

*Healthcare System of Hungary:  
Healthy or Ill?*



# *Healthcare System of Hungary: Healthy or Ill?*

The Investigations on the Right To Health of the  
Hungarian Ombudsman,  
with Special Attention to Children's Rights

The Commissioner for Fundamental Rights expresses  
his sincere appreciation for the financial assistance provided by the  
*National Cultural Fund* for this publication

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ISBN 978 963 89682 2 7

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Publisher: PROF. DR. MÁTÉ SZABÓ

Cover graphics by Attila Zách

Printed by mondAt Kft.

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# Foreword

Investing into the physical and mental health of our children; creating universal and equal opportunity access to health care services; implementing preventive measures against harmful addictions; guaranteeing protection against any form of violence; helping to develop a healthy image of the self and the body – these are all moral duties of our society and constitutional responsibilities of the state.

Unhealthy living conditions and lacking access to a healthy lifestyle lead not only to health problems and the high costs of overcoming them, but may also produce disadvantages in all spheres of life: they may have a negative effect on a child's school performance, a young adult's chances on the labor market, or the opportunities of making a decent living. [Children's rights project on right to health]

*For our children's health, welfare, and well-being, it is indispensable to create a child-centered society. In order to reach this, it is necessary to*

- adopt comprehensive, child-centered legislation;
- ensure universal access to children's health care services;
- create children-friendly health institutions;
- implement wide-ranging health improvement programs at educational institutions;
- launch school programs preparing for 'positive parenting' and supportive family life;
- develop teaching methods for self-understanding and conflict management;
- work out training and remedial programs for underprivileged and disadvantaged children and their parents; and
- introduce effective measures for improving the mental health of children, reducing the chances of children's accidents, and preventing child-abuse.

Children's health is a social issue that cannot be restricted to the realm of health care only. Therefore, in its survey programs for 2011, the Office of the Commissioner for Fundamental Rights also sought to promote the rights of children to physical and mental health and protection from a comprehensive perspective. Respect for these special children's rights was thus analyzed in the wider context of implementing international legal norms and fulfilling constitutional obligations.

We also launched a second annual project, titled "Diseased rights - hale dignity" which considered it fundamental that the quality and scope of health care services are not compromised either temporarily or in longer term.

On basis of the fundamental right to human dignity, disability issues are interconnected with the problems of the elderly, the special needs of the homeless with that of the patient or the child. The 20th century brought about a change of discourse in which the rights of the patients have gained a wider meaning.

During the recent years the number of complaints received by our office has increased continuously and it reached almost 8,000 in the year 2011. The reported problems related to health care system and patients' rights, however, was only a fraction of it: 200 during the last year. The significance of these complaints, on the other hand, overshadows their mere number: even if fragmented, they are quite revealing. Suffering derogatory or undignified treatment during hospital care demands the same attention as not receiving sufficient care due to the lack of necessary health care services. But how can a doctor work with due diligence if the proper working conditions are not secured? In this volume, our responses to such questions are based on our reference on fundamental human rights.

# 1.

## Introduction

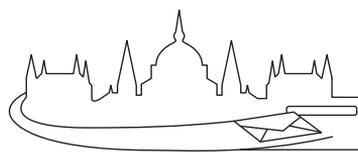
### 1.1.

#### On the Ombudsman

##### 1.1.1.

##### The Commissioner for Fundamental Rights and His Office

The work and the mandate of the Commissioner for Fundamental Rights and his Office are determined by the Article 30 of the Basic Law of Hungary adopted in 2011 and based on the Act CXI of 2011 on



the Commissioner for Fundamental Rights – both entering into force on January 1, 2012. Pursuant to the relevant regulations, the Commissioner for Fundamental Rights is the legal successor of the Parliamentary Commissioner for Civil Rights, who ensures the effective, coherent and most comprehensive protection of fundamental rights and in order to implement the Basic Law of Hungary.

The Commissioner for Fundamental Rights pays special attention to the protection of

- the rights of children,
- the rights of nationalities living in Hungary,
- the rights of the most vulnerable social groups,
- the values determined as ‘the interests of future generations’ (so called “green issues”).

The Commissioner for Fundamental Rights gives an opinion on the draft rules of law affecting his/her tasks and competences; on long-term development and land management plans and concepts, and on plans and concepts otherwise directly affecting the quality of life of future genera-

tions; and he/she may make proposals for the amendment or making of rules of law affecting fundamental rights and/or the recognition of the binding nature of an international treaty.

The Commissioner surveys and analyzes the situation of fundamental rights in Hungary, and prepares statistics on the cases of violating fundamental rights in Hungary. Therefore, the Commissioner submits an *Annual Report* to the Parliament, in which he/she gives information on his/her fundamental rights activities and gives recommendations and proposals for regulations or any amendments. The Parliament shall debate the report during the year of its submission.

In the course of his/her activities, the Commissioner cooperates with organizations aiming to promote the protection fundamental rights. As a new mandate, the Commissioner for Fundamental Rights may initiate the review of and legal norms at the Constitutional Court as to their conformity with the Basic Law.

Furthermore, the Commissioner participates in the preparation of national reports based on international treaties relating to his/her tasks and competences, and monitors and evaluates the enforcement of these treaties under Hungarian jurisdiction.

### 1.1.2.

#### The Mandate of the Commissioner for Fundamental Rights and the Deputies

The Parliament elects the Commissioner for Fundamental Rights (by the proposal of the President of the Republic) and his/her Deputies for a six-year term. Any Hungarian citizen can be elected as Commissioner for Fundamental Rights or the Deputy-Commissioner, if he/she holds a law degree, has the right to stand as a candidate in elections of Members of Parliament and who also has outstanding theoretical knowledge or at least ten years of professional experience; furthermore he/she has reached the age of thirty-five years and has considerable experience in conducting or supervising proceedings concerning fundamental rights.

The mandate of the Commissioner and his/her Deputies is incompatible with any other state, local government, social or political office or mandate or any other gainful occupation, with the exception of scientific, educational, artistic activities.

The Commissioner and his/her Deputies have the right to immunity

identical to that of Members of Parliament. The Commissioner for Fundamental Rights may be re-elected once.

The mandate of the Commissioner for Fundamental Rights and his/her Deputies' terminates

- upon expiry of his or her mandate;
- upon his/her death;
- upon his/her resignation,
- if the conditions necessary for his/her election no longer exist;
- upon the declaration of a conflict of interests;
- upon his/her dismissal; or
- upon removal from office.

### 1.1.3.

#### Proceedings of the Commissioner for Fundamental Rights

Anyone may turn to the Commissioner for Fundamental Rights, if in his/her judgment, the activity or omission of the public and/or other organs performing public duties (see: the exhaustive list below) infringes a fundamental right of the person submitting the petition or presents an imminent danger. When the person reporting has exhausted the available administrative legal remedies, not including the judicial review of an administrative decision, or if no legal remedy is available to him or her.

The list of organs:

- a public administration organ;
- a local government,
- a nationality self-government;
- a public body with mandatory membership;
- the Hungarian Defense Forces;
- a law-enforcement organ;
- any other organ acting in its public administration competence, in this competence;
- an investigation authority or an investigation organ of the Prosecution Service;
- a public notary;
- a bailiff at a county court;
- an independent bailiff; or
- an organ performing public services.

Inquiries into an organ performing public services may be carried out only in connection with its public service activities. Independently of its form of organization, organs performing public services shall be the following:

- organs performing state or local government tasks and/or participating in the performance thereof,
- public utilities providers,
- universal providers,
- organizations participating in the granting or intermediation of state or European Union subsidies,
- organizations performing activities described in law as public service as public service, and
- organizations performing a public service which is prescribed in law and use of which and the use of which is mandatory.

The Commissioner for Fundamental Rights *cannot inquire into the activities* of the Parliament, the President of the Republic, the Constitutional Court, the State Audit Office, the courts, or the Prosecution Office (with the exception of the investigation organs of the Prosecution Office).

The Commissioner for Fundamental Rights can conduct *ex officio investigations* in order to have such improprieties terminated as are related to fundamental rights and which have come up in the course of the activities of the authorities. Ex-officio proceedings may be aimed at the inquiry of improprieties affecting not precisely identifiable larger groups of natural persons or at a comprehensive inquiry of the enforcement of a fundamental right.



#### **Cases where the Ombudsman cannot help:**

- If the procedure has begun before October 23, 1989.
- If the non-appealable decision was made more than one year ago.
- If the legal proceeding is pending or is already *res judicata*.

#### **In the course of his/her investigations, the Commissioner for Fundamental Rights**

- may request data and information from the authority subject to inquiry on the proceedings it has conducted or failed to conduct, and may request copies of the relevant documents,

- may invite the head of the authority, the head of its supervisory authority or the head of the organ otherwise authorized to do so to conduct an inquiry,
- may participate in a public hearing, and
- may conduct on-site inspections.

The Commissioner may request a *written explanation, declaration, information or opinion* from the organization, person or employee of the organization having the *obligation to cooperate*.

The Commissioner for Fundamental Rights may turn to the *Constitutional Court* in accordance with those laid down in the Act on the Constitutional Court.

*Exceptional inquiry:* If, on the basis of the petition, it may be presumed that the activity or omission of the organ not qualifying as authority gravely infringes the fundamental rights of a larger group of natural persons, the Commissioner for Fundamental Rights may proceed exceptionally.

The Commissioner for Fundamental Rights submits an *Annual Report* to the Parliament, in which the Ombudsman gives information on his/her fundamental rights activities and makes recommendations and proposals for the legislators to introduce or amend a law. The Parliament shall debate the report during the year of its submission.

## 1.2.

### On the New Project Method

After his election to the office of General Commissioner in September 2007, Professor Máté Szabó introduced a new conceptual and methodological approach in the Ombudsman's work. This new approach entails the selection of different fields of investigation each year, to focus on issues that are especially important for the society as a whole, from the perspective of enforcing the rule of law and respecting the fundamental rights and freedoms. Thus, besides dealing with the investigation of individual cases, the Commissioner launches annual projects that explore how fundamental rights are recognized and observed in the particular selected field, turning media attention towards respecting the rights of a certain social group.

Since there is no independent parliamentary institution for the protection of the rights of children, the Commissioner acts also as an ombuds-person for children rights during his mandate. Therefore, during the six-year term in his office, the Commissioner also initiates an annual children's right project that focuses on a specific subject each year.

#### 1.2.1.

##### On the Patients' Rights Project



Within the series of the so-called “Dignity Projects”, in which *securing and protecting the right to dignity for all* is at the center of the project work, investigation and expert analysis by the researchers of the Commissioner's Office, the health care project of 2011 is already the fourth after those dealing with the rights of the home-

less (2008), the disabled (2009), and the elderly (2010). Besides exploring the general framework of fundamental rights in the health care system, the Commissioner pays a more focused attention to the enforcement of the rights of *persons belonging to vulnerable groups* – children, homeless people, psychiatric patients, prisoners, or persons with HIV – during their health care treatment.

Within the system of fundamental rights, the starting point is always the *respect for and protection of the right to human dignity*, from which specific patients' rights can be derived, such as:

- the content and scope of the right to self-determination in health care;
- the system of state obligations related to securing the right to the highest possible standard of physical and mental health; and, strongly interrelated with this,
- the social security model of the health care service system: the access to health care.

Within the framework of the Patients' Right Project, we paid particular attention to the fundamental rights control of the health care institutional system: more specifically, we checked if the various authorities and institutions provide adequate protection from the decisions, procedures, and omissions that could violate the rights of patients most frequently. Thus, with this project, the main intention of the Commissioner was to explore the state of protective measures and to oversee the activities of the supervisory authorities.

The project

- drew from the experiences of the Commissioner's previous investigations and projects related to the institutions of the health care system;
- utilized the time-tested means of the Ombudsman's system of legal protection;
- provided a discussion forum to facilitate the cooperation between the stakeholders; and
- sought to improve the legal knowledge of patients using health care services.

During the project work, the Commissioner took into consideration the general rule stated by the Constitutional Court that *in matters of scientific issues the scientists and not the legal experts are to decide*. The Ombudsman does not inquire into questions that are within the competence of science,

including medical science. It should also be mentioned here that within the realm of health care not only legal norms, court and constitutional court decisions have great significance, but also the written and unwritten rules of medical ethics, professional protocols and standards.

The project focusing on how patients' rights are respected in Hungary gained special importance after the dissolution of the Health Insurance Supervisory Authority (Egészségbiztosítási Felügyelet, or EBF) in September 2010. Some of the tasks this authority performed were taken over by the National Public Health and Medical Officer Service (Állami Népegészségügyi és Tisztiorvosi Szolgálat, ÁNTSZ), but the state protection of patients' rights was suspended. As of September 2012, the successor institution still has not been established, thus two years passed without creating a state authority to protect patients' rights.

The ill and hurt persons in need of medical service are defenseless towards the health care institutions and the authorities – and, unfortunately, in many cases treated as inferior by them –, thus their rights are especially vulnerable. The constitutional duty of the state should therefore be extended to the protection of the fundamental rights of persons in need of health care services, and to the enforcement of the obligation of equal treatment.

The Hungarian Constitution (and the Basic Law in effect from January 1, 2012) does not refer to patients' rights *per se*, but these can be deduced from the right to dignity or the right to self-determination. It is the Health Care Act that provides substantial guarantees for patients' rights; the right to dignity is implemented in the catalogue of patients' rights listed in this act, such as the right to health care, the right to be informed, the right to self-determination or the right to refuse treatment. Ensuring the *right to self-determination within health care* and applying the *principle of informed consent* stand at the center of the patients' right system; therefore all persons shall enjoy the wide constitutional protection of their right to have free, informed, and responsible control over their body and their life. Exercising the right to self-determination in health care, on the other hand, has a precondition: namely, that all patients are provided with equal access to the different general and special forms of health care services. Within its chapter on the patients' rights and obligations, the Health Care Act prescribes the requirement to inform a patient before his or her treatment on their rights, and has a special provision on enforcing patients' rights and investigating patient complaints, and on the work of patients' rights representatives.

Among the obligations based on European Union law, the most rele-

vant is *Article 35 of the Charter of Fundamental Rights of the European Union*, which addresses *health care and health protection* explicitly and states that

“Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.”

Concerning the protection of *patients' rights* on the international, European level, it should be mentioned that the *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine* (Oviedo, April 4, 1997) and its *Additional Protocol on Prohibiting Human Cloning* was implemented in Hungarian law in 2002. Article 1 of the Convention sets its purpose by stating that “Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine.” The Convention has special provisions on ensuring equitable access to health care, on the right to make an informed consent, and on the right to respect for private life in relation to information about one's health.

