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ACCESS TO HEALTHCARE FOR BENEFICIARIES OF INTERNATIONAL PROTECTION IN HUNGARY – ANALYSIS AND RECOMMENDATIONS

SOCIAL INTEGRATION OF BENEFICIARIES OF INTERNATIONAL PROTECTION IN HUNGARY – NIEM POLICY BRIEFS

JUDIT TÓTH

5

HEALTHCARE

EUROPEAN UNION
Asylum, Migration and Integration Fund
Safe harbour

INSTITUTE OF PUBLIC AFFAIRS

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Executive summary

This analysis reviews how beneficiaries of international protection can access the healthcare system and the operating health insurance system which are important for their integration and protection. Not only the awareness and attitude of social and healthcare providers but also the care capacity and the needs of people under protection play an important role in this. Although for lack of targeted data collection and research and also due to the current pandemic there is little relevant data in Hungary, it is possible to build on the decades of experience in asylum regulations and administration. We can contribute indirectly to the integration of beneficiaries of international protection by having elaborated the proceeding scheme described at the end of this analysis from lodging the application to completing the healthcare treatment, furthermore by involving refugees in healthcare provided they have the suitable qualifications. If healthcare professionals (doctors, nurses, organisers) follow the Refugee Healthcare Protocol (hereinafter '**RHP**', Hungarian acronym: MEP), this proposal will provide higher healthcare security to beneficiaries of international protection and it provides help for those working with them in Hungary and maybe elsewhere, too.

1. Introduction

The integration of asylum-seekers and beneficiaries of international protection may be facilitated by applying more indicators and by the coordinated operation of several special areas and line policies. In this project (National Integration Evaluation Mechanism – NIEM) aimed at forming proposals relevant to each special area, those pertaining to healthcare are indispensable. The baseline is provided by specifically three areas that are almost inseparable from each other:

- **(a)** How can asylum-seekers and beneficiaries of national protection (refugee, beneficiaries of subsidiary protection, persons granted tolerated stay) obtain legal entitlement for health insurance required for funding of care.

- **(b)** How can they use health care once their entitlement is ensured, taking into consideration the special circumstances of beneficiaries of international protection: their place of living/residence, communication and cultural differences, the potential lack of medical documentation and their specific supporting documents.

- **(c)** What are the characteristics of circumstances deriving from forced migration in healthcare services. What types of care is there an increased need for by the stakeholders in view of the pandemic situation and trauma experienced?

The COVID-19 global pandemic and the lack of statistics form serious obstacles nowadays. For this reason, we can lean on the analysis of the reference literature for legal regulations and only to a small extent we can lean on empiry. Therefore, in the following, we only focus on the improvement of access to care, *specifically by raising awareness among healthcare professionals (and social workers).* According to our hypothesis, people working in the care professions received very little preparation for (public) health care related to beneficiaries and asylum-seekers of international protection. Therefore, if we give them a certain kind of *procedure scheme or protocol*, it can make the access to care more uniform, can improve treatment so that we can indirectly help the integration of beneficiaries of international protection.

Our analysis includes the arguments and explanations supporting the launch of the *Refugee Healthcare Protocol*. We also discuss the lack of data and the regulations pertaining to legal titles, placement in the health policy system, professional concerns, works-targeting training and research and the relevant recommendations by the WHO. The description of RHP – about which a few physicians also provided their opinions – is after the analysis and its schematic table can be found in **Annex 4**.

2. Data and Discrepancies

Pertaining to integration, NIEM builds on the use of 15 types of indicators concerning integration including healthcare legal regulation indicators pertaining to the asylum-seekers and beneficiaries of international protection, furthermore it uses healthcare statistics, data on the operating and financing of healthcare services available for them and on professional and social dialogue[1] The Hungarian data collection system is also structurally different from the above, and *for this reason for the indicators to be usable the basic data that are relevant for the healthcare services are missing.* Healthcare statistics do not record separately the asylum-seekers and beneficiaries of international protection (according to legal status or by vulnerable groups), *for this reason in the future we can only calculate with partial and sporadic data.*

1 Indicators are included in **Annex I.**

Why? Because for decades[2] *the basis for data collection has been the statistics of illnesses and interventions and their financing units (ICD and HDgs).* Due to the statement of a maximum threshold for the insurance budget as of 2004, limitations on the performance volume of healthcare providers were ordered accordingly, that is the number of interventions for the specific period was defined because the National Institute for Health Insurance Fund Management (hereinafter 'HIFM', Hungarian acronym: NEAK) only finances interventions in this framework. Due to this, institutions had no interest anymore in increasing performance, as this was disadvantageous for them. This way the lack of capacity and waiting list3 appeared (active state capacity management instead of the market) because there is a valid financing contract only for the committed specialist care capacity. The weekly/annual data of HIFM also provide information o*n the number of infected and deceased people, hospital utilisation and expenditure*. None of the listed groups of data includes a breakdown by *age, gender, citizenship, or other legal status*.

The lack of data could theoretically be eliminated by setting up the National Health Platform (hereinafter "NEHP", Hungarian acronym: EESZT)[4] as the publicly financed care must be recorded in the healthcare profile from 2018 and private care from the second half of 2020. Based on this a significant electronic database, simple to manage and organise, was set up where a lot of data are input. However, it was not set up for the purpose of use later in care services, nor to secure fundamental rights, or for other governmental planning,

2 Thanks to WHO, the code system for The International Statistical Classification of Diseases and Related Health Problems was introduced so that the diagnosis of a person who becomes ill or gets injured in any of the countries could be classified according to a uniform code system. According to the standard coding also applied by HIFM (National Health Insurance Fund until 2017) various statistics and country reports can be compared based on a common coding method. Homogeneous disease groups (HDGs) are used in the financing of in-patient care; those active hospital care cases are classified in this financing group which have the same performance values, that is the professional and technical funding needs are nearly the same and the classification is also acceptable from the medical perspective. The classification is primarily defined by the diseases justifying the care and the medical interventions assigned for the classification. The system of homogenous disease groups is not only used for the classification of hospital care cases, but also for cases that can be treated without the patient spending an entire day in the hospital. One of the most important tasks to be implemented is setting up the normativity of the financing which means creating uniform care fees across various service providers but excluding depreciation costs.

3 The registry of the national waiting list of HIFM, from which we can find out how many patients are waiting for priority surgeries in each hospital and what waiting time needs to be allowed for; the number of people waiting and the waiting times for the entire country and in each region.

4 Defined by Chapter III/A of Act XLVII of 1997 on the Processing and Protection of Health and Related Personal Data. (hereinafter: Health Data Act), and the annexes to the Decree of the Ministry for Human Capacities no. No. 39/2016, Dec 21 on the detailed rules related to the National eHealth Platform, while the continuity of on-call, emergency and ambulance tasks are defined by Decree No.47/2004, May 11 ESzCsM of the Minister of Health, Social and Family Affairs on Certain Organisational Issues of the Continuous Operation of Health Care and by Government Decree No.154/2020, April 27 regarding the amendment of Government Decree Gov. Decree No.43/1999, March 3 on the detailed rules of financing healthcare from the National Health Insurance Fund of Hungary.

but primarily for the control of the financial manageability and operation in accordance with the healthcare contributions collected as taxes. Therefore, the following are included in the NEHP:

▶ The type of and number of I.D. of the person in care (Social Security Number hereinafter "SSN", Hungarian acronym: TAJ) – but since only some of the beneficiaries and applicants of international protection have SSN (see later), no statistics can be put together based on this, asylum-seekers and beneficiaries of international protection who are relevant to us (all of them) do not get into the registry in this way.

▶ In primary care, there is a reimbursement category based on which financing from social insurance, from the state budget, from international and private insurance companies could be separately collected.

▶ Furthermore, in emergency care the care recipients are recorded including their citizenship, reference and the further fate of the patient as these data are kept here,

▶ Data to be added to the health profile related to patients

- name of vaccination, name of immunity (disease), date of vaccination,
- resolved, closed or inactive problems, dates of previous surgeries and medical interventions,
- current problems/diagnoses, therapeutic recommendations,
- current medication,
- description of disabilities,
- lifestyle factors,
- pregnancy, and
- healthcare documentation (final hospital report, outpatient medical records, surgery description, ambulance datasheet) and the reports to be uploaded about the results of laboratory tests.

The NEHP is built on the ability to query the period of contractual insurance relations and the data of the GP service belonging to the specific social security number. In inpatient care specialist care only those care events are accountable towards the HIFM that are prescribed in the NEHP.

