the sources of the information. The most important for migrants, especially those coming from the countries without health care system, is to get to know how to get access to the GP, who is a gatekeeper in Hungarian health care system.

b) Lack of language competences

Linguistic issues present significant barriers for many immigrants. Migrants who speak neither Hungarian nor English may have basic practical problems with access to health care services (making an appointment, communication with the doctor). According to research, many migrants speak little or no Hungarian even after a few years in Hungary. Professional translators should be available and, what is more important, migrants must be informed about their right to have one. The migrants' knowledge of language is related to self-reported health status and use of health care services.

c) Economic factors

They are especially important in case of economically vulnerable groups of migrants (undocumented migrants, labour migrants and asylum seekers). In Hungary patients must pay for certain treatments a charge for using health care services. It can be a problem for some categories of immigrants. Migrants underutilize the health care system if they are not covered by health care insurance (undocumented migrants); cannot afford to pay for visits (refugees, poor labour migrants) or do not want to spend money on health care services (labour migrants who send money home).

In sum, it can be stated that the access of illegal migrants to health care or in a wider sense to the social security benefits is an unsolved issue in Hungary. The government and different NGOs must pay more accurate attention to the question. Recently, Hungary has been a transit country and the majority of the illegal migrants move towards economically and linguistically more attractive EU countries, but this trend might be changed in the near future.

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AZ ILLEGÁLIS MIGRÁNSOK EGÉSZSÉGÜGYI ELLÁTÁSA MAGYARORSZÁGON

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(Összefoglalás)

A bővülő Európai Unió egyre komolyabb szociális kihívásként szembesül az illegális migráció jelenségével. Európát illegális migránsok százezrei lepik el évről-évre. Maga a migráció – és így az illegális migráció is – nem az utolsó évtizedek sajátossága, az emberiséget mindig is jellemezte a jobb életfeltételeket biztosító térségek irányába való vándorlás. A valós veszélyt az illegális megnyilvánulási forma, az „ellenőrizhetetlenség", továbbá a kapcsolódó, illetve az arra épülő és abból hasznot húzó cselekmények így pl.: a) az embercsempészet és emberkereskedelem; b) a prostitúció; c) a hamis úti,- és személyi okmányok előállítása; d) a feketegazdaság növekedése; e) a korrupció, stb. jelentik.

Az emberek többsége az illegális migrációt és az illegális migránsokat előítéletekkel kezeli, noha az illegális migránsok zöme sajátos, érthető okból választja a helykeresésnek ezt a módját. A hétköznapi ember fél a feketegazdaság felvirágzásától vagy a különböző fertőző betegségektől, melyeket gyakran az idegenekkel társítanak. Napjaink médiatudósításai is egyre gyakrabban foglalkoznak azokkal a betegségekkel (pl. TBC, AIDS) melyek terjedésében nagy szerepe lehet a jóval fertőzöttebb – nem európai – területekről térségünkbe érkező illegális migránsoknak.

Maga az illegális migránsok számára is zsákutca a migrációnak ez a formája. A konfliktusokkal, gazdasági problémákkal terhelt térségeket elhagyva, és előnyösebb életfeltételeket keresve valós céljaikat, az új választott társadalomba való beilleszkedést teljességgel nem képesek elérni. Tény továbbá az is, hogy a migráció illegális formája az esetek többségében automatikusan kapcsolódik a különböző illegális tevékenységekhez, hiszen a migránsok engedélyek és papírok híján kénytelenek illegális tevékenységekből megélni. Nem hagyhatjuk figyelmen kívül azt sem, hogy „kéretlen" megjelenésük, számtalan gazdasági, egészségügyi, és szociális feszültségforrást eredményez.

A cikk a fenti problémák közül elsősorban az illegális migránsok egészségügyi ellátásával foglalkozik.