Among other international conventions binding Hungary, the *European Social Charter (Revised)* provides in its Article 11 “the right to protection of health,” while its Article 13 states “the right to social and medical assistance.”

The basic ideas of this project are not without precedent: the Parliamentary Commissioner for Civil Rights and later the General Commissioner for Fundamental Rights has always paid special attention to the problems of the health care system, to the functioning of health care institutions, and to the enforcement of patients' rights.

In the practice of the General Commissioner, health care institutions are considered as organizations performing public service, thus the Ombudsman is entitled to investigate their activities. On the other hand, it is also true that the Ombudsman has a rather narrow range of authority to conduct substantive inquiries: it is not possible, for example, to investigate ethical and professional issues in the medical sphere from a constitutional perspective. Similarly, the General Commissioner cannot take a stand in damage claim cases because it is the competence of civil courts to decide in such cases.

The annual reports of the Ombudsman testify that investigations and recommendations related to patients' rights have been a significant part of the General Commissioners' work over the past fifteen years. Thus, complaints against the activities of public institutions providing health care service (hospitals, clinics, general practitioners) or those criticizing the existing legal regulations related to patients' rights have been duly investigated and the results of these inquiries have been published in various reports.

### 1.2.2.

#### On the Children's Rights Project

In Hungary, there is still no independent body or institution to act as an ombudsman for children. Until January 1, 2012 the Act XXXI of 1997 on Child Protection laid down the responsibilities of the Parliamentary Commissioner for Civil Rights (general ombudsman), defending the children's rights.



Under this Act the Ombudsman helped defending the constitutional rights of the children with his special legal means (handling complaints, initiating *ex officio* investigations, proposing law amendments, etc.). In the interest to ensure the effective, coherent and most comprehensive protection of fundamental rights and in order to implement the new Basic Law of Hungary (which entered into force on January 1, 2012), the Hungarian Parliament adopted a new Act on the Commissioner for Fundamental Rights (Act CXI of 2011) pursuant to the Article 30 of the Basic Law. Article 2 of this new law creates a more emphasized legal obligation for the General Commissioner to defend children's rights. In this process the main task is to investigate the known abuses of children's rights, and to initiate general or specific measures to provide redress.

It is a general characteristic of complaints related to children's rights that an overwhelming majority of them is submitted by adults. The primary target group of the children's rights are the children themselves. Children's rights and fundamental rights should not only mean abstract concepts for the minors of the society but that they should have live contacts with those rights, and that they should think it over how those rights appear in their life; they should ask questions and express problems.

The Commissioner launched a special children's right project in 2008

aiming to improve legal awareness and increase legal knowledge related to children's rights of children as well as of adults dealing with them, as parents, educationists, guardianship administrators, experts of child protection, members of the judiciary system, etc.

The Commissioner's activities related to children's rights are not limited only to the utilization of traditional means. He protects children's rights by a set of specific means adjusted to the enforcement of children's rights. Therefore, in addition to dealing with individual complaints, the ombudsman lays greater emphasis on legal protection in a holistic and proactive way:

- to activities enhancing consciousness about law,
- to shape public opinion,
- to ex officio launched and comprehensive investigations
- to organizing mechanisms of cooperations.

The ombudsman, in addition to his primary task exploring problems related to children's rights and deprivations of those rights during the course of his investigations and to word recommendations for their remedy as well as to press for the elaboration of solutions also considers it indispensable in the interest of efficient and broad realization of children's rights to establish direct contacts with the target groups of the project. For this purpose he discusses experiences and his related findings, recommendations and initiatives obtained during the investigations of the Commissioner's Office with experts dealing with children in professional meetings, workshops and conferences. He initiates cooperation between children, civil and state professional organizations, and experts dealing with the vindication and protection of children's rights. In addition, in proportion to his own resources he also takes up roles in the presentation of children's rights and opportunities of the enforcement of those rights, including the protection of rights by the Ombudsman.

In this spirit, the Commissioner and his colleagues have participated in and addressed several professional events. In 2008 the main focus of the children's rights project was awareness-raising among children; in 2009 violence against and among children; and in 2010 family substituting institutions and children in care.

In 2011 the ombudsman focused in his investigations on the mental and physical health of children. According to the constitutional right to health and to Article 24 of the UN Convention on the Rights of the Child (UN CRC), every child has the right to mental and physical health on the highest level.

The special issues to be investigated were:

- drug and alcohol abuse among the younger generations;
- sexual exploitation and other forms of violence against children;
- child prostitution;
- healthy food and school meals;
- access to sport and physical education;
- missing children;
- health care in youth prisons and in youth detention centers;
- child psychiatry;
- health care of disabled children;
- access to health services in childcare institutions; and
- the system of school doctor, school dentist, school nurse, and school psychologist services.

The basis of the project was the Hungarian Basic Law, and Article 24 of the Convention for the Right of the Child, which states that

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

- a) To diminish infant and child mortality;
- b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
- d) To ensure appropriate pre-natal and post-natal health care for mothers;
- e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
- f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

During the one year work the Commissioner and his colleagues kept in mind that the general level of human development in a society depends significantly on the general health conditions among the population and on the fair and equitable distribution of health across the different social strata. This perspective was reinforced with great urgency by the publication of a *UNICEF report on children's health* in November 2010 (*The Children Left Behind: A League Table of Inequality in Child Well-Being in the World's Rich Countries*, UNICEF Innocenti Research Centre, Report Card No. 9.)

The UNICEF research measured the well-being of children in three main dimensions: in their access to material goods, their education, and their health. While among the 24 OECD countries surveyed in this research Hungary provides better than average educational services, in terms of material well-being, it is in the bottom third of the list. What is even more alarming is that compared to the OECD average Hungary lags far behind in children's health conditions and Hungarian children suffer the greatest health inequalities. The health dimension was measured by three indicators, derived from data provided by a World Health Organization research (*Health Behavior in School-Aged Children, 2005–2006*) conducted in 41 countries: (1) complaints on one's own health condition (11, 13, and 15-year old children were asked if they had experienced headache, stomach ache, discomfort, nervousness, irritation, sleeping disorder, dizziness in the previous six months); (2) access to healthy food; and (3) regular exercise.

### 1.3.

## On the Work of the Health Care Projects

### 1.3.1.

#### The Patients' Right Project

In the framework of this project in 2011 the first important event was the presentation of our report on the problems of enforcing patients' rights at a conference held on April 28, 2011, at the Office of the Commissioner of Fundamental Rights. This report explored patients' rights issues by analyzing the transformations in the institutional background.

ATTILA PÉTERFALVI, former Commissioner on Data Protection, then the director of the Office of the Commissioner of Fundamental Rights, discussed the findings of his own practice, especially those related to the fate of the medical documents of closed institutions, and *called for the creation of a unified and well-managed center of medical documentation*. When it comes to data on patients, it is important to initiate an ethical review, because in the health care system all pieces of information and data could be significant.

ÁGNES DÓSA, Associate Professor at the Institute of Behavioral Sciences of Semmelweis University of Medical Sciences discussed the 20th century achievements in medical ethics, ethical thinking, and patients' rights. One of the most heated debates in the 21st century is related to the end-of-life decisions, including the possibility of refusing treatment that could keep the terminally ill alive. Concerning the system of patients' rights representatives, she noted that *the patient is a consumer of health services* and, as such, he or she is in a peculiar situation since the medical treatments and preventive interventions actually increase his or her feeling of comfort.

JUDIT SÁNDOR, Professor at the Central European University emphasized the *growing influence of patients and donors in the field of biotechnological research* and discussed the ethical problems related to advances in biomedical research. She considered the possibility of applying the fundamental right to human dignity to the level of human cells and tissues in cases of utilizing them in therapy and research.

The conference also gave room for a presentation on the care of patients with HIV, with reference to the specificity of the different types of health care service. At the end of the conference the colleagues at the Ombudsman's Office presented a review of the previous activities of the Parliamentary Commissioners in the field of health care.

In 2011, the annual children's right project of the Ombudsman focused on the right of children to physical and mental health. This program was implemented together with the health care project titled *Patients' Rights and Dignity in Health Care*. Since in the previous years the thematic projects all had a dimension affecting the life of children (see the project on the rights of the disabled or on the rights of the homeless), it was clear that this will not be different this year either.

On June 7, 2011 we had another conference at the Office of the Commissioner for Fundamental Rights, under the title *Patients – Children – Rights*. The first half of this meeting focused on the problems related to the health of children and the provision of health care for them, and discussed the results of mapping these problems in our investigations.



In his opening speech to the conference, TIBOR NAVRACSICS, Deputy Prime Minister and Minister of Public Administration and Justice presented a brief summary of the Hungarian government's role in promoting children's rights in the context of European standards in this field, and emphasized the importance of the family as the primary location to maintain and improve the health condition of children.

The Commissioner's Office then made a presentation on its analysis of functional deficiencies in the network of district nurses, and the related problems in basic health care. Andrea Odor, head nurse at the National Public Health and Medical Officer Service coordinating the network of district nurses, explained the importance and indispensable role of the district nurse services in Hungary.

ANDRÁS HUSZÁR, President of the Association of Family Pediatricians reported on the difficulties pediatricians face on a daily basis, and then BEA PÁSZTHY, associate professor at the Semmelweis University of Medical Sciences explained the importance of developing the institutional system

of psychiatric care for children and adjusting it to contemporary needs. In relation to the transformation of the children's psyche she mentioned, our Office has conducted a comprehensive research on the consequences of drug and alcohol consumption among the minors and the deficiencies of the institutional system dealing with this problem.

In the following, the one-day conference turned to the discussion of the professional and social debates on the institutionalization of child-birth, focusing on the circumstances of pregnancy and giving birth, their institutional background, the dilemmas related to children's health care, and the importance of health awareness in society.

In her presentation, ILONA ÉKES, Member of Parliament emphasized the relationship between the social situation of the pregnant woman and the quality of giving birth. Then she recalled the history of home birth and institutionalized birth, analyzing the effects of the current debates on the general health conditions in society, in the context of 21st century Europe. She underlined on the importance of the movement for the mother and baby-friendly birth and reported on the renewal of the institution of midwives. Professor ZOLTÁN TÓTH, director of the University of Debrecen Obstetrics and Gynecology Clinic, spoke about the advantages of institutional obstetrics, the contradictions in the discourse of "safety" and/or "the hospital", and emphasized that the baby-friendly maternity wards within medical institutions are acceptable alternatives for the supporters of homebirth.

Dr. DOROTTYA MOGYORÓSI, a patients' rights expert participating in drafting health care related laws, briefly introduced the system of patients' rights and reported on the planned establishment of the National Center of Patients' Rights and Medical Documentation (Országos Betegjogi és Dokumentációs Központ, OBDK). She emphasized that the Semmelweis Plan of the government of Hungary prioritizes the improvement of providing health care for children, and that there is a horizontal agreement on this priority across the different policy areas.

At the end of the conference, the participants discussed a topic that figures prominently in the work of the Office of the Ombudsman, namely the current state of psychiatric care. More specifically, the debate centered on the question of how can be the fundamental liberties of the psychiatric patient respected when the circumstances of psychiatric care are far from adequate.

The closing event of the project, titled "*The Highest Law is the Patients' Benefit*" and held in November 2011, at the Office of the Commissioner of Fundamental Rights, gave an opportunity to conclude the year-

long project work of our Office and to present the findings of the most recent investigations. In his opening speech, MIKLÓS RÉTHELYI, the minister responsible for social affairs, emphasized that the patient is at the center of modern medicine today, but the future of medical practice depends not only on the doctors but also on other medical professionals.



Next in the conference program came a summary report by STEFÁNIA KAPRONCZAY, the patients' right program leader at the Hungarian Civil Liberties Union (Társaság a Szabadságjogokért, TASZ), on a survey made in twenty European countries (mostly member states of the European Union) under the coordination of the Active Citizenship Network on the implementation of the European Charter of Patients' Rights in 2010. The findings of the survey were drawn from four different sources, and they revealed that *in terms of enforcing patients' rights, Hungary stands at the last but one position.*

Following up on the Commissioner's 2009 project on the rights of disabled persons, we conducted a comprehensive review of the situation of the different disabled groups and found, for example, that certain disabled persons, such as autistics or mentally disabled, and their families face great difficulties even in the case of a simple dental care treatment. We also presented our report on providing the health care for homeless people, and the summary of our research on the dilemmas of mental status monitoring and threatening condition. These latter programs dealt with the severe difficulties that particularly vulnerable social groups face in their daily lives unnoticed by the wider public, and presented them in the fundamental human rights perspective that the first step in fighting against social exclusion is the true understanding of what equal opportunity means.

### 1.3.2.

#### The Children's Right Project

*In 2011 the annual children's right project focused its activities on the rights of children to physical and mental health.* Thus, this program was implemented together with the patients' right project titled *Patients' Rights and Dignity in Health Care* we discussed above.

Following the tradition developed in the previous years, the final conference of the annual project was organized in November 2011 to cel-

celebrate the International Children's Rights Day. The returning participants in the annual conference, who are now familiar with our activities, were given a presentation by the children's rights project leader on the 2011 annual children's rights project and the results of its special investigations. Then, the Ombudsman's colleagues summarized the findings of the comprehensive research on multipurpose children's home; the inquiry into the sexual abuse of children living in care and the mapping of child prostitution.

After these presentations, SZILVIA GYURKÓ, a researcher at the National Criminological Institute and at the Eszter Foundation helping the children victims of sexual abuse, commented on the Commissioner's reports in her lecture. MÁRIA HERCZOG, the president of Eurochild and a member of the Children's Rights Committee of the United Nations, put the findings of the Ombudsman's projects into an international perspective and reported on the activities of the UN Children's Rights Committee in 2011. She also presented on the government Report that the States Parties to the United Nations Convention on the Rights of the Child have to prepare on the implementation of its provisions and mentioned the important role the Alternative Report of the non-governmental organizations play in complementing the government reports.

Within the framework of *ex officio* investigations, we sought to explore from the perspective of children's rights, as completely as possible,

- the drug and alcohol consumption patterns among children;
- the deficiencies in the system of psychiatric care for children;
- the different aspects of school health care, including the access of children to medical, dental, and psychiatric care at schools, as well as to district nurse services;
- the problems of mass catering focusing particularly on school canteens; and
- the current state of physical education and physiotherapy for children.



Within the framework of the annual children's rights project and following the holistic conception of children's physical and mental health, the Ombudsman initiated investigations into the cases of sexual abuse of children living in care and child prostitution.