The *Certified public register for health insurance* is managed by the health insurance institution appointed to manage the Health Insurance Fund. For that matter, the personal data recorded in the register may not be deleted for 30 years after the natural person's death. Subsequently, certain statistical data collection could be carried out from there.

The NEHP indicators *are closely linked and partially overlap with the indicators related to social care.* It would be important to identify recipients of healthcare on a means-tested basis, but because of the fundamentally SSN-based access/register, these data are not available. For example, if the person has a SSN, but has not paid for the contributions, due to the unsettled legal relations, means-tested care helps them. The data serving as a basis for the common European research (Baseline) such as age, gender, vulnerability (e.g. single parents, people living with disabilities, unaccompanied minors, victims of torture) and other data breakdowns are not available in Hungary not even the contents of the asylum procedure, or for the purpose of identification of the vulnerable. At the most sporadic data can be queried about healthcare services and expenditure related to the specific groups.[5]

With the launch of the RHP in Hungary data can be generated for people who came into contact with the refugee procedure and then with the healthcare. This is also important because it makes the social acceptance and integration of people in need of international protection more difficult if they become a hidden population. There are now hardly any asylum seekers and beneficiaries of international protection[6] and the statistical recording (as a micro census, or even a ten-year census, or based on the SSN[7]) includes the beneficiaries of international protection only partially (undercounting, due to the non-

5 For example, the Ministry of the Interior paid out HUF 72.2 million in 2015 and HUF 15.2 million until 31st August 2016 to the National Health Insurance for the health care of refugees placed in the reception facilities in Hungary. From January 2015 until August 2016, Hungary spent a total of HUF 87.4 million on the medical care of refugees, while one and a half times the same amount was spent during the same time on the publishing of anti-refugee referendum posters in a pro-government newspaper. By September the expenses of the entire advertising campaign reached HUF 20 billion. (See: We pay one and a half times more for mocking migrants only to Hungarian Times (Magyar Idők) than for the actual care provided for migrants Zsolt Kerner Zsolt, 24.hu, 23 September 2016.)

6 According to the Hungarian Central Statistical Office (hereinafter "HCSO", Hungarian acronym: KSH) between January and March of 2020, 73 people and between April and June only 22 people applied for asylum in Hungary. In summer the transit zones in Röszke and Tompa closed and the approximately 300 people staying there were transported into the reception facility located further inside the country. This means the maintenance of the crisis situation (until 7 March 2021) caused by mass immigration was legally unsubstantiated, because it is not justified by either the number of applicants or the situation at the border especially when asylum applications may be submitted based on preliminary procedures, to the embassies of Hungary located outside of the EU (see: in the procedure prescribed by Act LVIII of 2020 and as per Gov. Decree No. 292/2020, June 7 the Declaration of Intent for the submission of application for asylum, which must be enforced as of 18th June 2020.

7 Anna Sára Ligeti: Circular Migration in Hungary. *Statistical Review,* Vol.97. 2019/4:327-346.

mandatory answers, or because the beneficiary of international protection still has a SSN even though they have already left Hungary), and does not include asylum seekers at all.

The WHO's Regional Committee for Europe issued a situation analysis on the migration healthcare in Hungary in 2016, which was created jointly with the Ministry for Human Capacities, also involving the international and civil organisations operating in Hungary.[8] In 2015 at least *400 thousand irregular migrants arrived in Hungary, but only 161 thousand applied for asylum and only 30 thousand people were screened while the government asked for the WHO's help for the provision of health care for the refugees*. In October 2015, on-site checks, in-depth interviews and thorough debates with stakeholders assessed what healthcare capacity is needed for supplementing the shortage of care and how cooperation among the various sectors can be facilitated. There is a large number of people among the refugees who belong to vulnerable groups including those suffering from chronic illnesses, acute infections or travel-related illnesses (as well as the victims of human trafficking, torture, pregnant women and infants...) who need to be provided efficient care within a realistic period; care must be properly documented at the service providers and the follow-up of patients is also needed. *However, the country still has not implemented its (emergency response) plan for the special situation – if it had one at all.* Although the police and the ambulance services set up screening stations, as a good practice, quick solutions were created to record data and provide care, *though there was no proper screening anywhere, nor any strategy for psychiatric patients, child care and infectious patients. The tools for providing informing to a large number of refugees and residents were missing, there was no interpretation, no forum prepared to manage cultural conflicts, no professionals, the comprehensive central system of communication related to infections and addressing refugees was missing.* This happened specifically because of the large number of care locations that were decentralised (transit zones, reception facilities, institutions providing surveillance, civil and church organisations, healthcare service providers), due to the national regulatory system and the changing legislations (closing of the borders, pushbacks at the border, the fence acting as a closed border). Furthermore, the lack of special training provided for healthcare staff was also a source of serious problems. *It was not the protocol that was missing, but the implementation of the national public health (crisis) plan and primarily in the frontline (at the border, at primary entry points, mass accommodations) the implementation of a crisis plan and a plan for communication and recording data about refugees was missing.*

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

The mass immigration crisis situation has been continuously going on for 6 years and the emergency situation due to the Coronavirus, then the health-care crisis situation has come on top of that; therefore, the planning for the crisis period (e.g. vaccination plan) requires certain protocols to be set up, of course, only if we want to learn from the past.

3. Legal Environment

The effective *Hungarian healthcare regulations are not specific*, because they regulate the health care to be provided not based on disease groups, or life situations, but based on forms of care and legal titles. However, r*efugee regulations are not detailed enough pertaining* to health status and individual life paths, because they are linked to certain sections of the procedure (obtaining the legal statuses of being an applicant, a detainee, or placed in a reception facility). Thus, it is doubtful whether the European standards were really transposed. Living and staying in Hungary under *the Common European Asylum System*[9] provides the following rights.

- Asylum-seekers have the right to *adequate* health care that is, at least to emergency care including medical treatment and substantive therapy for mental illnesses, while asylum-seekers with special needs must be provided reception and psychiatric treatment in accordance with their needs also including the rehabilitation of child victims;

- Beneficiaries of international protection (whichever category they belong to, until the end of their status) must be provided health care under the same terms and conditions provided *for citizens* and it must be *equivalent* to the same including psychiatric care, prenatal care, care provided for people living with disabilities, the treatment for victims of violence, torture, abuse and armed conflicts taking into consideration their specific needs.

The Table 1 summarises the health benefits to which applicants for international protection and migrants who have been granted some form of international protection (i.e. those falling into the categories of protection that exist in the legislation), i.e. applicants, detained applicants (in asylum detention), recognised refugees, beneficiaries of subsidiary protection, tolerated migrants and beneficiaries of temporary protection (a category that has not been applied so far) are entitled. Since the budget (through the HIFM and the migration authority) finances different types of care for the various categories with various financial

9 Directive 2011/95/EU of the European Parliament and of the Council (13 December 2011) 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, Article 30 (Qualification Directive), Directive 2013/33/EU of the European Parliament and of the Council (26 June 2013) laying down standards for the reception of applicants for international protection, Articles 19 and 23 (Reception Directive)

instruments. Thus, *the columns indicate the categories* while *the rows show the various types of care.* As can be seen there are certain common points, but even the wording of legal regulations is not consistent. At the end of the table, there are categories of other persons, who rarely come into contact with healthcare or if anyone becomes a social security client, they do not need to be financed from the budget anymore as their own contributions paid will provide the coverage for care.

Table 1. Who is entitled to what health care[10] under Hungarian legislation?

Applicant	person under asylum detention	Refugee	beneficiary of international protection	Persons granted tolerated stay	Beneficiaries of temporary protection
Entitlement: screening, vaccinations, treatments ordered by authorities, epidemiological care, primary care, emergency care including outpatient/ inpatient specialist care, therapeutic appliances and medications, dental care, prenatal care, obstetric care, autopsy, health crisis care, patient transport, For persons requiring special treatment rehabilitation, psychological, and clinical special psychological care, furthermore psychotherapy treatments, too		Entitlement: screening, vaccinations, treatments prescribed by authorities			
		Entitlement: for 6 months after the has been granted and legally effective if the person needs primary care and GP care, specialist care, medication supply, emergency care, patient transport, obstetric care, prenatal care		Eligibility: after the status had been granted and become effective if the person needs GP care, ambulance, emergency care, autopsy and crisis care	Eligibility after the granted status becomes effective if the person needs primary care and emergency care, patient transport

10 Pursuant to the Asylum Act. Articles 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); Gov. Decree No.301/2007, Nov 9 Articles 3-4., 4/A., 15-16., 26-28., 32-36., 44., Act CLIV of 1997. Articles 142., Gov. Decree No. 43/1999, March 3, Act CXXII of 2019, Act III. of 1993.