# 2.

## Presentation of the Investigations and Their Results

### 2.1.

#### Children's Health in a Comprehensive Perspective – The Right to Protection from Abuse and Exploitation

##### 2.1.1.

##### Investigation on Drug and Alcohol Consumption among Children

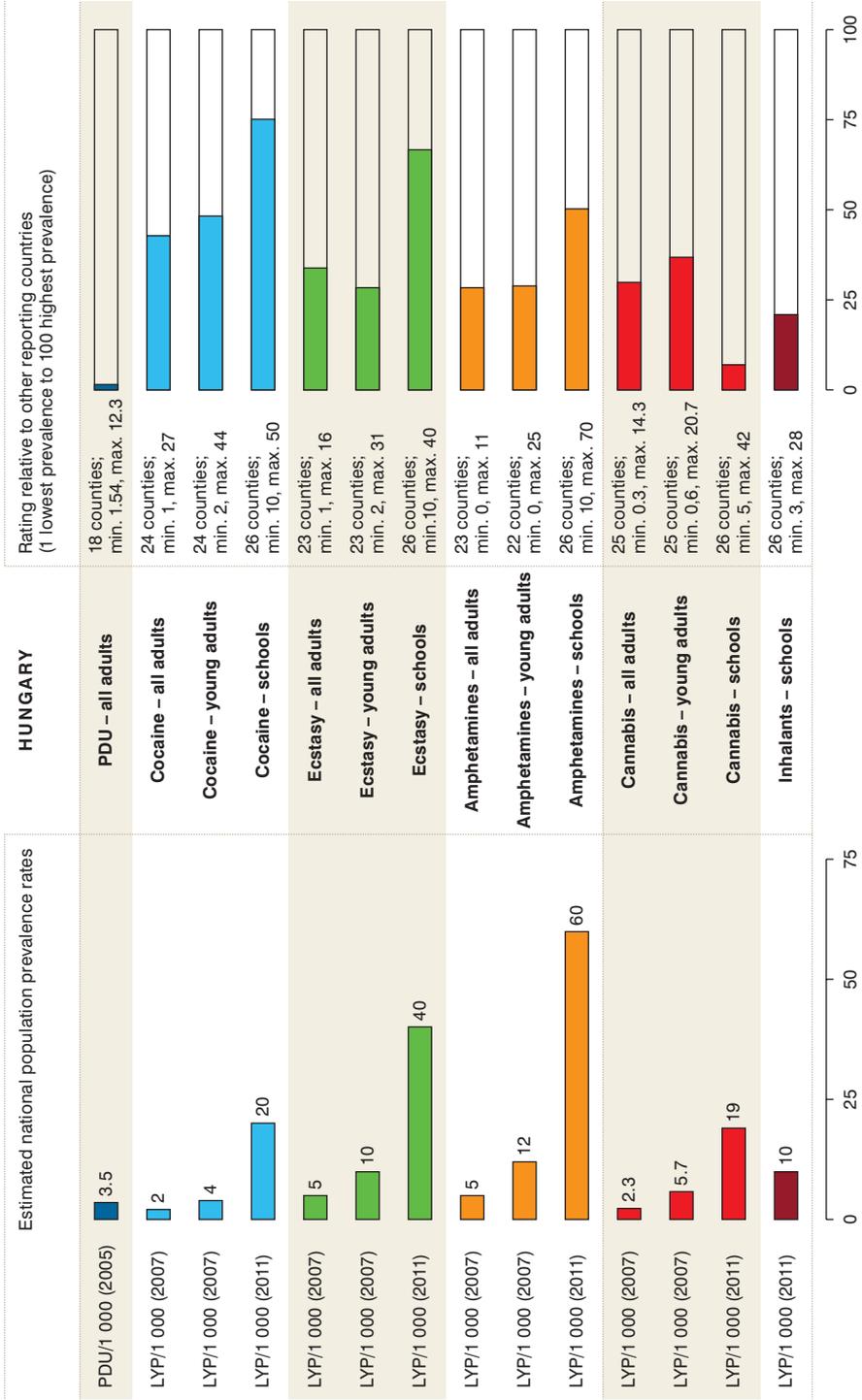
In an international comparison Hungary seems to be *moderately affected by drug and alcohol problems*. There is, however, an emerging tendency in drug and alcohol consumption and the average age of children who try out drugs or drink alcohol has also decreased. In the first half of the 1990s there was a sharp increase, although with varying intensity, in the consumption of illegal substances and inhalants: the number of consumers of these substances had doubled. Later, the increase in drug and alcohol consumption slowed down, but it is alarming that during the recent years the *abusive consumption of medicaments has increased by 25 percent*.

##### *Available Data on Drug and Alcohol Consumption among Children*

The cross-national survey of the World Health Organization (WHO), *Health Behavior in School-Aged Children (HBSC)* was conducted in Hungary in 2006. It found that the rate of children trying out alcohol is relatively high and it intensifies together with the increase in age. Most children drink alcohol for the first time when they turn 14, but every sixth boy has tried to drink alcohol by their 11th birthday and every sixth girl before their 12th birthday.

According to the HBSC survey made in 2010, across the whole sample, only 53.1 percent of the children responded that they had never got drunk before. Multiple cases of drunkenness are much more widespread

ESTIMATED NATIONAL POPULATION PREVALENCE RATE



among older children. Almost one-third of the respondents in the 9th and 11th grade (15 and 17 years old adolescents) stated that they have tried out some illegal substance or consumed medicaments and inhalants in an abusive way. Among all drug-using adolescents, the rate of cannabis consumers is the highest and the second most frequent practice is abusive consumption of medicaments or mixing alcohol with medicaments.

*Putting these results in a European perspective*, we collected the findings of the 2006–2007 HBSC cross-national survey from the National Institute for Children's Health. This shows that three percent of the 11-year-old girls and six percent of the 11-year-old boys *drink alcohol at least once a week*. Among 13-year-old girls and boys these rates are seven and eleven percent, respectively; while among 15-year-old adolescent girls already 24 percent and 15-year-old adolescent boys 35 percent. This sharp increase between the groups of 13-year-old children and 15-year-old adolescents is not unique to Hungary, it can be observed in other countries as well, and it is also characteristic for other types of health-risk behavior among adolescents. In this respect, among the 40 surveyed countries, Hungary is ranked 21st, 22nd, and 16th in the list of the three age groups – thus, Hungary stands in the middle of the ranks.

The tendency is similar when data on *drunkenness* is compared. While only one percent of 11-year-old Hungarian girls and three percent of 11-year-old boys have reported that they had been drunk at least twice in their lives, the similar figures for the 13-year-old group is nine and twelve percent, and for the 15-year-old group 32 and 40 percent. This means that as the age increases, Hungary performs worse in the international comparison: it ranks 23rd, 20th, and 13th among the 40 surveyed countries.

To summarize the data presented above: *in the cross-national comparison of alcohol consumption among children, Hungary stands in the middle of the ranks, while drug use prevalence in Hungary is lower than average among the surveyed 40 countries.*

In the *European School Survey Project on Alcohol and Other Drugs (ESPAD)* conducted in 2007 with the participation of 35 European countries, young adolescents were asked to report on their use of alcohol, tobacco, and other harmful substances. The survey revealed that among the Hungarian student respondents in their 8th to 10th grade, 64.1 percent had tried to smoke a cigarette and 21.9 percent smoked on a daily basis; 92.2 percent had drunk alcohol and 55.8 percent during the month before the questions were asked; while 15.9 percent (17.7 percent among adolescent boys and 14.2 percent among girls) had tried some form of illegal drug or

substance (marijuana or hashish, ecstasy or amphetamines, LSD or other hallucinogens, crack, cocaine or heroin). The percentage of those young adolescents who had used some substance as drugs (such as magic mushrooms, GHB, organic solvents, balloons and cartridges) was 21.2 (23.3 among boys and 19.3 among girls). In the whole group of 8th to 10th grade students, 28.3 percent (27.8 among boys and 28.7 among girls) used illegal and legal substances as drugs.

According to ESPAD survey made in 2007 among students in their 8th to 10th grade living in Budapest, drug consumption in the capital is higher than the national average. Thus, 22.7 percent of young adolescents living in Budapest have tried some illegal drugs at least once in their lives (25.8 percent among boys and 19.9 among girls). In addition, 28 percent have tried some legal substance intentionally as drugs (30.7 percent among boys and 25.6 among girls).

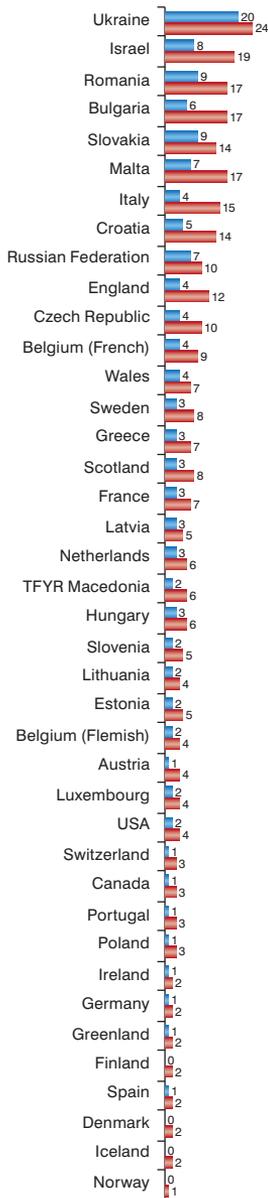
We have also asked ZSUZSANNA PAPP, the president of the Blue Line Child Crisis Foundation, which operates a hotline, about addiction among children. She reported that in 2010, *more than 25 percent of the callers (56 calls in total) were from the 13 to 15-year-old age group*, which is the group that calls the hotline most frequently. At this age, the young caller characteristically starts the story with the phrase "I have a friend who has a problem." It can be suspected that in these cases children ask their own questions in the frame of these made-up stories because they are able to share their problems, or part of their problems, only through such multiple transfers. *Almost half of the phone calls to the hotline, 98 calls were in addiction or substance abuse cases that affected the 16 to 19-year-old age group.* Here it is more usual that the caller himself or herself is a regular drug user or testifies other types of addiction (games, internet, etc.)

According to the datasets related to *inpatient care* between 2005 and 2010 the highest number of patients was hospitalized because of mental and behavioral disorders; the toxic effects of alcohol; and the deliberate self-toxication by antiepileptic, sedative, and anti-Parkinson medications. Among the patients younger than 18 years old, the number of those in need of care due to the toxic effects of alcohol increased the fastest (from 319 patients in 2005 to 710 in 2010). There was a slight increase in the number of those patients who were hospitalized because of mental and behavioral disorders caused by different drugs and psychoactive substances.

Concerning *outpatient care*, there is a significant difference between number of cases and the number of patients. The highest number of cases among patients younger than 18 years old was related to mental and behavioral

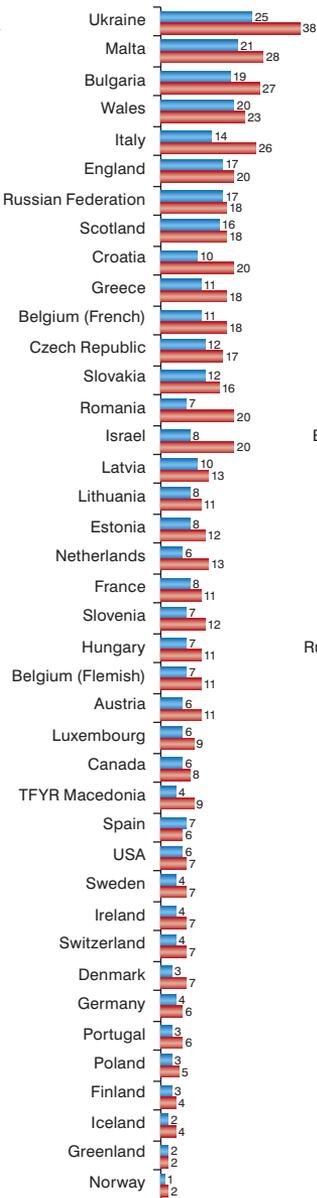
RESULTS OF HBSC SURVEY ON HUNGARY (2010)

11-year-olds who drink alcohol at least once a week



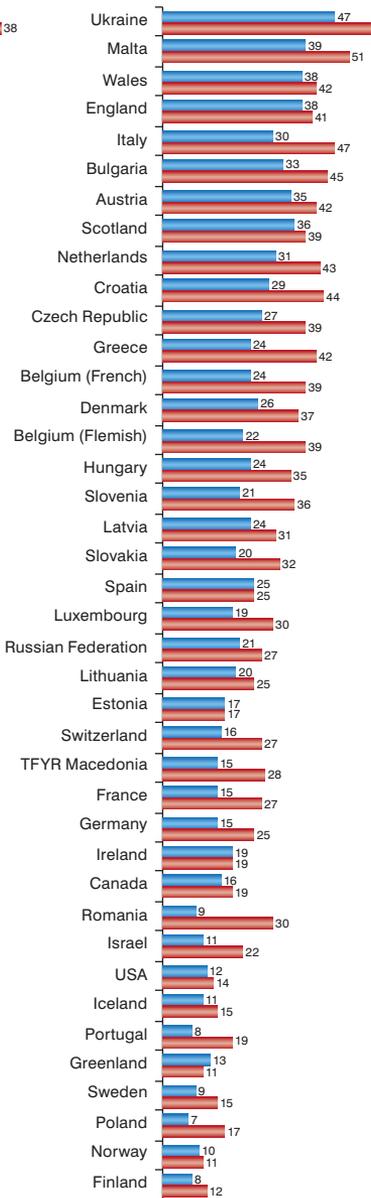
HBSC average (gender) 3  
 HBSC average (total) 7  
 5

13-year-olds who drink alcohol at least once a week



HBSC average (gender) 9  
 HBSC average (total) 13  
 11

15-year-olds who drink alcohol at least once a week



HBSC average (gender) 21  
 HBSC average (total) 31  
 26

Girl %

Boy %

disorders caused by alcohol consumption: while the number of patients was 49,269 in 2005 and 38,353 in 2010, the number of cases was 177,025 in 2005 and 116,691 in 2010. There is a similarly wide gap between the number of cases and the number of patients in relation to mental and behavioral disorders caused by opiates, sedatives and sleeping pills, cannabis and its derivatives, stimulants, and other drugs and psychoactive substances. All this suggests that *there is a high recurrence among the patients.*

The *Chief Police Superintendent* informed the Commissioner of Fundamental Rights that among the underage offenders committing crimes under the influence of alcohol is still much more prevalent than that of drugs. In 2010 5,789 perpetrators committed drug abuse, which is 12 percent higher than the number registered a year before. Concerning the underage and child-age offenders, twelve children under the age of 14 committed abusive drug consumption (compared to four in 2009, it is a 300 percent increase) and three committed abusive drug distribution. Among the age group of underage (14 to 17 years old) adolescents, in 2010 there were 564 offenders committing drug consumption (compared to 361 in 2009), which meant a 56 percent increase. There were 30 underage offenders to perpetrate drug distribution, which was a 25 percent decrease compared to the previous year – but it is important to emphasize the high level of latency in this type of crime. However, some particularly negative tendencies can be observed in certain counties: for example, in Baranya County, Southern Hungary, the number of crimes committed increased by some 50 percent, and in Borsod-Abaúj-Zemplén County, Northeastern Hungary, it doubled. In the administration of the Budapest Police Headquarters, on the other hand, ten percent decrease was registered, although the number of underage offenders increased by 13 percent. *Besides marijuana, the most common types of illegal drugs are the various synthetic drugs, and the spread of “legal” substances that are not on the list of banned drugs is becoming increasingly pronounced.*

### *Levels and Forms of Drug Prevention*

1. *International research projects dealing with drug prevention* have identified a number of risk factors that can play a role in the development of dangerous patterns of drug use and social exclusion. Vulnerable groups can be identified in different ways, but what is common in all of them is that there is a proven causal relationship between the risk factor and the evolution of the drug problem. In fighting drug use, preventive

interventions are targeted at vulnerable groups, which are listed by European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as follows:

- children in care institutions;
- truants and school dropouts;
- children of parents struggling with drug and/or alcohol problems or living in poor families;
- homeless young people;
- young people living in deprived neighborhoods;
- ethnic minorities; and
- “party going” youngsters.

In Hungary the *National Drug Prevention Office* is responsible for coordinating drug prevention activities on the state level, in accordance with the objectives and tasks set down in the Parliament Resolution on the National Strategy for Combating Drug Problems. The Office focuses on the methodological support of professional and non-governmental organizations as well as civil initiatives that take part in the work of drug prevention and harm reduction. The organizations, institutions, and communities working on the field have programs that deal with the drug problems of children and adolescents as well.

*The everyday practice of drug prevention is laden with many contradictions.* Obviously, there is a wide gap between the value system and problem solving mechanisms of the different prevention programs, on one hand, and the social world in which they are embedded, on the other. Another problem is that many prevention programs are of ‘technological’ nature: they are primarily confined to the dissemination of well-structured knowledge. In many cases, ‘prevention’ activities, being ‘drug-centered’, almost have the effect of promoting the use of certain substances by giving ideas. Research has also shown that the material and mental resources available in the school system for drug prevention have diminished, while there has been a shift towards school prevention programs that focus on general mental health (mental hygiene).

### *Vulnerability*

According to the information received from the director of the Child Protection Service of the City of Budapest, 83 young persons with drug or alcohol consumption problems were examined between January 1, 2010 and May 1, 2011. Thirty-five children left their families during the

time of the survey, while 48 of them had been admitted to child care institutions earlier. Among the 77 substance users, eight were consumers of alcohol, while the others committed drug abuse or used medications as narcotics.

ESPAD surveys also examine the relationship between the substance abuse of young people and the *various factors of family background*. The ESPAD survey in 2003 found a significant correlation between truancy and substance use for both girls and boys. Looking at the family structure, it could be concluded that complete families have a protective effect against the use of legal and illegal substances, while young people growing up without one of the biological parents are more vulnerable. Not surprisingly, the most vulnerable children are those whose parents are drug users.

*The National Drug Focal Point does not have information about the vulnerability of children and adolescents who are treated within the health care system due to their drug abuse.*

### *New Trends – ‘Legal Highs’*

The emergence of the so-called ‘legal highs’ or ‘designer drugs’ has presented a serious challenge to the decision-makers because the appearance of these new psychoactive substances revealed the deficiencies of the current regulative system: its lack of transparency and the sluggishness of the decision making process.



Designer drugs are psychoactive substances that have a chemical structure slightly different from those listed as illegal. Therefore, before they are detected and banned, these substances can be distributed freely, without any legal sanctions – although they frequently appear on the market for illegal drugs, sometimes as their replacements. These ‘legal highs’ are plants or herbal compounds of unknown composition, powders of synthetic drugs or ‘party pills’, which can be taken in different ways (inhaled, sniffed, swallowed) – even though they are advertised and distributed as herbal incenses, fragrances, bath crystals, or experimental chemicals. Thus, these substances can be distributed legally exactly because their chemical composition differs a little bit from that of

the illegal drugs. In Hungary, so far, only the mephedron derivatives have been included in the list of illegal substances but experts agree that other substances should also be added.

Various methods have been developed in the different countries to regulate the prohibition of drugs. The generic system lists the agents according to the similarity in their chemical composition, while the analogue system considers physiological and toxicological similarities as well. There are different procedures also for adding newly emerging substances to the list: the general or '*standard procedure*' which might take a long time; the '*rapid procedure*' which is justified by the urgency of putting a substance on the list; and the '*emergency procedure*' which results in a temporary addition to the list of controlled substances until the standard procedure is completed.

In 2010 a professional committee was set up in Hungary to coordinate these procedures: to officially initiate the process at the competent authorities, to collect expert opinion, to perform the necessary risk analysis, to develop its professional point of view, and to make a recommendation towards the responsible minister as to the inclusion of the new chemical compound in the list of controlled substances, or to the reclassification of an already known substance. Already during the very first session of this committee, on March 29, 2010, the idea emerged to initiate the standard procedure for including mephedrone on the list of controlled substances, and it was added to the list from January 1, 2011 after the EU resolution in December 2010 to declare mephedrone an illegal substance.

### *Findings of the Commissioner's Survey*

At the time of preparing this report, the National Drug Strategy in effect was a supplement to the Parliamentary Decision on the national strategic program to fight drug abuse. However, the Action Plan connected to the National Strategy, planned to be in effect from 2010, has not yet been submitted to the Government. As far as the enforcement of the requirement of legal certainty is concerned, however, we have to emphasize first that although there is an operational National Drug Strategy adopted by Parliament that aims, among its priorities, to create addictology for children and young people, the relevant action plan has not been adopted.

*Due to the lack of an effective national drug strategy, and the elaboration of operational action plans to implement the strategy, no strategic policy has been developed at the time of writing this report, which could be used as a professional*

*guideline in the institutions and organizations fighting drug abuse. This has resulted in a complete lack of regulation in the field.*

*In consequence, the Commissioner has concluded that the lack of normative framework creates problems in relation to the requirement of legal certainty, thus runs against the principles of the rule of law. In his report, the ombudsman states that this lack of regulation yields serious problems in the field of addictological care not only for children and young people, but also for adults.*

The review of the relevant legal norms revealed that they are far too complex and diverse, and the regulations (including those concerning the acquisition, storage, and distribution of drugs and psychotropic substances) do not provide clear guidance for the experts working in the field as to what protocols they should follow and how should they implement the relevant laws.

In relation to this it has to be emphasized that the Supplement to Act XXV of 1998 on Medicinal Products for Human Use (which had been countermanded in its other provisions) contains a list of those substances that are considered drugs or dangerous psychotropic substances but not under the Vienna Convention on Psychotropic Substances.

Concerning the appearance of designer drugs, the report pointed out that the different countries have developed various ways to regulate the categorizing and listing newly emerging substances. These methods are: the general or *'standard procedure'*; the *'rapid procedure'* which is used when it is urgent to put a substance on the list; and the *'emergency procedure'* which results in a temporary addition to the list of controlled substances until the standard procedure is completed.

*In Hungary, however, neither the rapid, not the emergency type of procedure exists for adding a chemical compound to the list of controlled substances. Thus, the system of review does not make it possible to react quickly after the appearance of a new substance.*

*On basis of these findings the Commissioner concluded that the so-called 'emergency procedure' – by which it would be possible to act quickly once new, dangerous substances, including designer drugs, appear – has not been introduced in Hungary, and this causes legal problems related to the requirement of legal certainty ensuing from the principle of rule of law and in problems related to the children's right to protection and care.*

Experts working in the field have suggested that the spread of designer drugs could be restrained if the distribution and selling of new substances that are not used as medications, distributed illegally, and are dangerously prone to abusive utilization – such as chemical compounds, herbal nutriment, bath crystals that can be used to produce designer

drugs – are made subject to a special permit. Today, no permit is necessary to obtain these substances.

At the time of writing this report, addictology for children and young people, as a form of specialized care, does not exist in Hungary, not even mentioned in legal documents. The National Center for Addictology prepared a complex program in 2010 to improve health care provided to children and adolescents coping with addictological problems. This program would review the addictological care provided for children and young people in Hungary; explore the technical and personnel needs of the different treatments; and make proposals for the creation of an institutional network to develop the professional and institutional environment of addictological care. The implementation of this program was postponed.

*The addictological rehabilitation of young persons under the age of 16 is currently unresolved*, as drug rehabilitation centers are categorized as social care institutions and, as such, they can admit inpatients only above this age (or get financial support for the treatment from the state). Those children who are 15 years old or younger can be treated only if they are first placed in a foster care institution, then in a specialized family group home – or as inpatients in a children's psychiatry ward within the health care system, but this is a less adequate solution for the therapy of heavy drug addicts.

There is a *boarding school and dormitory* Hungary that is available for therapeutical purposes and it would be suitable for treating children and young people with less severe drug problems (but those who nevertheless need to be taken out of their environment), while children and adolescents with the most severe problems (who are in need of habilitation, rather than rehabilitation) could be placed in rehabilitation centers (two to four persons by institutions), provided there is sufficient financial support available for this from the state.

It is possible to provide *outpatient care* for children struggling with drug or alcohol problems within the system of basic health care and social services, but there is a shortage in qualified professionals (children's psychiatrists, psychologists specialized in addictology, etc.), therefore this system of health and social care provision also suffers from a variety of shortcomings.

Not only rehabilitation, but also acute care faces the lack of resources, and out-patient treatment needs cannot be satisfied adequately either. This holds for all areas of addictology – although in relation to alcohol abuse only treating acute intoxication suffers from problems.

Acute detoxication treatment for children is provided at *emergency wards* and children's *intensive care units* – of course in institutions where these services are accessible. If there is no available toxicologist doctor, adult psychiatrists are often invited to take part in the medical consultation, even though psychiatrists working with adults, in principle, may not propose medication treatment for children. It is not possible to treat withdrawal symptoms in a hospital ward but adult psychiatry wards may be forced to treat an adolescent older than 14 temporarily before he or she is transferred to a child psychiatry ward.

The situation is similar in ambulatory care, with a further complication that an adult addictology psychiatrist is not allowed to treat a child with medications; a child psychiatrist is not allowed to take a drug using a child for therapy; and an adult addictologist can never reject someone who wants to be diverted for treatment.

On the basis of professional opinions collected, we may conclude that in order to rectify the current situation the *addictological expertise of pediatricians, child psychiatrists, and psychologists should be improved*: they should be motivated to obtain an addictology degree or, at least temporarily, students of podiatry, child psychiatry, and psychology should be required to pass basic level special exams in addictology.

According to the Addictology Division of the Health Board, the disfunctionalities of the system of providing health care for children and young persons are mainly the results of the severe shortage of professionals in this field within the health care system. More often than not, these problems are intensified by the lack of optimal material conditions.

From the perspective of addictology, the institutional form of a *daytime hospital*, utilizing complex methods of rehabilitation, would better correspond to contemporary needs, it would provide greater freedom for the patients, its operation would be less costly, and it would be more acceptable and less stigmatizing within the wider society.

*It can be concluded that psychiatric care for children and young adults suffer from structural, organizational, and human resource problems.* The institutional systems of health care, social services, and education operate in isolation from each other; the boundaries between them are often made impermeable by bureaucratic obstacles, thus they function inefficiently.

As addictological care for children does not exist in practice, intoxicated children and adolescents are treated at an emergency ward for both children and adults or at a toxicology ward, but the ensuing outpatient care or specialized treatment is provided for them on an *ad hoc* basis. If the child has an additional psychiatric disorder, he or she is treated at

children psychiatries, where they exist, but the rehabilitation of the increasing number of young drug addicts is not solved yet. In certain cities there are rehabilitation centers for young drug users, but these are specialized in the care of young adults between the age of 18 and 28.

Alcohol and drug ambulances for young people admit patients older than 16 and this applies also for rehabilitation. Intoxicated patients younger than 18 are treated at children or adult detoxication units or emergency wards, but beyond this, the form of their care are uncertain. If any other psychiatric problem or disease may be suspected behind the intoxication incident, then the patient is transferred to psychiatric care units, which are usually overloaded and lack the necessary resources for proper care.

It is important to call attention to the special role the so-called *child protection signaling system* plays in recognizing drug and alcohol abuse and addiction among children. Based on the experience of child protection experts, one of the pivotal problems of this signaling system is subjectivity. Certain experts are on the opinion that drinking a couple bottles of alcohol or experimenting with one or two drugs already constitutes alcohol or drug abuse. Others argue that even repeated substance use may be considered typical of adolescent behavior that the child can grow out of. Thus, the signals sent to the child protection system are quite diverse and therefore it might happen that a young person, who has only experimented with one drug, is sent to mandatory diversion treatment, while an adolescent who is on the way to addiction disappears from the radar and does not receive any help.

The report received from the director of the child protection service of Budapest emphasized that lack of information on the emergence of new substances with narcotic effects constitute a crucial problem in the signaling system, because the concrete impact of these substances is not always known for even the experienced professionals.

Young people using psychoactive drugs may receive specialized care within the system of child protection. Children and adolescents are housed in groups of eight, boys and girls separated, in children's homes or family group homes that have permission to give shelter to children with these problem profiles. The treatment program at these care providing places aims to reduce drug use and to reach abstinence. The professional team includes a psychologist and usually an addictologist, and a psychiatrist is also often present. The program is set to last for two years. If the two years is not enough for the treatment of the young person, then the period of specialized care may be extended.

In cases of severe drug abuse, specialized care is provided in a children's home maintained by the ministry. The program lasts two years in this case, too, and this period may be also extended, if necessary. In the case of a stronger motivation, the more mature adolescent or young person may be admitted to an adult drug rehabilitation home where their rehabilitation follows the same protocols as in the case of the adults.

## RECOMMENDATION

The Commissioner's Report states that in other countries the quickly emerging new designer drugs are often added to the list of controlled substances as soon as possible, by emergency procedures. The Report emphasizes that in the current decision-making system in Hungary it is not possible to react promptly when a new type of drug appears. For this reason the Commissioner recommended the Minister of Human Resources to work out new regulations to include designer drugs on the list of controlled substances; to introduce the system of emergency procedures; to review the rules of licensing and distributing dangerous substances; and to invite the civil organizations working in the field to take part in the process.