	Eligibility: 0-18 years (minors), if the person has a permanent residence or temporary address in Hungary, they are eligible for comprehensive health care	Eligibility: 0-18 years (minor) if the person has a place of residence in Hungary, they are eligible for comprehensive healthcare
	If the person is socially deprived and has a registered place of residence, they are eligible for comprehensive health care[11]	
	Full-time students (over 18) are eligible for comprehensive health care	
	If the person is homeless (using one of the social institutions), they are eligible for comprehensive care	
	A person that qualifies as a resident[12] maintains his/her eligibility for healthcare services for 45 days after the their legal relation has been terminated (passive right based on social insurance)	
Eligibility: ambulance services		
Healthcare eligibility for other personal categories:		
Foreign minors placed in care or education with a temporary effect by the Hungarian authorities pursuant to the Act on the Protection of Children and the Administration of Guardianship are eligible from comprehensive health care		
Third country nationals placed in community accommodation, transit zone, victims of human trafficking are eligible for epidemiological, ambulance, emergency care, autopsy, healthcare crisis care including therapeutic equipment, medication, furthermore, they are eligible for statutory vaccinations (refugees who are victims of human trafficking may prove this with a humanitarian residence permit, or a certificate for temporary residence)		
As a detainee the person is entitled for comprehensive health care (Specifically: prison physician/ central penitentiary hospital as primary care, specialist care and inpatient care provider)		

11 The Metropolitan district or district unit of the Government office responsible for social affairs states the eligibility in response to an application by issuing a certificate for those persons where in the family the monthly income per person does not exceed 120 percent (HUF 34 200) of the lowest amount of the current old-age pension (HUF 28500), or if they live alone and their income does not exceed 150 percent (HUF 42750) of the lowest amount of the current old-age pension and their family do not have assets. Pursuant to Act III. of 1993.

12 Resident: as defined by Act LXVI of 1992 on Keeping Records on the Personal Data and Address of Citizens Hungarian citizens, immigrants and people with a resident status, or people recognised as refugees, or beneficiaries of international protection, or homeless people

Persons with a health insurance contractual relationship (via work or business regardless of their citizenship[13]) are entitled to comprehensive healthcare

Source: edited by the author

The colours of the table also indicate the financing technique and its trend, the blue is paid subsequently by the asylum authority, the pink is financed directly from the state budget to the care provider and green is relevant to care available based on social security contributions. The expression "trend", is justified, because *it has to be applied together with other rules without the rules clearly referring back to the care categories (legal titles) providing the basis for the care.*

▶ *HIFM manages a certified public register on the legal relations ensuring entitlement for care.* People with social insurance are entered into the register based on the report by the employer, people who are only entitled for healthcare are entered into the register based on the report submitted by the institution obligated to make the report. (For example SSN for people placed in reception facilities is arranged by social workers.) This is used when the legal relation is verified: whether the person has a SS card/number, or other documents (ID card, address card, decision recognising the legal status) for verification. Thus, if someone is not entered into the register, or they cannot prove eligibility, HIFM contacts the institution obligated to send the report (based on the report sent by the government office). Accounting based on the reports is sent by HIFM monthly – broken down by healthcare services - to the authority operating the immigration accommodation. At the same time according to the general rules[14] the reimbursement from HIFM to the care provider is only *possible based on the healthcare report.* (Annex 2 shows certain content elements of the report.) It causes a problem that the terminology of healthcare (service and financial) rules did not follow the changes in immigration/asylum regulations.

▶ Regarding persons having the right to free movement and residence and third country citizens staying in Hungary l*aboratory screening tests are to be carried out to identify illnesses imposing a risk on public health and pathogen-*

13 As of July 2020. there is no option anymore to subsequently settle the legal relation after more than 3 missing months by paying the unpaid health services contributions (for residents HUF 7710/month, for others based on the minimum wage) that is after receiving the care, the patient must pay for the service and after that the monthly insurance fee, but emergency care still must be provided.

14 Gov. Decree No. 43/1999, March 3

carrying conditions[15], for tuberculosis (tic), HIV-infection, syphilis, typhoid fever and paratyphoid fever pathogenic conditions, Hepatitis B. The mandatory screening is paid by the budget/health insurance fund. Since COVID testing is not listed therein, it is paid by the foreign citizens unless they have such contractual relationship, or there is a legal regulation that takes over the payment universally.

▶ *The group of conditions and diseases falling under the scope of emergency and scope of life-threatening conditions have been set forth in a decree*[16] , in its annex 31 cases are listed (e.g. giving birth, renal colic, electric shock, infectious disease, amputation). All healthcare interventions belong here that are carried out for the professional treatment of life-threatening conditions and diseases defined in the annex, and in order to prevent the long-term adverse effects of the same – until the patient's condition is stabilised –, or those interventions that are carried out in the framework of professional care or to prevent long-term adverse effects in the framework of inpatient care from the point of setting up the diagnosis until the first professional treatment provided after the medical condition has been clarified. This provides quite a significant discretion for medical professionals if the emergency care is included in the legal regulation as a condition.

▶ Specialist health care can be used at the *healthcare service providers operating with a care obligation on a territorial basis*. The service provided by the healthcare provider - in accordance with the legal regulation on the detailed rules of financing from the Health Insurance Fund – is reported in the form prescribed for the reporting and accounting of the specific care service to the *National Institute for Health Insurance Fund Management (HIFM)*. The report-based accounting – with the breakdown by healthcare services – is sent by the HIFM on a monthly basis to the asylum authority that reimburses the care costs subsequently.

▶ The request for the reimbursement of care cost can be submitted by *the healthcare service provider – in case of prescription pharmaceuticals – by submitting the prescription indicating the number of the (humanitarian) residence permit of the person requesting recognition,* and the summary invoice issued for the asylum authority as a buyer and indicating the name, price and quantity of the pharmaceutical. The prescription and the invoice is forwarded by the healthcare service provider to the HIFM that is the money and the invoice travel among the authority, the fund manager and the service provider.

15 Decree No. 32/2007, June 27 of the Minister for Health

16 Decree No.52/2006, Dec 28 of the Minister for Health

▶ The healthcare service for which no coverage is ensured by the Fund, or the budget is ensured by the healthcare service provider – in view of provisions set forth in separate legal regulations – for a defined t*reatment fee, and this is where it becomes significant what is considered by the healthcare staff, to be falling into the scope of urgent, necessary and primary care*. Namely, because people who lose their SSN due to unpaid debt can only receive non-urgent health care after having paid the invoice first. Emergency care was an exception so far, everyone is eligible for it, but *people who have no valid SSN must also pay for any emergency care. The invoice can also be paid after the medical intervention, but the patient, or the patient's relative must be informed about the expected fees already before the intervention*. Hospitals may charge for the care the same amount they would receive from the HIFM, but maximum HUF 750 thousand. Therefore, the treating physician may not provide publicly financed care for patients in absence of the SSN.[17]

These difficult-to-understand/apply rules may also have a role in what opinion refugees have about the Hungarian healthcare. *The interviewed refugees usually refrain from using the healthcare system*, even if they know that they are eligible, because it can turn out that their employer does not legally employ them, does not pay contributions after them and this means they would not get free care, or they would need to pay something for the healthcare provider. If possible, they choose private dentists. Those who have first-hand experience of Hungarian healthcare had more good than bad impressions, but as a negative aspect they mentioned that their requests and signals (for example when they were hungry or cold…) were neglected either due to the language barrier or for capacity overload reasons; it was unclear where and who should have provided the treatment for them so the access to care was often difficult and they were sent from place to place.

The provisions of the EU Directive *may not be fully validated due to regulatory confusion*, because the legislation requires the indication of either the life situation (e.g. homeless), or the legal status (e.g. refugee, beneficiary of international protection), or both of them at the same time (e.g. minor immigrant), but for example a refugee can also be homeless, or a full-time student, or even deprived. *This regulatory technique of building on a sole/main criterion also makes the application of the law more difficult*, because it is not clear whether it wants to manage certain life situations, or distribute rights among

17 Decree No. 28/2020. (VIII. 19.) EMMI of the Minister for Human Capacities on health care provided for persons staying in Hungary who are not eligible for healthcare services in the framework of social insurance and on certain rules of the agreement of the provision of healthcare services. The new rule can entail unforeseeable consequences. It can happen that a patient taken into emergency care with a stroke, or their relatives will not ask for the care services after hearing the price of the intervention, because they cannot afford it. The new act on social insurance is effective as of July 2020 and the following 6 months are already monitored by the Tax Authority. Those who accumulate 6 months unpaid arrears – first possible date is January 2021 - the HIFM shall invalidate their SSN in a mandatory manner.

people with various legal statuses; it does not respond to what should happen to cases that can be classified into multiple categories. Furthermore, it is a problem that for people needing special attention and care (e.g. psychiatric and psychological help, therapy, physical and mental rehabilitation, or requiring a different placement due to disabilities, old age or traumatisation) *there is no provision that would give priority.* The only exception are perhaps for pregnant women and children requiring paediatric care. The registration for persons with an ongoing procedure is carried out based on the number of their

Humanitarian residence permit, and for other people based on their Social security card (hereinafter 'SS card'). This, at the same time, provides another explanation on why *there are not statistical data* on the care provided for asylum-seekers and beneficiaries of international protection.

From the interviews made with GPs in the framework of the preparatory work for the procedural protocol included in this analysis it turned out: there needs to be a solution elaborated for the identification of asylum seekers and refugees as the Hungarian system is primarily operated based on the SS card, but people in question usually do not have such a card so care should not depend on holding an SS card. For this reason, the pandemic drew attention to the fact that an increasing number of Hungarian citizens' and foreigners' COVID test results are not accessible because of the lack of SS card while the burden of epidemiological measures to be taken is on the GPs. As refugees and asylum-seekers often change their place of residence, it would be a fundamental imperative to connect them into the NEHP (cloud-based data provision) since changing their place of stay inevitably means that more doctors see them and without access to their basic data, their care will be of extremely low efficiency while each time a lot of time is spent on the repeated administrative work. It would be especially important that at least their immunology data (at least the data of vaccinations) should be accessible internationally in a cloud database.

With the introduction of RHP sufficient number of physician and care feedback i.e. data would be generated in the future about asylum-seekers who (previously) did not receive care, about beneficiaries of international protection if the legal regulations are amended in order to create the reception conditions in Hungary.

4. The Government's Policy Objectives

The applicability of legal commitments and directives pertaining to refugee health care can also be facilitated by *the harmonisation with the various public health programs and healthcare action plans.* Looking back over the past

decade *there was a plan created to save healthcare*[18], but there was not a word in it about refugees. The objective of the document addressed to the healthcare professionals and the health industry is to make healthcare accessible to all residents according to their needs, in proportion with the economic performance, with social reality, with the fair sharing of public burden and with the principle of solidarity. Self-financed care is of supplementary nature so waiting lists could be replaced by payment. The respect for human dignity and patient rights (also the free choice of doctors) is only a tool to achieve other objectives. The essence of the reform is IT development and the *institutional concentration* (into national centres and university clinics), because it can lead to savings. Although it could have been a guarantee for persons in need of international protection, too, the proposed National Centre for Patient Rights has not been established, moreover, the previous insurance supervisory and complaint management institutions were also closed.[19]

In 2015 the reform targeting *the strengthening of primary care* formulated an obligation from the directives as an objective in a short paragraph: *Primary care must be made fully accessible also for persons with a legal status as asylum seekers, refugees or beneficiaries of international protection* for the period allowed by Act on Asylum (that is during the procedure and maximum for 6 months after that). According to the concept the eligibility for healthcare services belonging to the scope of primary care are provisioned by legal regulations on various levels (GP care, dental care, district family nurse care), and "*the provision of services is territorially not consistent and continuously generates interpretative issues. Since settling this situation does not only serve the protection of the affected groups of people, but also the protection of the population, clear access to and eligibility for primary care must be created for the abovementioned groups of persons as soon as possible.*"[20] However, the act following the concept did not clarify anything even for the providers of primary care and provisions on the existence of "foreign" patients were only created in the amendment in 2018, expanding the district family nurse care also to children living here.[21]

18 Semmelweis Plan to Save Health Care. Professional concept, State Secretariat responsible for Healthcare of the Ministry for Human Resources, 6 October 2010.

19 The Health Insurance Supervisory Authority was terminated by succession on 26 September 2010, its general legal successor is the Ministry of National Resources, the following institutions are its partial successors and exercise parts of its previous scope of duties: Office of the Chief Medical Officer at the National Public Health and Medical Officer Service, pervious regional institutions of the National Public Health and Medical Officer Service and currently the public health administrative offices of the government offices, the National Health Insurance Fund.

20 The concept of strengthening primary care. State secretariat responsible for healthcare, April 2015, --- Health care provided for asylum seekers, refugees and beneficiaries of international protection, 36.

21 Act CXXIII of 2015 on Primary Care amended by Act CXVIII of 2018

Neither the sectorial healthcare strategy for 2014-2020 nor the related Public Health Strategy acknowledged foreigners as patients except for health tourism. For 2017 and 2018[22] the only highlight was that the improvement of general access to public health services, the improvement of the efficiency of prevention, care and treatment, harmonisation with international electronic health systems and their standards must be facilitated with targeted measures. This can facilitate the review of health status inequalities and the efficiency of care if by the right selection of statistical data sets some of the common European health indicators (European Core Health Indicators, ECHI[23]) are included in the domestic data records and thus help monitoring.

This means that the special policy area *has been long overdue to provide a development concept of the specific needs and healthcare provided for persons in need of international protection.* Therefore, we must make do with the partial objectives aimed at the improvement of access to general healthcare. However, even these are critical, as *the reduction of inequalities, the inclusive nature of access and the tasks to be carried out should be made better applicable even in the most frequent discriminative situations. Such an area is for example the facilitation of access to birth control, the predictability of emergency care* (e.g. clear definition of competences, scopes of responsibilities, harmonisation of emergency care with the geographical features and the operating conditions), capacity building for the ambulance, the enforceability of patient rights especially by introducing *an efficient and transparent complaint management system,* furthermore heritable developments of the community care provided in drug prevention and for people living with mental disorders and support provided for patients discharged from psychiatric treatments.[24] As the aforementioned steps would also provide significant guarantees for the refugee health care.

The publicity of the National Public Health Strategy (2017-2026) is low[25], therefore, we do not know whether the elaboration of the details has halted because of the pandemic, or for other reasons. In 2019 the strategy only got to the point that it wishes to *strengthen outpatient specialist care and primarily care*

22 Government Resolution No.1886/2016, Dec 28 on the "Healthy Hungary 2014-2020" – Strategy of the Health Sector for 2017-2018, Annual Action Plan

23 ECHI is basically a public health-oriented indicator system: out of the total of 88 indicators (for which in many cases breakdowns are also available so in total we can discuss more sub-indicators) about 20 are relevant to the description of the operative levels of the healthcare system that go beyond the public health system (e.g. primary care, hospital care).

24 The Hungarian Civil Liberties Union (Hungarian acronym: TASZ) expressed its feeling of lack related to "Healthy Hungary 2014-2020" Strategy for the Health Sector pertaining to amendment of legal regulations on the subject of health

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

also by announcing tenders to motivate the widest possible spectrum of co-operation, the setting up of GP clusters, the expansion of citizen-friendly care also by setting up the network of Health Promotion Offices (HPO). Although officially 116 of these are operating, in reality, none of them adopted to the needs of the population and they do not even have the sufficient methodology which will be handed out by the National Public Health Centre. Stakeholders have critically indicated[26] that patient paths must be shortened. Although the introduction of EHP has slightly improved patient safety, in the daily clinical practice *opportunities offered by cloud-based system are utilised, but the development of professional registers is needed*, which would also show the required points of intervention for health policy makers. *Any development can only be carried out by leaning on reliable data and though the data collection is spread out on all levels of the healthcare system, the reliability of the data is questionable according to the aforementioned professional forum.* No one undertakes to share their criticism as they are afraid of retaliation. Therefore, regulations would be needed that Healthcare providers are able to comply with. *Mutual accusations are not over here:* healthcare is not a government priority while according to the government as long as the system is wasting money they refuse to provide more funding for Healthcare.[27] There are also examples when the expert recommendations of the health care reform are created by foreign companies and as decision preparation documents their contents are not public.[28] All we know is that *hospital care would be reorganised by territorial units also including specialist and primary care.* Even this *centralisation* does not guarantee that as a special area the *screening and treatment of people in need of international protection would be differentiated and it also contradicts the previous care decentralisation.*

Creating a real strategy is urgent because according to the competitiveness report of t*he Central Bank of Hungary (2020) the ratio of unprovided health care is 6%* among Hungarian residents so it is surely not lower among refugees. Measuring the performance of strategies/sectors the *Hungarian State Audit*

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

27 For example: Healthcare has never been a priority, Medical Online, 24 October 2016., Report of Figyelő (Observer) magazine on the XXXIV. Medicina Conference, 22 October 2016

28 Népszava, Tamás Koncz, 27 Aug 2020.

Office[29] *examined three healthcare strategies.*[30] Despite the advancements experienced in the strategies prepared after 2012 there is still no uniform strategic space created where the specific national and line policy strategies could be found together pertaining to a specific period. In absence of this the sectorial plans are fragmented, they do not strengthen each other, and they are not harmonised. Healthcare sectorial plans do not prescribe the system of personnel and material assets serving the implementation of the goals – just like in the case of the emergency patient care highlighted as an example –, the government decree did not provision this either in 2011 or in 2015.