Considering the deficiencies and financial inconsistencies in child addictological, child psychiatric, and youth psychiatric care in Hungary, the Commissioner asked the government to take urgent and effective measures to establish the institutions of child addictology care and to solve the problems of the related child psychiatric care without delay. The government should also adopt an action plan to implement the National Drug Strategy or initiate the elaboration of a new drug strategy after reviewing the complete system of drug policy regulations.

In his response, the minister responsible for social affairs acknowledged the existence of the above mentioned deficiencies and argued that this is the reason why the health reform plan adopted by the government (the so-called Semmelweis Plan) has a special emphasis on the strategy of developing child psychiatric care. Concerning the implementation of the National Drug Strategy, the minister stressed that the Drug Strategy of the European Union for 2005–2012 and its Action Plan are considered crucial documents for drug policy coordination in Hungary. Although the current Drug Strategy is in line with the EU recommendations, the government has decided to elaborate a new

strategy because it finds it necessary that a stronger emphasis is laid on prevention and healthy life in the elaboration of drug policy guidelines. Thus, the Hungarian government participates in the European drug policy process by following a comprehensive, balanced, and multidisciplinary approach that aims to reduce the supply and demand of drugs in parallel with each other.

The universal and targeted prevention programs conducted in the educational institutions focus especially on the age group below 18. These programs may build upon the pedagogic program of the school, and on the health development and health education tasks, including the drug strategy, that are part of the program. The findings of the research on school programs have revealed that during an average school year seminar discussions on prevention reach out to some 310,000 students, which means that compared to the total number of elementary and high school students nationwide (between the first and twelfth grade), each year approximately every fourth student takes part in a program that (also) has an aim to prevent drug use.

According to the minister, it is clear that there is an increasing need to provide adequate care for underage children below 16. Thus, in order to reduce inequalities within this age group, a complex development program is to be implemented for them, in the frame of which organizations providing addictological and psychiatric rehabilitation are invited to apply for state support. Priority is given to applications that focus on the development of inpatient care services in the field of psychiatric and addictological rehabilitation or the improvement of integrated outpatient care services that are connected with these units.

Concerning the activation of the child protection signaling system, the minister explained that the Act XXXI of 1997 on the Protection of Children lists those institutions and persons who may send a signal within this system to the children's welfare service in the case a child is threatened or initiate administrative procedure in the case a child endangers himself or herself.



## 2.1.2.

## Investigation on Sexual Abuse against Children in Special Care

*The Rationale and Major Findings of the Survey*

Cases of sexual abuse of children are rarely made public, even though it is the young victims who are the most vulnerable and least able to lobby for their own interests. In the children's right project, the Commissioner intended to investigate this often concealed problem.

Among the different forms of violence, sexual abuse is the most difficult to discuss and handle. For most people it is almost impossible to speak about this problem. According to the unanimous opinion of the experts, it is still difficult to develop a tolerant and accepting environment in which, in line with the children's psychosexual developmental needs, the children could acquire the knowledge and skills that, on one hand, could protect them from sexual abuse or from keeping the case hidden and, on the other hand, could ensure that as they grow up the children can reflect on their own sexuality in a healthy and balanced manner, being aware of their own physical integrity and having a healthy image of their own body.



In cases of *sexual abuse* of children latency is very high, exactly because of the children's vulnerability, weak lobbying capacity, and, consequently, their defenselessness. Cases of sexual abuse remain hidden also because of the victim's feelings of guilt, shame, self-accusation, and fear of the reaction of the environment.

The WHO definition states "Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person".

According to various estimates, 10 to 20 percent of Europeans have experienced some form of sexual abuse in their childhood. According to a study written in 1999 on the findings of a questionnaire survey made among the twenty Regional Child Protection Services in Hungary, each of the Services reported on cases in which children were victims of sexual

abuse. In all, 138 such cases were reported, 82 percent of these children were girls. The most widespread form of sexual violence was touching or stroking the child's genitalia (35 percent); making sexual intercourse with the child (22 percent); and forcing the child to perform oral sex (15 percent).

This survey does not provide details on the various types of sexual abuse. At the same time, it mentions the cases that are relevant from the perspective of criminal law and are sanctioned by the Criminal Code, emphasizing the principle that the system of child protection works well if criminal law plays a role only exceptionally. The Criminal Code punishes the following acts: rape; assault against decency; seduction), in which case the victim's young age, or when the victim is reared by or under the care or guardianship of the perpetrator, is a qualifying factor. The Criminal Code also punishes incest and abuse of illegal pornographic material

*Sexual abuses* are often concealed by the seeming cooperation of the abused child. However, the child does not want to engage in a sexual act, only longs for the emotional and physical attachment to the adult person, seeking a harmonious, loving relationship with him or her. The child's gestures of unconditional love are then misinterpreted by the adult as signs of sexual attachment, within the framework of his or her own erotic desires. The adult, capitalizing on his or her advantageous, more powerful position, misuses the child's trust and longing for love by satisfying his or her own unilateral sexual desires. The sexual abuse of a child neglects or misinterprets the child's own desires, thus questions the self of the child, humiliates the child damaging his or her dignity, doubting the child's emotional and bodily-sexual freedom.

The report briefly mentions that the relevant literature distinguishes between two forms of injuries the victims of sexual abuse may suffer from: *primary injuries* that are inflicted by the sexual crime itself and *secondary injuries* that are caused by the lack of proper, informal or formal reactions to the sexual assault.

The constitutional right of the child to protection and care establishes, at the same time, the *duty of the state to provide institutional protection for the child's personality development*. This obligation of the state to provide care and protection for children involves keeping them away from harmful influences and deflecting the risks that might have a decisive effect on the development of the child's personality and, thus, his or her life in the future.

A previous report of the Commissioner has dealt with certain aspects

of mistreating children, and in this report the ombudsman emphasized that *the main task of the child protection signaling system is to prevent children from conditions increasing their vulnerability, thus to identify and remedy all factors that might hamper or hinder the child's physical, mental, or moral development.* The ability to recognize vulnerabilities and the adequate functioning of the child protection signaling system are crucial in uncovering the cases of mistreatment against children.

There are factors that aggravate the risk that a child becomes a victim. Living in an emotionally deprived environment or growing up in institutionalized foster care makes children more susceptible to becoming victims of sexual abuse. Therefore, it is vital that the state, based on its objective duty to provide institutional protection for children, guarantees the emotional, physical, and mental safety of children living in care.

This is where the problem of *institutional abuse* emerges. Institutional abuse refers to all methods, procedures, individual actions that negatively affect children in institutional care, by which the caretaker assaults, abuses, exploits, or neglects the child assigned to him or her, which threaten the child's health, safety, physical or mental well-being, and hampers the enforcement of the fundamental rights of the child. International and Hungarian experts are all on the opinion that placement in institutional care is a risk factor that increases the possibility of abuse. *The more closed an institution is, the less chance the children have for the violence that occurred behind doors to become public.* If a child suffers abuse or is a witness to the abuse of other children inside an incarcerated institution, such acts are less likely to take air and become subject to an investigation, which precludes the possibility to provide immediate assistance for the victim or to ask for damages. This situation sustains the freedom to abuse in the long run, makes it uncontrollable and legitimate, without the chance of calling the perpetrator to account.

In his report on the results of the investigation conducted in institutions taking care of young children between zero to three years of age, the Commissioner found that institutional upbringing, especially in such a young age, is not suitable to provide the individualized psychological conditions necessary for the child's healthy development. This is why the psychological development of children may suffer irreversible damages in such institutions even only within a couple months time. And this is why the European Union does not support institutional foster care for children younger than three, and a significant majority of the international organizations are in favor of an explicit ban on the institutional placement of such young children.

While deinstitutionalization is becoming an ever intensive international trend, there are, according to certain estimates, eight million children in institutional care across the world, and one million in East Central Europe only. However, *there is no available data on institutional abuse in Hungary: we do not know what kinds of abuses are inflicted on children in such institutions, with what frequency and gravity, or who the perpetrator is.* Violent acts against children or among children would be important signs of institutional deficiencies and by learning about them it would be possible, at least, to reduce the extent or acceptance of such problems.

The Commissioner also received information on the sexual abuse of children from children's homes, from civil assistance and medical professional organizations, from the Chief Police Superintendent and the Prosecutor General, and from the government service of victim assistance. The children's homes, for example, do not have either a unified professional protocol to detect acts of abuse or a methodological guideline to deal with the situation.

The ombudsman's investigation also revealed that the child protection signaling system traces significantly less cases of abuse than the social scientific surveys do. There is no data whatsoever on abuse against children growing up in specialized care, though international research shows that not only there is high latency in this field but the number of known cases is also high. One might conclude that the situation is probably not better in Hungary either.

It was a striking finding of our investigation that the various institutions and organizations taking part in the signaling system reported on a *very low number of cases*, and not too many children asked for help either. This latter can be explained by various ways: they are too young to identify the problem, to call the adults' attention to their problem, to enforce the respect of their rights, and the members of the child protection signaling system are also not sensitive enough to listen to the children's complaints. The right of the children to complain is formally respected, but the adequate functioning of the child protection signaling system depends on the personal commitment of the workers in these organizations. There are known cases in which the individuals working in the child protection signaling system did not fulfill their duties because they were afraid of the revenge of the persons reported on.

*"Over the past five years no abuse-related criminal procedure was initiated with regard to the relations between children in institutional care and the employees."* (TEGYESZ Budapest)

*“Four years ago there was a case in which a girl abused her roommate and she received a penalty of imprisonment for it. ... The children did not make any complaints in the year 2010–2011.”* (a children’s home in Budapest)

The Commissioner would find it essential that during their training and retraining programs, the employees of specialized care institutions could learn about the newest methodological guidelines and the findings of the most recent research in the field. The ombudsman suggested that the minister for national resources should pay special attention to the legal awareness-raising of children and to the development of information materials that explain to the children where they can turn to in case of child abuse, sexual abuse, or neglect. The ombudsman also asked the director of the Child Protection Methodological Service of the Municipality of the Capital City of Budapest to elaborate unified professional standards to detect and deal with cases of child abuse, especially sexual abuse, to follow up these cases, and to distribute them in the form of methodological guidelines to the institutions under its jurisdiction.

### *Survey on Child Prostitution*

Sexual exploitation is present in almost all countries of the world and as a transnational phenomenon it has also emerged as a form of international organized crime. In the United States, every third street prostitute is younger than 18, while half of those working off the street are underage. The United Nations Report of the Special Rapporteur on the Sale of Children, Child Prostitution and Child Pornography estimates that one million children are victims of sex-related trafficking in Asia but child prostitution is an emerging trend in Europe, North America, Japan, and Australia as well. Across the world the average age of starting prostitution is between 11 and 13.



In Hungary the general view is that a *child* is an underage person who is younger than 14. According to this perspective, *child prostitution* may occur only in sporadic and exceptional cases, mostly in the poorer and deprived segments of society. However, according to the United Nations Convention on the Rights of the Child, all young people below the age of 18 should be considered as children. Thus, all those who become prostitutes before reaching

18 should be considered also as victims of child prostitution. In Hungary there are more and more (very) young girls, and sometimes boys, who are forced to sell their bodies but the majority in our society pass by them impassively, unconcernedly, with downcast eyes.

The Commissioner for Fundamental Rights found it therefore important to launch an inquiry into the phenomenon of child prostitution in Hungary and to assess the measures the authorities have taken to size up and reduce the extent of child prostitution. The aim of this inquiry was to understand if the current legal regulations are adequate for the protection of children from sexual exploitation. On the other hand, the ombudsman also sought to find out how the authorities responsible for child protection come to know the cases in which children become prostituted and if they learn about such cases then how do they proceed, how do they handle the situation, and what kinds of steps do they take to protect such children. Do authorities fulfill the obligations prescribed for them by the international legal norms and national regulations? Is there a well-functioning institutional safety net in which qualified professionals are able to help treating and healing the mental and physical injuries the children victims of prostitution have suffered?

In order to conduct the inquiry effectively, the Commissioner asked for *detailed reports from the members of the child protection signaling system*, thus from:

- the local child welfare services;
- the network of children's homes;
- the county level police headquarters; and
- the regional custodian offices.

And *in order to gain a comprehensive picture representing the whole country*, the ombudsman *extended the survey to six districts in the capital city of Budapest and to five counties* (out of nineteen). In all counties and districts the same local organizations were asked the same type of questions. Besides preparing detailed answers to the questions, the Commissioner asked the members of the signaling system to provide all relevant data and the related documents as well.

The responses to the inquiry revealed that practically all organizations and institutions have dealt with or currently face the problem of child prostitution, or at least *suspect* the existence of such cases. As child prostitution is a fundamentally latent type of phenomenon and remains mostly hidden from the child protection professionals, quite often it can only be suspected but cannot be proven. Thus, on basis of the number of recorded cases the real weight of the problem cannot be assessed.

## CHILD PROSTITUTION – COUNTIES INVOLVED IN THE OMBUDSMAN’S INVESTIGATION



*“We suspect that child prostitution is present in our district, there is a high latency, but the investigating authorities cannot deal with our notification in substance.” (Children’s home in Pécs)*

*“Child prostitution has appeared, although in a marginal form, in the system of specialized child care protection.” (Csongrád county Children’s Welfare Service)*

*“Our service has not been notified on any case of suspected child prostitution. In certain cases, however, we did suspect that in the family care center one or two underage person act as prostitutes.” (Baranya county Children’s Welfare Service, Pécs)*

*“With reference to your concrete question, I declare that we do not have reliable statistical data on child prostitution.” (Budapest Police)*

The Commissioner’s investigation found that the most vulnerable are adolescent girls aged 14 to 17 who live in deprived family and poor material conditions. Members of their families can be characterized by low level of education, extreme poverty, divorced parents, lack of strong emotional bonds between the members of the family, the acceptance of early sexual relationship, and in certain cases the presence of addiction and in the family. In many cases childhood sexual abuse, child molestation, and the presence of pedophiles in the family aggravate the situation.

From the reports the Commissioner’s office has collected, the ombuds-

man concluded that the children welfare services and the professionals working in basic care, those who meet the problems of children firsthand or directly, have difficulties in recognizing the signs of prostitution – but so have the other organizations within the child protection signaling system. Furthermore, *as long as prostitution is “only” suspected, no measures are taken*; the authorities do make an attempt to protect the child. They do not want to face the consequences when it turns out that the suspicion was false. *They wait until the act of prostitution is proven unambiguously or until another organization in the signaling system notifies them.* Unfortunately, this is the period when there is a chance that the child can be saved and the process of her becoming a prostitute could be stopped.