It would be important that *development strategies reform plans in healthcare should be prepared in line with the legal regulations.* From 2011 legal regulations should only be presented as a proposal after *their impact assessment*,[31] and since 2012 it has been mandatory *to elaborate a strategic planning document for each line policy* (country forecast, 5-9 year national strategy, medium term strategy ministerial programme, institutional working plan, furthermore 10-15 year that is a long-term concept, white book and based on all these the operation of line policy strategies line policy programmes, institutional strategies and the green book should be composed)[32]. These can be approved by the government and then by Parliament following the preparation by the responsible ministry, the detailed social debate and the publication of data of public interest. This way refugee health care surely would not be left out from professional strategies.

5. Professional and reference literature concerns[33]

Human rights conventions (e.g. UN Convention on the protection of migrant workers and their families) and the Charter of Fundamental Rights of the European Union (2000) also protect everyone's human dignity and their life free

29 State Audit Office: sectorial strategies, evaluation of the performance of the public sector (2020)

30 Semmelweis Plan to save Hungarian health care (2011). Ministry of National Resources, State Secretariat responsible for Healthcare; „Healthy Hungary 2014-2020" Strategy of the Health Sector (2014), Ministry for Human Capacities; National Public Health Strategy 2017-2026 (2016). Ministry for Human Capacities, State Secretariat responsible for Healthcare.

31 Government Resolution No. 1144/2010, July 7 (part of the Government's rules of procedure) Decree No. 24/2011, Aug 9 of the Minister of Public Administration and Justice On Ex-ante and Ex-post Impact Assessment, then the replacing Decree No.12/2016, April 29 of the Minister heading the Prime Minister's Office on Ex-ante and Ex-post Impact Assessment

32 Government Decree No.38/2012, March 12 on Strategic Management by the Government

33 International Journal of Migration, Health and Social Care has published a lot of specialist studies on the topic since 2004, here we focus mostly on our region.

from exploitation, which means even irregular migrants can refer to this solidarity minimum.[34] Forced migration severely harms children's rights, because even in countries with advanced care systems the optimal care provided for migrant children and young people is obstructed. According to the UN Convention in the Rights of the Children (1989) without differentiation (Article 2) all children have the right to life and optimal development (Article 6), children have the right to express their views freely in all matters affecting them and their views must be taken into consideration, (Article 12) and they have the right to health and health care (Article 24).

However, the Regional Representation of the United Nations High Commissioner for Refugees has been emphasising for a long time that in Central-Europe refugees do not have access to healthcare.[35] Although pursuant to the EU Qualification Directive (2011 / 95 /EU) refugees should have access to healthcare with the same eligibility conditions as local citizens, but the healthcare provided for them does not necessarily include comprehensive care and is often limited to primary care and emergency care services. (If refugees enjoyed complete equality to local residents in Hungary the table above would be unnecessary!) Experiences show so that several refugees do not know the healthcare system of the host countries sufficiently, so they do not even know what they would be eligible for and how. Without *basic language skills or access to interpretation and translation services*, they will never be able to communicate with healthcare professionals, they do not get referrals for the correct specialist treatments; it can happen that healthcare service providers do not know the types of documents used to verify the eligibility of refugees for health insurance and for this reason *they refuse treatment to refugees* or send them somewhere else (to a specialist). In countries where participation in integration programs, for example language courses, is compulsory, refugees with special needs (the elderly or survivors of torture or trauma) who are not capable of participating in the courses may lose their eligibility to health insurance although they are the ones who would need medical care the most. On the other hand, regarding circumstances influencing health there are rather large territorial, municipal and social differences in the member states. Therefore, a comprehensive policy would be needed that includes measures aimed both at improving the health status of the entire society and also measures specifically targeting vulnerable groups (people living in poverty, disadvantaged migrants, ethnic minorities, people

34 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. 164.

35 Regional Representation of the United Nations High Commissioner for Refugees, Budapest, 2009.

living with disabilities, elderly people) because this affects fundamental rights.[36] On the other hand, receiving irregularly arriving migrants and managing their applications also *raises public health (primarily epidemiological and occupational health) issues.*[37] For example the arriving people may have diseases with long incubation periods that can often be prevented by vaccination, and they can have different epidemiological profiles (HIV/AIDS, tuberculosis (TBC) hepatitis B, hepatitis C); at the same time in EU member states there is no uniform vaccination schedule. Treatment provided for asylum seekers arriving with mental hygiene problems or suffering from post-traumatic stress disorder (PTSD) requires sufficient expertise. There is big fluctuation among asylum seekers and there is a minimum time frame available to record the data required for their asylum application, c*onducting the health care examinations and screenings in the reception facilities/immigration institutions imposes an impossible burden on the staff performing the health care tasks.* It's a contradiction that when evaluating asylum applications according to the applicable legal regulations it is required to check for the described diseases and pathogen carrier conditions.

This means that beyond the law enforcement aspects, having the screening tests for revealing the health status of the asylum seekers and their cooperation in potential therapy are indispensable for admittance. Moreover, refusing to accept medication therapy because of a potential pathogen carrier condition can serve as a basis for the rejection of asylum application with reference to the lack of cooperation with the authority. It is concerning that screening data are incomplete although by taking a blood sample, or by collecting a stool sample and by making an x-ray screening the health status of asylum seekers can be clarified.[38] However, to complete this, asylum-seekers need to go to different healthcare institutions which is difficult to organise. The highest screening ratio was 76% among asylum-seekers while it was the lowest in 2014 when only 6% of incoming asylum-seekers went through a blood test. Data pertaining to syphilis, typhoid fever and paratyphoid fever bacteria carrier conditions are even more deficient, because samples are taken in vain if before

36 The link between healthcare and solidarity is discussed by several institutional communications. Vö. COM (2009) 567 final: Solidarity in Healthcare: Decreasing health disparities in the European Union. Related to the referenced communication please see the opinion of the European Committee of the Regions (2010/C-000/01), and the opinion of the European Economic and Social Committee (2011/C-18/13).

37 Zoltán Katz: The health status of asylum seekers in view of the prescribed screenings – Facts, conclusions, recommendations. In: From border policing to police research and science. Gyula Gaál, Zoltán Hautzinger (Editor.), , Pécs, The Pécs Special Group of the Border Policing Department of the Hungarian Military Science Society, 2016., 253-261.

38 For example between 2007 – 2014 in the Reception Facility in Debrecen there were 3727 blood tests, but applicants only went for an X-ray in 1687 cases, while in the period 2012-2014 1072 stool samples were collected. see Decree No.32/2007, June 27 of the Minister for Health

the result of the screening or in case of a positive test result during medication therapy the asylum seeker leaves for an unknown place of stay. It is obvious that *it is almost impossible to adhere to the screening test protocols* and the efficient management of healthcare challenges that go hand-in-hand with migration is hindered by the complicated reporting procedure, the long period passing between the placement and the implemented screenings and by the further migration and disappearance of asylum-seekers.

WHO devotes special attention to the issue of migrant and refugee health[39] to *which* the International Travel Health and Vaccination Centre operated under the National Epidemiological Centre *should respond more strongly.* Before 2004, there was little experience in the field of travel health, which did not only include assistance medical services (healthcare services provided for tourists abroad and accompanying tourists to their home countries[40]), but also the health care of asylum-seekers and beneficiaries of international protection. The amendment of the Health Act effective as of 28th October 2015 (Article 74/A) gives entitlement to the chief medical officer *to prescribe a mandatory screening test for asylum seekers in a health crisis caused by mass immigration or other reasons.*

If the person is in the transit zone, they must prove that the samples for the screening have been taken to be able to enter Hungary. The Public Health Authority (district/metropolitan district government office) communicates the result to the asylum authority, but the rejection of the asylum application may not depend on the results, only in cases of lack of cooperation. However, according to both WHO and UNCHR scheduled screening would be important and in terms of vaccinations the same vaccination treatment should be applied as for the local population as in mass accommodations social distancing is especially difficult and the risk of infection is high[41].

The pandemic highlights the news even more that refugees receive the same screening tests as the local population for example in Serbia, and in cooperation with the WHO in 2021 refugees and asylum-seekers will also be vacci-

39 Kereszty, Éva – Julesz, Máté: Migrant in Hungary – A few legal and public health considerations. *Hungarian Science* 2016/4:438-451

40 There is no trace of refugee affairs here, only citizens travelling abroad are vaccinated

41 On 21st May 2020 WHO and UNHCR signed a new agreement on the reinforcement and improvement of public health services for millions of people globally forced to leave their homes. It is a priority objective in 2020 to support continuous efforts aimed at the protection against COVID-19 infection of around 70 million forcefully displaced people and of the 26 million refugees 80% of whom were granted asylum in low-or medium income countries where the healthcare system is weak. The solidarity and the serving the vulnerable people can ensure that the people affected could get healthcare services whenever and wherever they need them.

nated against COVID-19 infection upon their request.[42] Refugee affairs regularly comes up in writings on *the screening and care of HIV patients*[43]: how much can latency be and whether those who are proven to be infected really have access to health care. According to the Code of Ethics[44] of the Hungarian Medical Chamber in case of severe or incurable diseases the implementation of increased information is desirable provided it serves the patient's interest. Usually, the person concerned does receive information about his/her HIV infection gradually, which can trigger a mental state leading to suicide. According to the Code of Conduct it is an ethical violation to justify financial decisions limiting patient care with medical argumentation,[45] i.e. *the doctor may not make it seem that despite the financial limitations the patient receives optimal care.*[46] And what do patients inform their treating physicians about? According to the survey made among HIV-infected patients[47] more than half of the respondents did not tell even their GPs that they are infected. Most of them are afraid that other people would also find out about their status, others wish to save themselves from stigmatisation, or from being refused treatment. 10% of respondents have already been in a situation when *they were refused some specialist care treatment because of their status*, every fourth person experienced discrimination during their hospital stay. There were more cases when their sensitive data were not treated correctly, for example, HIV was written in big red letters on their medical chart, or they spoke about their status in such a way that other people could also hear it. Several respondents' dignity was violated by *placing them separately and by taking unnecessary cautionary measures, for example the nurses approached the patient in a mask and rubber gloves.*

42 According to the UN statement Serbia is the first European country where they started the vaccination of refugees staying there. According to Francesca Bonelli, Head of UNHCR Representation in Serbia it is an important sign that Serbia cares for refugees and sets a good example how to treat them as part of the Serbian society. In March 2021 in 19 reception facilities in Serbia there are about five thousand refugees and asylum seekers. The vaccination of refugees staying in private accommodation has been started earlier. According to the representative of WHO in Serbia it is important to vaccinate refugees living in camps, because it is difficult to keep the social distance under such circumstances and to prevent the spreading of the epidemic (*Vajdaság Today*, 26 March 2021)

43 Tóth, Judit: Judit Tóth: HIV infection and AIDS in the international migration regulations. Hungarian Law, 1994/12: 730-734; Judit Tóth: The role of HIV status in alien policing. In *HIV/AIDS and Human Rights in Hungary*. Editor: Eszter Csernus. Budapest, Hungarian Civil Liberties Union, 2003, 87-109.

44 Article II. 5./7)

45 Article II. 14. / (1)

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

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

The Hungarian doctors interviewed pointed out: t*he age of the patient and related to that determining how to behave with them has big significance*. Determining the age, especially whether the person is a child or an adult is not a policing, but a healthcare task, for which a well-formed cooperation is required by involving an endocrinologist, psychologist, paediatrician, cultural anthropologist, and of course a lot of empathy is needed as well. Because certain standards that were elaborated for the determination of age for average American young people are not applicable to people coming from other parts of the world specifically because of the different lifestyle, diet and culture. As this is a *time-consuming and complex task*, time needs to be devoted to completing it. This would also require separately elaborated rules on procedure, as a further part of the problem within this area is that although the patient may have already reached the age of majority, but they only understand the world or environment here on the level of a child. Therefore, it would be important to provide education and training on this topic for healthcare professionals.

Paediatricians have declared:[48] *refugee children and young people need special physical and mental help while the purpose of routine age determination is the decision on the eligibility, although there is no objective and culturally accurate method for determining the age. T*herefore, paediatricians and other health care professionals must be involved in the planning and the reception of children and young people and in the implementation of clinical and public health programs and protocols. *In the course of physical mental and social assistance professionals must take into consideration the traumas that affected the children and young people in their home countries and during the migration*. After the arrival at the safe place refugee children's physical and mental status must be assessed so that they could receive the medical and prevention care that suits their needs, *it must be defined whether there is a need for emergency care, risk and protective factors must be assessed and the examination of family members or other accompanying persons without stigmatisation also belongs here*. Comprehensive primary care and the locally available specialist care must be provided for refugee children and young people. The primary objective of the assessment of development and behaviour status is to ensure optimal placement. *Interpreters must strictly adhere to healthcare and confidentiality rules. This holistic approach is part of the care provided in correspondence with the needs*.

In the area of *occupational health* and health and safety at work *border police and law enforcement officers on duty must be prepared for cultural differences*

48 Budapest Declaration on the rights of refugee children and young people, their health and welfare. Conference of the International Society of Social Paediatrics and Child Health, Budapest, October 2017.

and prevention of health risks[49] while doing administrative work controlling or accompanying migrants. Back in 2009 along the new Eastern Schengen borders of the EU (in Poland, in Slovakia and in Hungary) the level of preparedness in the areas of public health safety, the care provided for special health problems of migrants was assessed specifically in the border area. There are concerns that the situation has not improved much; in the majority of the interrogation rooms where the body search of migrants is also carried out there were no wash basins, medical examination rooms that are in line with health care standards were only located at detention centres, the work uniforms of law enforcement officers which they wear at the green border, or when questioning or doing body search on asylum seekers with unknown health backgrounds and potential infections are washed at home by the staff members together with the clothes of other family members.

6. Policy Recommendations

Based on what has been explained earlier, the following recommendations are made:

▶ **(a)** To take further measures in the EU related to the healthcare needs of vulnerable social groups including beneficiaries of international protection. The institutional cooperation of member state authorities is needed order to facilitate raising awareness, improving the access to and suitability of healthcare services, health promotion and preventive care for migrants, ethnic minorities and other vulnerable groups. This would include healthcare and the identification and exchange of best practices supported by healthcare. The questions of how the Agency for Fundamental Rights may collect information about vulnerable groups and the extent to which these groups are suffering from healthcare disparities in the EU, need to be examined. In cooperation with member states sensitisation and the exchange of best practices must be started in order to ensure the accessibility and suitability of healthcare services and to prevent the lack of care in vulnerable groups;

▶ **(b)** For efficient action t*he examination protocol effective in EU member states must be harmonised and a transparent electronic health information system must be created.* The Hungarian electronic administration system and database should be adapted in such a way that based on the health data of asylum seekers and beneficiaries of international protection it should be suitable for *the planning of separate, special care, for prevention and for professional*

49 István Szilárd – Árpád Baráth: *Migration and healthcare safety: new challenges in occupational health*, Pécs, Scientific publications of Pécs Border Patrol 2011, , 269–278.

and research purposes as well. This means it is not necessary to standardise the care for all foreigners exactly based on the specific epidemiological profiles;

▶ **(c)** D*octor/s should be continuously available* at the reception facilities, in alien policing institutions depending on the capacity and the number and health status of asylum seekers and detention centres should only be open periodically as there should be an opportunity for placement in smaller homely accommodations for human scale placement, because this would improve the mental health of people staying there;