According to the ombudsman, this kind of approach is unacceptable. The mere suspicion should justify that the authorities responsible for the protection of children take the necessary measures, to identify the risks and threatening conditions, and to eliminate them, if possible.

The *children's homes* involved in the investigation reported that although child prostitution itself is rarely mentioned as a reason for admittance into the home, suspicion of such activity emerges in the case of many children. The children's home is not a closed institution, therefore the nights out cannot be controlled, thus running away from the home presents the biggest danger for them. During the time of escape children may start to mingle with bad company where alcoholism, drug and substance abuse is widespread, and prostitutization might also develop. In many cases it turns out only much later what happened to the child while she or he was away, from the minutes of the child's hearing. The young girls said that during their escape their “pimp” gave them room and board, presented them dresses, cigarettes, and so on. They explained that it was important for them to wear the same branded clothing as their peers, and to be able to buy things that children growing up in normal circumstances would be able to get only from their parents.

Although all cases of running away (leaving without permission) are reported to the police, which order a search warrant for the child, it happens often that the she is treated at a health institution (toxicology, psychiatry, or maternity ward) without notifying the child welfare authorities. There was a case in which the child on the run returned to visit her patron every month, who in turn did not notify the children's home or reported on the new location of the child.

It is close to impossible to provide care for the child at home because family relationships become deteriorated as a result of the child's experi-

ence with prostitution or, in other cases, it is acceptable that in the child's family women work as prostitutes.

Children's homes may provide relationships of trust, attachment to a home, or the emotional support of personal conversations to the child but, unfortunately, this type of institution does not have other means to ensure the efficient and safe protection of the child.

Concerning the *role of the police*, the Commissioner found that the local police in all counties and also in the capital city have encountered cases of child prostitution. However, the police officers dealing with such cases, as representatives of the investigative authority responsible for exploring criminal acts, usually see the children as perpetrators and not victims. Thus, if they catch the child in the act of prostitution, they initiate a felony or misdemeanor procedure. This procedure usually affects only the underage child and not the criminal network in the background or the clients using the services of the child prostitute.

The police offices have also emphasized that, according to Hungarian criminal law, only minors younger than 14 can be considered children, while those between 14 and 18 years of age are considered as underage persons. Thus, different legal consequences apply and different procedural duties are imposed on child (aged below 14) perpetrators, on one hand, and underage (aged between 14 and 18) perpetrators, on the other.

The county police superintendences claimed that the relatively low occurrence of child prostitution in their jurisdiction was due to the regular surveillance actions of the police in the "contaminated" areas exposed to prostitution; to the so-called youth protection patrols; and to the presence of uniformed police personnel.

In relation to the phenomenon of child prostitution, the police forces also have the important task of preventing crime. They give lectures on the dangers of prostitution in the framework of awareness-raising programs to the students of elementary and high schools, and to children raised in institutional care, thus children can learn about and the threat of being forced into prostitution.

Concerning *child welfare authorities*, the Commissioner found that their procedures usually do not start with the suspicion of prostitution. During the procedural acts (hearings, record-taking, collecting expert opinions) the authorities usually do not learn about acts of prostitution, they remain hidden in front of them. Most children becomes connected to child protection professionals and child welfare authorities because they have

behavioral problems, they are repeatedly absent from school, they use some kind of psychoactive drug, or become part of committing misdemeanors or felonies. In such cases one can only presume that the child worked as a prostitute or was forced to prostitute herself.

Those child welfare service offices that did not find traces of child prostitution in their jurisdiction, did not report on any disfunctionality of the child protection signaling system. On the other hand, where child prostitution is indeed present, the member organizations of the signaling system complained that they were either not informed about such cases or were notified only informally, out of fear of being accused of slander. The opinion of the child welfare offices on the activities of the police is similarly diverse. The child welfare offices not affected by child prostitution have only a general view of the police's work in prevention or in catching the child in the act of committing a crime. In contrast, the child welfare authorities that do face concrete cases of child prostitution experience that the police takes steps only when a suspicion is proven, and the time period between a case is reported and the investigation is closed is unreasonably long.

All organizations approached by the Commissioner's office reported that none of their employees had participated in conferences, trainings, and retrainings on child prostitution and that they did not have a colleague a specialization or experience in this field. They also emphasized that among the member organizations of the signaling system the competence boundaries are not defined clearly, thus they do not know in which cases they are supposed to alarm the other organizations.

### *Findings of the Commissioner's Investigation*

In sum, the Commissioner concluded that the children's right to protection and care is violated by the disfunctionalities of the child protection signaling system: the member organizations in the system do not alarm each other when a case of child prostitution is suspected, they do not cooperate with each other, and they do not take the necessary measures to protect children. With regard to the duty of the state to provide legal and institutional protection for children and young people, this results in a constitutional anomaly.

*The report also revealed that the child protection experts do not have professional protocols, practical guidelines, and specialized knowledge that could help them in uncovering cases of child prostitution and in taking the mandatory measures to protect children. In the lack of these, in turn, they are not able to respond*

*in a timely manner and with adequate efficiency, and to provide the necessary assistance to the victims of child prostitution.*

## RECOMMENATION

In order to prevent abuses, the Commissioner made a recommendation to the responsible minister to work out the necessary professional protocols and methodological guidelines, and ensure their efficient distribution, so that the organizations of the child protection signaling system could fulfill their duties to send signals indicating problematic cases and cooperate with each other in solving them. The ombudsman also suggested that the minister should initiate a complex investigation into the social factors that lead to the development of child prostitution. Based on the results of this investigation the minister should elaborate a prevention program for the vulnerable groups of children and young people. The minister should pay special attention to improve the children's legal sensibility and knowledge of the legal system, especially with regard to making them aware of the dangers of sexual exploitation and to teaching them where to turn to get help in such cases.

Furthermore, the Commissioner asked the Minister of Interior to initiate decisive measures to liquidate the criminal organizations that exploit children sexually, and the Chief Police Superintendent to make sure that the members of the police corps receive detailed information during their training on the phenomenon of child prostitution and on the measures the police may take to prevent and fight off this phenomenon.

## 2.2.

### Comprehensive Investigation on District Nurse Care

The complainant working as a district nurse turned to the Commissioner for Fundamental Rights because she objected that in her district consisting of three settlements she alone had to take care of more than 600 children, instead of the 250 allowed by law. She had already sought to have her district partitioned at the local municipality, the head nurse, and the competent ministry but no substantive change ensued. She also made a grievance of not receiving either the salary supplement for her extra work or the ‘territorial bonus’ that she would be entitled



to for working in an underdeveloped district because the municipality argues that the beneficiary of this bonus should be the service provider, that is, the municipality itself. Her petition to the Commissioner was signed also by many parents, kindergarten and school teachers, emphasizing that the grievance affects not only her but also the children she takes care of.

The Ombudsman started his investigation by asking the responsible minister and the head nurse to send him a comprehensive overview of the nationwide network of district nurses, besides addressing the concrete grievance of the complainant.

The minister informed the Commissioner that, according to law, it is in the competence of the local governments to provide district nurse care within the framework of the basic health care system and therefore the municipal council is entitled to define the boundaries of the districts. The amount of the district nurse's salary is determined by the relevant regulations in proportion to the number of children she looks after – but this number cannot be higher than 250, which means that

the district nurse cannot be compensated for taking care of more than 250 children. On the other hand, no relevant regulation exists to clarify whether the municipality or the district nurse is entitled to receive the above-mentioned 'territorial bonus'.

In relation to this, *the Commissioner concluded that the requirement of legal certainty following from the principle of rule of law is violated, in itself, when a district nurse is forced to take care of substantially more children than the maximum allowed by law. Moreover, the functional deficiencies of the network of district nurse care result in a legal quandary that infringes upon the right of children to health.*

This condition may be maintained only exceptionally and temporarily until the creation of a new district. Neither the health care provider, nor the authorities overseeing its operation should require or expect from the district nurse to look after more children than the maximum number allowed by law. While the municipality and the society as a whole expects that the district nurse provides adequate care for all children even beyond her regular work time, no health service providing municipality should abuse this expectation by citing financial difficulties. The service provider has to take all steps necessary, including the possible partition of the district, in order to make sure that the district nurse may continue her work according to the way determined by law.

The Commissioner also emphasized that in establishing the system of financing the operations the municipality must take the number of children belonging to a district into consideration and has to make sure that the district nurse receives higher salary as long as she temporarily provides care for more children. However, the financeable number cannot be higher than the maximum number allowed by law; otherwise the increased financial support would make district nurse herself in the maintenance of the bigger districts – which, in turn, might sustain the condition that violates fundamental rights.

The investigation has also unfolded that *access to district nurse care* differs greatly across the individual regions within the country, and also across the districts within the regions. In her report sent to the ombudsman, the head nurse explained that in many cases the district nurses also act as school nurses. According to official data from September 2008, out of the 4,004 district nurses 1,222 (or 30 %) worked only in their districts, while 2,782 (or 70 %) provided nurse care in their districts and also in individual schools. In the case of the district nurses working in 'mixed districts' (in their territorial district, as well as in kindergartens and schools) it is obvious that they have more limited

time and availability for the families living in the district. Unequal access to nurse care may also be caused by *the high number of people in need of special care* and by the fact that *the district includes several (even six or seven) villages* that are far from each other. In such districts the nurse spends a lot of her time on traveling and may have less time for actual nurse care work.

Further inequality is caused in many cases by the practice that district nurse positions are filled with long-term replacements. In such districts, nurse care is provided within the same work time than in the 'own districts' of the nurse. Since it is not defined what can be considered a 'minimum level of care' provided and, theoretically, no distinction can be made in terms of the care provided in the different districts, it is likely that sufficient access to adequate nurse care is not provided in these particular districts covered by the same nurse (in her 'own' and, as replacement, in the other). There are 719 villages and towns in the 33 micro-regions listed as suffering from multiple disadvantages and in 364 of them (more than 50 percent) *no organized district nurse care is available*. According to the reports of the district nurses, the number of families administered and looked after by the network was 610,810 – out of which 69,884 families (or 11 percent) lived in the 33 most disadvantaged micro-regions. These data reveal that access to the adequate level of district nurse care service is most difficult exactly in those regions – Northern Plains, Northern Hungary, Southern Plains, and Southern Transdanubia – where the 33 most disadvantaged micro-regions can be found.

In her account, the head nurse also called attention to the unfavorable age distribution of district nurses: while almost 40 percent of them are older than 45 (11 percent is aged 46–50, 14 percent 51–55, nine percent 56–60, four percent 61–65, and one percent is older than 65), the proportion of those in the age group of 21–25 is a mere six percent. As a consequence, it is anticipated that in the upcoming years 300 district nurses will retire annually. Since only about 200 college students graduate as district nurses every year (and not all of them in tend to look for district nurse positions), it is clear that the number of district nurses will continue to decrease in Hungary, creating further tensions in the field.

*In his conclusion to the investigation the Ombudsman found that the inequality of access to district nurse care, its functional inaccessibility or limited accessibility, results in breaching the right of persons living in the district, especially the right of children to health.*

## RECOMMENDATIONS

The Commissioner for Fundamental Rights called the responsible minister for taking the necessary steps to eliminate the existing severe inequalities between the different nurse care districts and to initiate the revision and amendment of the legal regulations on financing the district nurse care system. Considering that the grievance of the complainant was remedied during the investigation of the Ombudsman – the nurse care district was divided as requested – the Commissioner did not initiate further action in the concrete case.

In his response the minister informed the Commissioner that, keeping in mind the principles of unity and consistency, he does not support the initiative to divide the financing of district nurse care because on this basis similar rules could be adopted for other groups of employees in the health care system. The minister also noted that the relevant regulations do not preclude the possibility that the service provider (the municipality or the health care institution) transfers a certain portion of the ‘territorial bonus’ to the district nurse.

The minister also does not support the proposal to give temporary salary supplement to the district nurse when, for a transitory period, she provides care for more clients than the number allowed by law, but less than the maximum allowed. The minister is on the opinion that the Act on the Legal Status of Civil Servants and its implementation regulation states clearly in which job positions it is possible to determine salary supplements; and the extra pay for district nurses is not mentioned on the list.

## 2.3.

### Investigation on Health Care at Schools

#### 2.3.1.

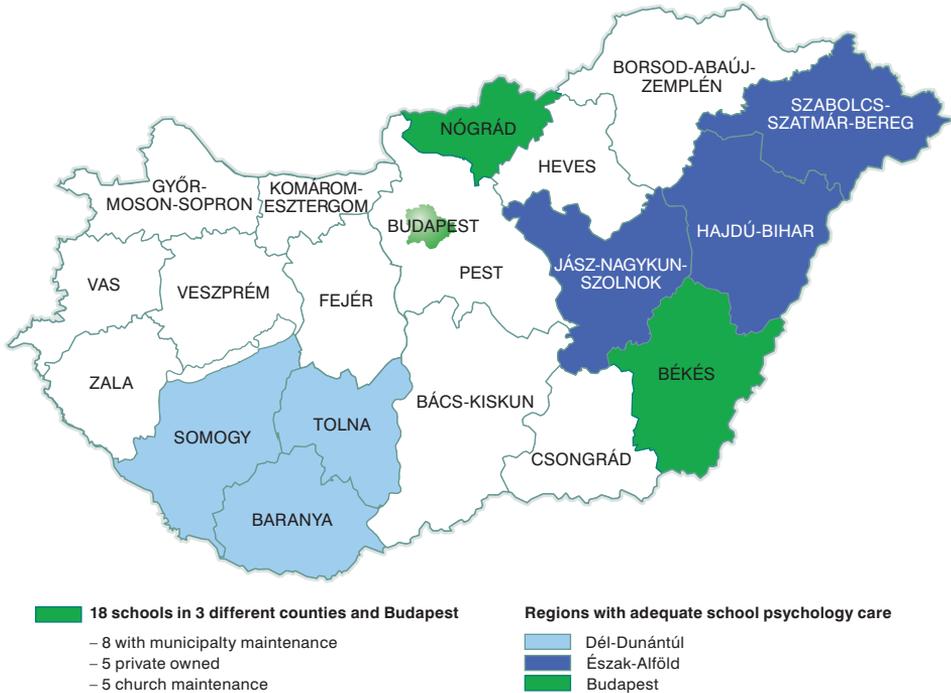
#### Investigation on Services of School Doctors-, Psychologists-, Dental Care

Within the framework of his annual children's right project for 2011, the Commissioner also surveyed the situation in health care provided at educational institutions (school health care). The investigation sought to find out if school doctor, school dentist, school psychologist and district nurse services are provided according to the relevant regulations for the school aged children (between 6 and 18 years old).