▶ **(d)** According to the interviewed medical doctors, *communication with patients* is a general problem, in the absence of which nothing can be found out about the symptoms, condition, medical history and requests of the patient, which means that treatment is impossible; therefore, there should be an *easily accessible, up-to-date (online) database of well-prepared interpreters who are sufficiently paid* by the authority, or the health insurance fund. Professional interpreters work excellently also over the telephone and most of them are refugees who have well integrated into the Hungarian society so they can help the curative work in a different sense as well;

▶ **(e)** Evaluation and examination of the vaccination status of adult asylum seekers must be set up along with the individual consideration of vaccination on a case-by-case basis, because according to WHO, one of the biggest public health risks is the potential reappearance of illnesses preventable by *vaccination*;

▶ **(f)** Related to the healthcare needs *the physical and psychological disorders (appearing in a potentially different ratio than in Hungary) brought along by people in need of international protection, furthermore, the effect of the psychological stress caused by integration must be taken into consideration and for this reason emergency care needs to be provided with a greater capacity and primary care by flexibly creating the necessary professional and infrastructural conditions* (e.g. setting up mobile medical care points)*;*

▶ **(g)** The basis of the trust between the patient and the attending professional is mutual information on the health status and treatment, which especially *for the uncovering and treatment of HIV infection, and the other healthcare treatments provided for HIV patients requires* substantial preparation, data protection, foreign language information materials and trust building measures;

▶ **(h)** Care provided for people in need of international protection also requires special cultural and language skills, so *professionals working with them need special language and cultural training,* they also need to learn to work together with interpreters. During the provision of care language, cultural and ethnical background need to be taken into consideration; informed consent and

participation in decisions impacting their own health need to be ensured and experienced trauma have to be considered.

▶ **(i)** It has great significance for those working with children and young people to receive with sufficient sensitivity and preparedness the aforementioned *cultural characteristics and the complaints of people who have been through abuse or trauma*. Paediatricians and child-health organisations should cooperate with large, international organisations (UNICEF, WHO, UNHCR, International Organisation for Migration) and with regional and national organisations, because age determination and the safe care provided for children require a holistic approach and due diligence. Jointly, by involving IPA (International Paediatric Association) the comprehensive *"Paediatric Healthcare Action Plan for Refugee Children and Young People"* in order to ensure clinical care for refugee children free of discrimination and prejudice, independent of their legal status, in the framework of state-financed, good quality healthcare service also safeguarding their human dignity. In the health policy of each country commitments must be made to ensure that refugee children and young people receive equitable care. Paediatricians and other child healthcare professionals shall act applying evidence-based protocols and guidelines. This means that interdisciplinary cooperation is needed for the fulfilment of the needs listed, in the course of medical-psychological care *trauma-relieving methods need to* be employed with the continuous evaluation and improvement of the programmes by integrating children's rights;

▶ **(j)** *Involving refugees in heath care and nursing tasks serves a dual purpose. T*he Council of Europe and the UNHCR encourages states to use the *assistance* of *healthcare professionals arriving as refugees for the maintenance of the operability of national healthcare systems.*[50] There are already such refugees and asylum seekers living in Europe who have the right healthcare qualifications, experience and who are also willing to help. As most healthcare professions are strictly regulated, the competent national healthcare authorities must approve the employment of refugees. To facilitate this in 2017 the Council of Europe started a pilot project: a European certificate was elaborated *(European Qualification Passport for Refugees* = EQPR)[51] for refugees with healthcare qualifications, because this not only assists their care, but also their *integration*. Ten centres were set up to recognise qualifications and with the contribution of the centres the first 500 people were successfully employed in these countries already in 2019.[52] EQPR does not replace the required professional certificates and permits, but helps the authorities to accelerate permit procedures by conducting certain procedures and obtaining documents.

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

51 Let us engage refugees in healthcare, Jogászvilág, 15th April 2020.

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

To supplement the shortage of healthcare workers, interpreters, mediators in Hungary, *it would be practical by introducing the EQPR, to assess the qualified refugee healthcare professionals, because in view of their data and headcount the healthcare and refugee authorities could plan to employ these people or at least involve them as volunteers.* Using the experiences of UNHCR there should be a cooperation with the other partners to ensure the reach of refugee communities with innovative methods, the finding and identification of healthcare professionals that can be involved as volunteers or employees and to evaluate their skills and qualifications;

▶ **(k)** *Migration and refugee healthcare must be made part of medical training*,[53] just as in public education, attention must be devoted to raising awareness about cultures that the majority of society lives together with;

▶ **(l)** The performance of border policing and asylum tasks requires specially prepared, trained staff, stress management, *a safe working environment and mental hygiene services for the prevention of burnout* that must be regularly provided and monitored;

▶ **(m)** It is necessary to *strengthen the cooperation of member state authorities*, especially in the areas of primary care workers, beneficiaries of international protection and the admittance of vulnerable groups to validate patient-centred, compassionate care that responds to the healthcare needs of refugees. This requires more research on what is lacking, as this is the way to create the right education and training materials.[54] These should also be made available for Hungarian GPs.[55]

The *general recommendation* of the Hungarian doctors interviewed: the recognition of the work of healthcare professionals should be stronger both socially and financially, because their level of empathy can also be improved thusly. *If efficient efforts are made to have more money in healthcare, sufficient staff and wages, refugees will not meet exhausted, worn-out doctors and nurs-*

53 For example at the University of Szeged it was included in the foreign language training program as of 2012, and at the University of Pécs six modules were incorporated into the Migration Healthcare MSc level course in 2011: (1) public health and applied epidemiology and infectiology; (2) The social and behavioural science related aspects of migration; multicultural aspects and their role in medical and social care; (3) Applied areas of occupational health (4) economic questions of integration; (5) Mental health of migrants, psychosomatic care, community level health promotion programmes; human rights of migrants (6) "Migrant-friendly" healthcare and social care systems and the related system manager knowledge and tasks.

54 For example, in the framework of the Horizon 2020 programmes; in 2016 under the supervision of the European Commission; Consumer Health Agriculture and Food Executive Agency (CHAFEA) financed the survey in seven countries in the EUR-HUMAN project.

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

es who do not improve their knowledge and devote little time to patients.[56] On the other hand, as long as the citizens are fear-mongered about refugees and the illnesses carried into the country by them, the public mood will remain hostile against refugees. This seriously hinders, or rather completely blocks their integration. One of the main targets of epidemiological measures are foreign nationals noting that even during the 2015 refugee wave there was no threat of an epidemic in Europe.

Tasks included in points (a), (b), (j) and (m) in the list can be assisted by the EU and its institutions in cooperation with the member states while all the other points are specifically applicable to the EU member states public administration coordination, healthcare governance, healthcare service providers and institutions providing care for people in need of international protection. Involving organisations of professional interest advocacy and education is indispensable for the recommendations in points (j) and (k).

6. Recommendation for setting up the Refugee Healthcare Protocol (RHP)

Building on the joint experience of the EU and the International Organisation for Migration (IOM), the rules of procedure for health examinations of refugees and asylum seekers has been elaborated (**Annex 3**)[57] and it can serve as a basis in any member state.

The purpose of the protocol we have elaborated is to organise the procedural steps related to beneficiaries of international protection for the healthcare staff (authority, care provider, helper), facilitating the safety and integration of people in need of protection and to safeguard public health in the receiving society. It is not the purpose of the protocol to erode any protocol pertaining to curative and preventive activities elaborated by any professional forum or to influence the contents of curative preventive work. Therefore, we emphasise that it is primarily a procedural system, which could be issued by the medical chamber, institutions involved in primary care, or maybe the sectorial minister and they could support and promote its implementation in order to *standardise the rules of procedure*. The procedure can be divided *into 12 units, tasks (**Annex 4)*** providing a certain example for the healthcare procedure to be standardised on a national level recommended under point (b).

56 Rules reorganising the healthcare service employment relationship becoming effective now Act C of 2020, Government Decree No. 528/2020, Nov 28 – do not set out more favourable working conditions and qualification criteria do not include treatment of special patient groups, people with cultural differences and respecting their human rights.