In the framework of the school health care investigation the Commissioner asked the competent ministry, the head nurse, the National Health Insurance Fund, and various non-governmental organizations to provide information on certain well-defined questions. Besides the responses sent by the schools and the education authorities, the ombudsman also requested the opinion of the parents, as well as the school doctors and district nurses providing health care for children.

Eighteen educational institutions (elementary schools, high schools, and vocational schools) were selected for the investigation, representing Budapest and three counties in different geographical regions and with different social and economic characteristics. Schools with three types of institutional maintenance (eight maintained by *municipalities*, five by *foundations*, and five by *churches*) were chosen to see if there is a difference in the care provided for children according to the type of institutional maintenance. Among the selected schools, three operates in larger cities with county rights, three in small towns, three in rural villages, and six in Budapest. All educational institutions were asked the same questions to generate comparable data from the survey.

## COUNTIES INVOLVED IN THE INVESTIGATION ON SCHOOL HEALTH SERVICES



Health care provided in educational institutions is a form of care that contributes to the reduction of unequal opportunities among children for health and in their access to health care. It ensures that the health conditions and development of all school-aged children are regularly screened, even for the children living in the most disadvantaged regions and in the most deprived circumstances, and it also provides vaccines against infectious diseases. The contribution of school doctors and district nurses to health education is an invaluable help for pedagogues and parents alike.

Health care provision at schools, including regular age-related examinations by the school doctor and the district nurse, serve mainly the purpose of prevention, and not diagnosis or treatment. Therefore, the basic task is to evaluate the physical, sensory, and mental development of the child and to carry out the related tests. This type of health screening involves the complete examination of the child's body, which should be part of any thorough medical examination, anyway.

According to the regulations in force, school health care should be provided in all educational institutions for the age group between 3 and 18, and also for students older than 18 who pursue their studies on a full time basis. This means that all kindergartens, elementary schools, and high schools should, besides their basic responsibilities in education and

training, provide special health care, focusing mostly on prevention and healing.

### *About school doctors*

In relation to the provision of *school doctor care*, the investigation found that the quality of such care is substantially affected by the number and proportion of full time school doctors. Unfortunately, there number of the so-called “mixed medical practices” is increasing, which means that a general practitioner provides also school doctor services for children. However, this form of care does not make it possible to carry out the complex tasks of a school doctor as in such cases the doctor is frequently overburdened, lacks the sufficient time, and the time necessary for providing health care service is not adequately regulated. The efficient functioning of the school health care network is greatly hindered by the lack of legal provisions on which institution has the obligation to ensure the material conditions of providing care (such as the doctor’s office and its furnishing): the educational institution, the health care service provider, or the municipality. There is also a frequent complaint among school doctors that although the relevant laws on public education stipulate the regulation of school health care activities, the rigid protection of the time devoted to regular classes greatly reduces the time available for the screening examinations.

The maximum number of students the school doctor may provide care for, with the help of a number of district nurses, is 2,400 – which in itself is quite high, especially if it is spread over several schools. In many cases, however, an even higher number of students belongs to one doctor. The basic care professional supervision of the service providers is not effective. As school health care requires a complex team work, it would be necessary to conduct joint supervision of all service providers based on the same protocols.

### *About school psychologist*

The basic task of *school psychologists* is to assist educational work as a whole, that is, to participate actively in the development of social and community relations and to support the realization of differential treatment, by applying psychological perspectives and developmental techniques in dealing with the individual children. The school psychologist network was created in 1986 with the support of the, then, Ministry of Education.

Since then, the number of school psychologists has increased slowly, but any further development depends on the available financial means of the municipalities. It is the responsibility of the employer to provide the material conditions of adequate service but – depending on the financial resources and approach of the employer (or the municipality) – there is a great variety in their provision.

On the national level, only about 20 percent of the schools employ school psychologists. The different types of institutions vary greatly in this respect. Elementary schools have the worst coverage *on care*: only 18 percent of them employ psychologists, part or full time, and 38 percent of the limited number of specialized vocational schools have school psychologists. Part time employment is most widespread, in 16 percent of the schools, while full time psychologists work in only 6.3 percent of the schools. No statistical data is available, however, on how many hours a week this would mean exactly.

Access to school psychologist care is strikingly diverse in the seven regions of the country. The regions of Budapest, Southern Transdanubia and Northern Plains have the best coverage. There are not too many full-time school psychologists in the country, but most of them are employed either in Budapest or in the county seats. Although there is no available statistical data, there are indications that in the most disadvantaged regions, access to specialized pedagogical service – including school psychology service – is much more difficult than in the larger cities or in the Northern regions. Although the different types of educational institutions would be willing to employ school psychologists, lack of financial resources at the municipalities prevent them from creating additional jobs.

#### *About dental care*

It is the joint responsibility of the health institution providing basic dental care and the agency maintaining the educational institution to organize preventive and curative *dental care in schools*, and to ensure the conditions of their operation. School dental care service is provided in group or individual form for pupils and students aged between three and 18. Twice a year dental screening examination is organized for students in the dental clinic where the school belongs to on a territorial basis; this is also the place where children can be treated as well, during the regular school hours. This service is free of charge until the age of 18. School dental care is to be organized in a way that each education institution is connected to one or another dental clinic and care is to be provided by

qualified dentists. This dentist is either a full-time school dentist or paedodontist, or works in a mixed dental practice in a so-called 4+1 or 3+2 scheme: providing service to adults on four or three days a week, while the remaining one or two days to students. In the capital city of Budapest, in the major cities and also in several small towns full-time school dentists work, while in the rural countryside dental care provided in mixed practice is more widespread.

From the perspective of the children and their parents it is problematic that no unified protocol exists with regard to the duties and responsibilities of the school dentist. For example, examination (checkup and diagnosis) and treatment cannot always be separated from each other in practice, but while examination may be mandatory for all, in case of a treatment the parents have to give their consent first. All this justifies the need to elaborate a unified professional protocol.

The investigation also revealed that it is unclear who or which institution should pay for the travel expenses if a child's appearance at the school dental examination involves traveling: the educational institution, the parents, or the municipality? The Commissioner is on the view that costs related to the obligations of the municipality may not be charged to the care recipients and their parents. Furthermore, it is necessary to establish clear rules on the organization of dental care for students attending educational institutions maintained by a church or a foundation. It is not acceptable that children attending to private schools do not receive dental care just because they are not students of educational institutions maintained by a municipality.

### *Findings of the ombudsman*

As a result of the investigation, with respect to the *school doctor* and *district nurse service*, the Commissioner found that the 6 to 18-year old children living in the territory of Hungary – who are subject to compulsory full-time schooling and take part in the training of an educational institution – have access to the mandatory health care screening and vaccination services provided in the schools. Although there are significant differences between the quality, accessibility, and frequency of the services depending on where the student lives, *all school children receive the mandatory health care services (screening, vaccinations)*.

The fact that there are significant differences between the school health care provided in larger cities and in smaller towns could already be established on basis of the responses coming from only a limited num-

ber of schools. As a consequence, the Commissioner concluded that the actual care provided varies greatly depending on whether a full-time pediatrician or district nurse can be accessed, even several times a week, in the consulting room created at the school (which is more characteristic of the capital and the larger cities), or a general practitioner provides the service at a health center, far away from the school, perhaps even in a different city (which is more characteristic of the small towns).

From the perspective of the quality of care it is also an important factor how many classes are the teachers willing to “do without” so that the school children could undergo truly in-depth examinations and not just superficial ones. Sufficiently thorough examinations require time which, in practice, could be gained only at the expense of the mandatory teaching classes.

On the other hand, the mere fact that a child attends a municipality-, church-, or foundation-run school, should not affect the provision of care as all maintaining institutions meet these statutory obligations. However, the investigation has also revealed that, within the range of the schools surveyed, the schools run by a church or a private foundation provide higher quality service than the municipality schools.

With regard to *school psychological care*, the Commissioner has also found that, depending on where they live, there are significant differences in the children’s access to the service (and in this case the difference is noteworthy not only between cities and villages, but also between larger cities). Respondents from all types of schools (primary, secondary, vocational) stated that in order to increase the efficiency of their educational and training work they needed this type care and not only the students but also some of the teachers would make use of this service. Nevertheless, in practice, only a very few schools could ensure that a full-time employed school psychologist assists the work of teachers.

In relation to *school dental care*, the investigation revealed that although it is required by law to have dental screening twice a year, the schools comply with this with great difficulty. The reason for this is that dental care is not available at the educational institutions but at dental clinics; therefore dental care, together with traveling back and forth, is a rather time-consuming service. Moreover, the educational institutions often pass the travel costs on the parents. A further problem is that dental care, also due to the time constraints, is almost exclusively limited to screening, and actual dental surgery or other intervention take place very rarely. In other words, the children do not actually receive dental treatment.

## RECOMMENDATIONS

In relation to all type of health care provided at schools, the Commissioner found that the stakeholders have very little information on the financing of the services and on the relevant mandatory professional protocols, and this may be due to the lack of professional supervision.

*The Commissioner determined that because of the inequalities that exist in the access to health care provision at schools, for those receiving only limited care, the right to the highest possible standard of physical and mental health provided by the Constitution is violated, and the problematic practice breaches the prohibition of unfavorable discrimination.*

*The investigation also revealed that in certain areas of school health care provision the professional protocols guaranteeing the quality of care are missing. In their absence neither the healthcare workers, nor those affected would know what type of service within what timeframe is to be provided mandatorily. This uncertainty constitutes a violation of the requirement of legal certainty following from the principle of rule of law.*

On basis of the above, the Commissioner called upon the minister to initiate the elaboration of professional protocols for the different types of school health care services; the establishment of an effective professional supervisory system; the provision of the technical, material, and financial conditions necessary; as well as to take determined and coordinated action to ensure that children receive the same quality care according to the same conditions.

In his response to the findings of the investigation, the minister informed the Commissioner that he agrees with the findings and will take them into account in their future activities, and also that the ministry plans to initiate a full review of the system of health care provided at schools.

## 2.3.2.

## Quality Food for The Pupils - Investigation on Public Catering in Schools

The complainants turning to the Commissioner took grievance of the quality of public catering services provided in their children's kindergarten or school and the widespread lack of catering to children with special dietary needs. In addition, a representative survey conducted in Budapest by the National Institute for Food and Nutrition Science in 2005–2006 revealed that childhood obesity is quickly becoming a pub-



lic health problem in Hungary: among the 7 to 14-year old children every fourth is overweight or obese (25,5 percent of the boys and 25.9 percent of the girls). Another survey conducted in the school year of 2009–2010 on a nationally representative sample of seven-year old children showed that every fourth girl and ever fifth boy is

overweight or obese. According to the data from school health reports, the occurrence of obesity has increased across all age groups, and it has tripled over the last ten years.

In his wide-ranging investigation, the Commissioner requested detailed information from a number of school maintenance and educational institutions and asked the Chief Medical Officer, the National Institute for Food and Nutrition Science, the National Institute of Children's Health, the Association of Hungarian District Nurses, and the authorities responsible for public catering to clarify their professional point of view.

Based on the information collected this way, the Commissioner identified the following findings:

**A.** According to the *Act No. CLIV of 1997 on Health Care*, public catering agencies – with special reference to public catering provided in health care, social service, and children's institutions – shall offer nutritious and good quality meals that correspond to the physiological needs of children and adults. In addition, the *Act No. XXXI of 1997 on the Protection of Children and Guardianship Administration* (amended in 2002) states that among the different types of daytime care school catering should be organized in a form that is adequate for the actual age of the child living in a family. This latter act, however, does not determine the daily number or type of meals served to school children, nor the meals catered to children with special dietary needs. The regulations on catering to children do not contain rules that could guarantee the adequate quality of meals and determine either the personal conditions necessary for preparing the meals in the provision of catering service (such as the staff needed in the cooking kitchen and the servery, or the qualifications necessary for the head of catering services), or the material conditions of high quality and well-organized food and drink consumption (such as the rooms dedicated to lunches and smaller meals or the provision of tableware and napkins in the amount suitable for the number of children).

**B.** As mentioned above, the Health Care Act stipulates that public catering services shall offer nutritious and good quality meals that correspond to the biological and physiological needs of children. *The detailed rules of this provision were laid down in the Ministerial Decree No. 67 of 2007 on the Conditions of producing catering goods, determining recommendations on the adequate energy and nutrition intake and on processing food raw materials in mass catering facilities.* Thus, it defined the recommended daily intakes of energy and nutrients by age groups, as well as the specifications for whole day catering, meals provided three times a day, and meals provided only at lunchtime (per capita for ten days of catering). A joint decree, however, specified the requirements only in the form of recommendations, and therefore its provisions did not have a binding force. Consequently, according to the results of the investigation, these requirements were not complied with at all. Even these weak rules of the joint decree have been repealed.

Nevertheless, the website of the Chief Medical Officer published on August 1, 2011 a document titled “*Nutritional health recommendations on organized catering services providing regular meals*” addressed to public catering companies. This recommendation contains definitions of terms and rules for planning diets, determines the number of meals to be provided per day and the personal conditions of providing service, the food raw materials that may be used and those that should be avoided, the rules of official supervision, and so on.

*The Commissioner pointed out that such a “recommendation” cannot make up for the legal lacuna created by revoking the annex of the repealed joint decree, thus that, in its present form, is not suitable for inducing the intended legal consequences* because guidelines created without statutory guaranties may easily become regulatory tools substituting for legislation, thus hindering the enforcement of laws, and this is incompatible with the requirements following from the principle of rule of law.

**C.** Concerning the procedures of authorities entitled to supervise public catering companies, the Commissioner found that, *in parallel, the agencies of both the health administration and the food supply chain supervision carried out monitoring examinations, following the same protocols with the same purpose.* However, neither one of these inspections covered concretely the quantity of servings provided, nor the quality of food, in compliance with their conditions stipulated in the joint decree in force.

*The Commissioner also reviewed the role of school doctors and district nurses in public catering.* The task of the school doctor is to inspect catering pro-

vided in educational institutions, to make recommendations in case he detects deficiencies, and to notify the territorially competent subregional public health office of the metropolitan or county government bureaus. The *school nurse*, on the other hand, is not entitled to act on her own because she carries out her tasks in cooperation with the doctor of the school. Moreover, her only designated task related to public catering is to take part in its hygienic inspection. In addition, the district nurse of the institution monitored, as well as the president of the district nurse association, reported that they drew up their opinions on public catering in vain, because the authorities were not responsive and no change was made in the provision of school meals. The bodies requested to send information to the ombudsman failed to respond to the questions on the inspections carried out by the school doctor and his cooperation in providing public catering service.