57 Health survey of refugees and migrants in the area of the EU/EEA. The European Commission's Directorate General for Health and Food Safety– IOM, 2015, Brussels

▶ **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 HIFM,[58] 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 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.[59] It is relevant to: personnel conducting patient admission

58 The health care service provider sends a report to HIFM on emergency care provided

59 As an example: www.semmelweis.hu/jogigfoig/files/2015/07/49_sz_2015_V_28_Teritesi_Dij_Szabalyzat.pdf; www.janoskorhaz.hu/kulfoldiek-ellatasa.html; http://www.kapas.hu/kulfoldiek_ellatasa.aspx

▶ **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. Since they often do not have any certified 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 it is possible and how it is possible to communicate with the patient. The language knowledge, 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. Foreign language

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 it 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, caretaker) 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** – this can even be swapped with the previous one- is revealing medical history, which is the known phase preceding the treatment process. Here we only highlight that in countries with mandatory vaccination systems, also in Hungary, it is important to find out *what vaccinations the person has received (in absence of documents the absence of all age-linked vaccinations must be assumed). 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). To whom it may concern: treating physician, personnel providing primary care, authority, (epidemic control)

▶ **The ninth step** is the physical examination of the patient, partly by recording the general data, and partly by recording their status perceived at the moment (injuries, suffering from infections, acute health problems and symptoms, pregnancy, urgent and acute treatment in outpatient care/referred to a hospital). Obviously various laboratory and specialist examinations will lead to the diagnosis. It is relevant to: treating physician, personnel providing primary care

▶ **The tenth step** is the patient's mental examination. Here we can highlight PTSS, dementia, uncovering addictions, treatment of people who are traumatised, suffer from depression or mental disorder, furthermore examination of infants and toddlers for age-appropriate development, discovering disorders as soon as possible. It is practical to register these, but the list is not comprehensive. It is relevant to: treating physician (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 PTSS, 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**, if the refugee has any kind of healthcare qualification and/or experience to see whether it can be used for the benefit of their community either as a volunteer helper, or by officially recognising their qualification. So far no one has utilised this supportive and integrative force although this is done all over the world and the opinion of healthcare professionals on this would be important. It is relevant to: treating physician.

Annex 1.

Indicators:

- pertaining to the health care needs of asylum-seekers and beneficiaries of international protection;

- identification based on residence permits and according to different groups (applicant, refugee, beneficiary of subsidiary protection, long term resident, resettled refugee, family member);

- access to healthcare (same as for foreigners or same as for Hungarian citizens);

- administrative burdens of access (waiting time, documentation...);

- inclusion in the health care system; rate of healthcare coverage (only emergency, only lifesaving, primary care...);

- Access to health care when special needs arise (paediatric/infant care, prenatal care, obstetric care, patients in need of psychiatric and mental care, elderly care, victims of torture and trauma);

- informing healthcare providers in legal statuses/care eligibility (authorities/service providers regularly inform their employees);

- information on eligibility and on the use of health care services (in institutions or privately);

- unfulfilled health care, treatment needs;

- freely/free of charge available interpreting services (in institutions or privately);

- average integration of beneficiaries of international protection into the healthcare system (how are refugees included in ministerial policies, monitoring of healthcare provided for refugees, regular review of legal regulations pertaining to refugees);

- healthcare budget (ratios),

- cooperation of authorities and municipalities regarding the health care provided for beneficiaries of international protection (is there any, in what way), partnership with the healthcare, professional and civil organisations (is there any and in what way).

Annex 2.

In the report sent by the healthcare service provider to HIFM the following must be included among other things:

10. Reimbursement category

A = admitted foreign citizen

D = refugee, applicant for international protection

H = care provided for third country citizens pursuant to Provision 140 of Government Decree No.114/2007, May 2 on the implementation of Act II of 2007 on the Admission and Right of Residence of Third-Country Nationals

S = emergency care not reimbursed from other funds provided in accordance with paragraphs (10) and (11), Article 4 for patients staying in the territory of Hungary

14. Type of ID

1 = SS number

2 = SS number created for children younger than 3 months

3 = passport number

5 = number of refugee, applicant certificate, number of certificate of admission

9 = personal identification used during the care provided before the application for refugee status, for international protection, or for subsidiary protection

[Personal identification: if the patient does not have a passport, the number of the police case or other registration number (excluding the humanitarian residence permit or certificate for temporary residence)

26. Diagnoses: Disease code according to the ICD 10

27. Interventions: Intervention codes according to ICPM codes

The HIFM points out: for emergency care –including ambulance services – the service provider is obligated to examine how the costs can be collected (pursuant to EU regulations or based on international agreement from an insurance company abroad or from reimbursement fee), if the person does not have an SS number. Since for people staying in Hungary epidemiological

measures, life-saving care, and urgent care must be provided without preliminary proof of legal eligibility, the care is to be provided even before the submission of the application to initiate the procedure for the determination of status. Healthcare service providers are obligated to examine whether the costs of care can be collected. "the service provider validates its claim by sending a payment reminder" is not examined by HIFM in case of beneficiaries of international protection considering the life situation of care beneficiaries if the "reimbursement category: S" "emergency care not reimbursed from other funds provided for patients staying in Hungary".[60]

Annex 3.

The rules of procedure drafted in 2015 by European Commission and the International Organisation for Migration (IOM) recommends to fill in a personal data sheet and using the ICD codes on it (e.g. A15-19, B20-24), *which can also be stored in the electronic database*. It consists of **four** main elements:

- *medical history,* also including vaccinations (with the suitable questionnaire, assuming absence of vaccinations);

- *physical examination* (16 elements + infectious diseases, parasites, and evaluation based on laboratory tests, recommendation for examinations, for further travel, treatment, vaccinations for adults and minors separately); here it can be included what help the person needs in their daily life (e.g. washing, feeding, placement of prosthesis, help with toileting based on the condition of sphincter muscles, daily, occasionally, continuously);

- *mental examination* - evaluation accordingly (e.g. dementia screening, childhood development for children aged 0-5 years);

- *recommendation* for laboratory tests, check-up, treatments and immunisation and sufficient information provided about this to the patient in a documented manner. This way parallelism, chaos, people acting without cultural competence, harm to public health, spreading of infections, and deterioration of health status can be avoided.

60 See NHIF/HIFM website

Annex 4.

1. Does she/he have a SS number?

YES

- The data available in the registration system and the data declared match ☐
- Data don't match: ☐ → **point 11**

NO

- 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/state funds ☐
- Financing based on means-tested ☐
- Willing to pay upfront ☐
- Covered by others ☐
- cannot pay → **point 11** ☐

3. Historical data

YES ☐

NO ☐ → **point 11**

4. Does her/his age determined?

YES, i.e.: _____ ☐

NO ☐ → **point 11**

5. Does the patient belong to a vulnerable group?

YES, i.e.: _____ ☐

NO ☐ → **point 11**

6. Can we communicate with the patient?

- ▶ Yes, language: _____ ☐
- ▶ Only with an interpreter: → **point 11**
  - interpreter ensured ☐
  - no interpreter ☐
- ▶ Via a relative:reason: ☐
- ▶ No, reason: _____ ☐ → **point 11**

7. Informing the patient

▶ On their health status

- orally: ☐
- with interpreter: ☐
- in writing: ☐
- through a relative: ☐ → **point 11**
- with a legal representative: ☐ → **point 11**
- partially: ☐

▶ On the necessary examinations

- orally: ☐
- with interpreter: ☐
- in writing: ☐
- through a relative: ☐ → **point 11**
- with a legal representative: ☐ → **point 11**
- partially: ☐

▶ On the necessary treatment

- orally: ☐
- with interpreter: ☐
- in writing: ☐
- through a relative: ☐ → **point 11**
- with a legal representative: ☐ → **point 11**
- partially: ☐

▶ **On other recommendations**

- orally: ☐
- with interpreter: ☐
- in writing: ☐
- through a relative: ☐ → **point 11**
- with a legal representative: ☐ → **point 11**
- partially: ☐

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, infectious disease: _____

▶ HIV: ☐

▶ Complaints, symptoms: ☐ → **point 11**

10. Mental examination

▶ Mood, perception, memory, concentration, orientation: _____ ☐

▶ Addiction: _____ → **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 (from where, what): _____
- Specialist examinations: _____
- Hospital treatment, referrals (emergency): _____
- Examinations for age determination:
  - recommendation for treatment: _____
  - medication: _____
  - therapeutic appliances: _____
  - lifestyle: (diet, exercise, placement) _____
- Examination to verify vulnerable groups:
  - recommendation for care: _____
  - occasionally: _____
  - continuously: _____
- Laboratory test: _____
- 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 refugee authority take into consideration the statements of the patient, other: _____
- Recommendation for travels/transfer:
  - If the person can travel, under what circumstances can this be done: _____
  - If the person is to be transferred to another facility, under what circumstances can this be done: _____

12. Healthcare qualification

YES, i.e.: _____ ☐

NO ☐

CAN BE UTILISED ☐

(which area, what conditions, recommendation)

_____