The Commissioner is on the opinion that the rules determining the tasks and responsibilities of the school doctor and the district nurse are too general and therefore, under the rules currently in force, neither the doctor, nor the nurse could take part in the supervision efficiently, even though their presence is almost continuous at the educational institutions.

**D.** The Commissioner pointed out that while *in the child protection institutions* the minimum standard of food and the daily frequency of meals are regulated, in the case of catering provided *at the public schools* these issues are not determined by law. *In the ombudsman's opinion, it is necessary to determine the conditions of safeguarding adequate public catering for all children regardless of providing such service within the framework of specialized service or in any other type of care. Thus, he found it necessary to make sure that the minimum level of resources to be used for the purpose of public catering is laid down uniformly for all type of service provision.*

**E.** Concerning *school canteens and snack bars*, the ombudsman stated that, with respect to the rules and regulations applicable to commercial establishments, it cannot be ignored that it is primarily the children's and the employee's nutritional needs that are satisfied with any catering provided at educational institutions. Therefore, because of the specific range of the groups using this type of service, the ombudsman deemed it justifiable that the food quality regulations pertaining to public catering are also extended to this type of canteens and bars. This would allow the enforcement of food safety and nutritional health standards also in the case of these establishments by determining the range of foods and beverages (energy drinks) that can be served.

## RECOMMENDATIONS

*In his report, the Commissioner found that in the lack of a comprehensive regulation of public catering cannot be ensured in all cases that quality service is provided. He expressed the position that it is necessary to adopt a unified act of legislation on public catering provided to children, which would cover, in a complex manner, all the areas of public catering explored in the report – such as the definition of the term ‘public catering’; the institutional range and sources of public catering; the costs of service and the rules of their reimbursement; the applicable quality and quantity standards; the provision of meals for children with special dietary needs; the selection of food and beverages offered in school canteens; the elimination of the practice of duplicating inspections; the use of healthy drinking water and the strengthening of school health care services in relation to this; and the safeguarding of the adequate material and human conditions of preparing and consuming food and beverages.*

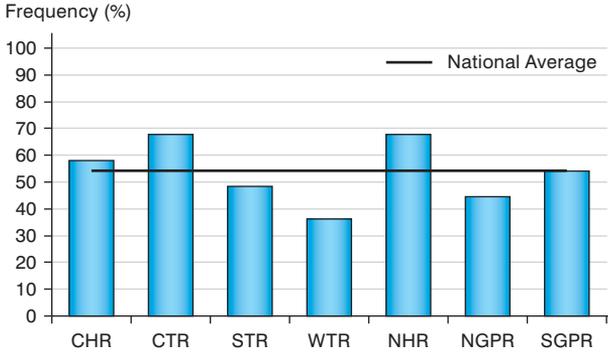
The ombudsman also found it necessary that the relevant ministries cooperate in the elaboration of the appropriate legislation on public catering. He also pointed out that it is because of the existing legal lacuna in this field that the Chief Medical Officer could publish a “recommendation” even though his office, as a body with nationwide authority, does not have the authority to make law.

On basis of the identified circumstances, the Commissioner found that the lack of laws or regulations on public catering, and the inequalities of access to care that follow from this, as well as the quantitative and qualitative deficiencies – in the context of the right of children to protection and care – *constitute an anomaly in relation to the requirement of legal certainty following from the principle of rule of law.* In order to remedy the controversies and to prevent them in the future, the ombudsman asked the government to initiate a comprehensive review of the system of rules related to public catering and consider a recodification of regulations to the extent necessary.

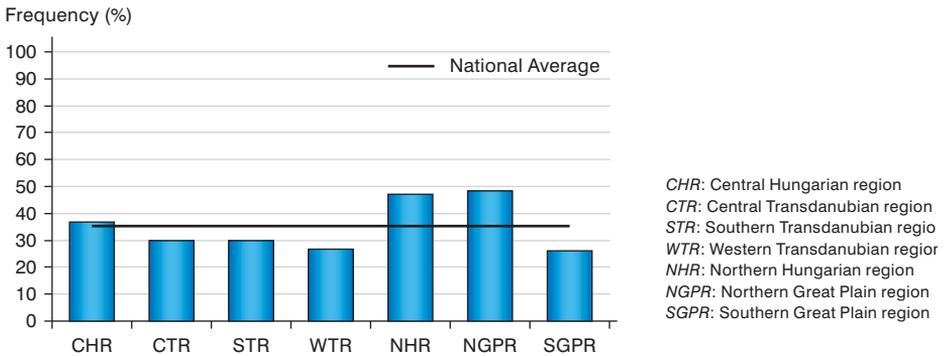
The Minister of Justice informed the Commissioner – after the ombudsman exchanged letters with different ministers several times – that an authorization order was issued to regulate children’s catering in a government decree, and this motion was also supported by the consumer protection committee of the parliament.

The government decree has not yet been enacted, however.

## SCHOOL KITCHENS PROVIDING DAILY FRESH FRUITS AND VEGETABLES, BY REGION



## KINDERGARTENS PROVIDING DRINKS NOT ADEQUATE FOR RE-HYDRATATION BY REGION



## 2.3.3.

## Problems Related to Physical Education (PE) and Psysiotherapy

In the framework of the Commissioner's project on exploring how children's rights to physical and mental health are enforced, the ombudsman investigated the situation of physical education and sports activities within schools as well as reviewed their regulatory framework. The investigation focused primarily on the tasks of education and training institutions related to physical education and student sports, and on the state of physical therapy provided at schools. It also thought to see if physical education suitable for specific age groups and tailored to individual needs is available for school aged children between 6 and 18.

*Eighteen educational institutions (elementary schools, high schools, and vocational schools) were selected for the investigation, representing Budapest and*

three counties in different geographical regions and with different social and economic characteristics. Schools with three types of institutional maintenance were chosen (eight schools were maintained by *municipalities*, five by *foundations*, and five by *churches*) to see if there is a difference in the personal and material conditions of providing physical education, sports activities, and physiotherapy for children according to the type of institutional maintenance. Among the selected schools, three operates in larger cities with county rights, three in small towns, three in rural villages, and six in Budapest. All educational institutions were asked the same questions to generate comparable data from the survey.

The ombudsman also asked the municipalities to provide information on the educational institutions they maintain, and requested information from the Minister for Human Resources and the Chief Medical Officer on the systemic management and regulation of physical education programs at schools.

Besides collecting responses from the schools and the school maintaining institutions, the Commissioner also sought the opinion of the physical education teachers, physical therapists, and parents; therefore he contacted the National Association of Hungarian Physical Education Teachers, the Hungarian Society of Physiotherapists, and the National Association of Hungarian Parents.

According to the regulating decree on keeping an inventory of the tools and equipments that should be mandatorily available in educational and training institutions, *one gymnasium should be set up in every school*: in each elementary school if it has at least eight grades; in grammar schools; in different forms of vocational schools, if they have a curriculum that includes general knowledge studies; and in a school that provides only vocational training if it was established to house at least 120 students. If it is not possible to set up a gymnasium, then *one exercise room should be set up in every school* (one for each building or building complex of the education institution) in each elementary school and vocational school. In case of disabled children, one exercise room should be created for 30 handicapped students, and in this case always within the auspices of the school.

Every school is required by law to establish a *sports yard* (one for each building or



building complex of the education institution). This may be substituted for, however, by a suitable outdoor space or facility, or may be replaced with a sports facility that the school uses under a rental contract. *Changing rooms and showers shall also be created in each school and separately for each sex.*

Some 80 percent of educational institutions have a gym or an exercise room, 20 percent does not have their own gyms but physical education classes can be held in an out-of-school indoor facility (e.g. a rented exercise room, swimming pool, or community center), while 0.1 percent does not have an access to a facility where PE classes may be held. In other words, in 99.9 percent of the educational institutions the conditions of holding indoor physical education classes are technically secured. However, as boys and girls have classes separately, because of this duplication the time slots for different classes often overlap, and the rented facilities are not considered a solution in the long term. Thus, currently, in 20 percent of the schools there is no available indoor facility for physical education.

In about 40 percent of the schools it is possible to create a sports yard. In 29 percent of the educational institutions the sports yard is ideally set up (it is suitable for sports activities, recreation, and playing games), in 31 percent of the cases it is adequate (suitable for sports, recreation, or game playing activities), in 40 percent it is not separated according to functions, in one percent there is no sports yard at all.

*The conditions of cleansing after the physical education class* (such as sanitary unit or time) show the following trends: in 48 percent of the educational institutions there is a sanitary unit and children have the necessary time to wash themselves, in 23 percent of the cases there is a sanitary unit but the children do not have time even to take a shower after the PE class, and in 29 percent of the schools there is no sanitary unit at all. In other words, *52 percent of the school children do not have the opportunity to wash themselves after the physical education classes or sports activities.*

The Hungarian Constitution states that every individual living on the territory of the Republic of Hungary has the right to the highest possible standard of physical and mental health. This right is enforced by setting up and operating the institutions of occupational safety and health care, by providing medical care and *regular physical exercise*, and by protecting the built and natural environment.

In order to ensure the healthy development of young people, the state provides the institutional foundation of organizing physical education and sports activities within public education and higher education, as

well as the opportunities for student sport activities outside the educational institutions. Furthermore, the state promotes the spread of mobile lifestyle and regular physical exercise by supporting recreational sport and student sport activities (see Act No I of 2004 on Sports, as amended). The kindergartens, schools, and dormitories – within the framework of their responsibilities determined by the Public Education Act – is responsible for the physical, intellectual, emotional and moral development of the school children and for the creation and development of community relationships among the children or pupils (see Act No LXXIX of 1993 on Public Education, as amended).

As a result of the investigation, the Commissioner found that the institutional foundations of physical education at schools and student sports activities are lacking. It is mostly the schools operating in smaller villages and towns – as opposed to the educational institutions in cities and cities with county rights – that struggle with these deficiencies. Most of the existing gymnasia are outdated, neglected, and dangerous; and the maintaining institutions do not have the necessary funds to renovate them. In many cases, there are no dressing rooms and not even the basic conditions of hygiene are met. Many types of equipment used in physical education are also missing from the schools: even though it is a fundamental condition of establishing a new educational institution to obtain all equipments that are mandatorily prescribed by law, the majority of school maintaining institutions fulfill this requirement only partially. Regarding the availability of equipments and institutional supplies, no substantial change can be foreseen as long as the decree on the operation of educational and training institutions obligates only a small number of schools to ensure the mandatory fulfillment of the relevant institutional and material conditions of operation. (These educational institutions are those that are *not* maintained by a municipality and receive the operating license only after the decree entered into force or those that are maintained by the state or a municipality and start their operation after the decree entered into force.) In order to support the construction of sports facilities (gyms, exercise rooms, sports fields and sports yards) and the renovation of existing ones it is necessary to extend the range of tender competitions and in the interest of the smaller municipalities to liberalize the legal requirements and conditions.

It would serve the children's safety and healthy development, as well as the professionalism of physical education, if during the first six years of public education (grades one to six) only trained and qualified physical education teachers or retrained instructors (with a degree in the field of

physical education learning) could hold PE classes. It seems to be necessary to transform the system of physical education teacher's training and retraining in a way to adjust it, by harmonizing expert opinions, to the practical needs of the educational system. By making it possible that holding a 'physical education trainer' BA degree qualifies someone to teach during the first six years of public education, teaching the subject of physical education to the youngest pupils by qualified teachers would be ensured. On the other hand, the training of PE teachers would also intensify and less university students would lose their motivation between the BA and MA levels and switch to a different subject field. In the training and retraining of PE teachers more emphasis should be placed on the development those forms of behavior that have a positive attitude towards physical education and the healthy way of life. In order to help the pedagogues to obtain the necessary professional qualifications, supporting their professional retraining from the resources of the educational and maintaining institutions, as well as the state, should be prioritized.

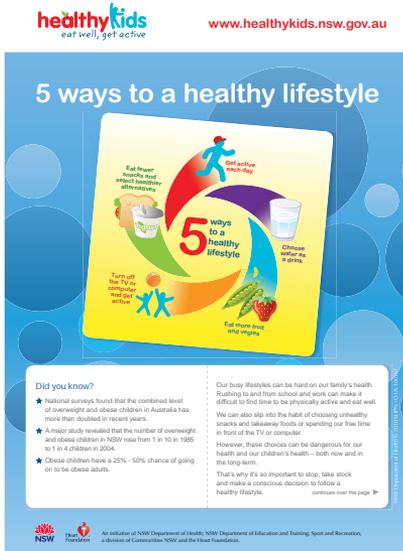
Sports equipments suitable specifically for children are often not available in the physical education classes. Therefore, it would be particularly important to establish a supervisory body to check if the technical and material conditions of teaching physical education are fulfilled. It is not acceptable that it depends on the financial situation of the educational and the maintaining institution if the equipments used in PE classes are in compliance with the quality standards and the accident prevention measures. This system of professional supervision would work continuously, following professional guidelines and on basis of action plans in order to ensure the professionalism of teaching PE classes, and to make sure that they meet the professional standards.

Although all educational institutions have incorporated the provision of daily physical exercise into their local curriculum or pedagogical program, the primacy of children's health education does not prevail in practice. Educational and training institutions do not offer physical education classes – held by a qualified PE teacher – to the schoolchildren every day and five days a week, as it is determined by law. Instead the number of PE classes is reduced, in favor of general education subjects to an average of 2–2.5 per week, which is the minimum allowed by law. Physical education should include the development of sports skills suitable for the children's individual abilities. It would also be useful to summarize the educational and developmental principles and methods of physical education and student sports, and distribute them in wider professional circles – for example, during training or retraining courses.

Currently, most educational institutions do not carry out the work of measuring and assessing the children's physical performance because, unfortunately, the data coming from these surveys have not been aggregated and analyzed recently by a central authority, thus in the lack of feedback this task has lost its meaning for the schools. In the future it is necessary to work out professional criteria and guidelines for carrying out such surveys and for evaluating the results. Special attention should be paid to the measurement of the children's physical condition and after the aggregated and individualized evaluation of the survey results it would be reasonable to elaborate a health development action plan.

The institutional and material conditions of student sports are provided for the children by the different municipalities (villages, cities, cities with county rights) in accordance with their development indicators. The majority of educational institutions do not organize sports activities themselves and where they do, it is not in compliance with the legal requirements. In the lack of financing from the maintaining institution, the costs of school sports are usually covered by the parents, if their financial situation allows. The number of hours devoted to sports activities, however, is determined not always or primarily in view of the children's interest but, rather, they serve the teachers and pedagogues in filling up their mandatory classes. Due to the widespread lack of funds for student sports the educational institutions are not able to purchase the necessary sports equipment, and the financial difficulties do not allow the organization of sports competitions within or between the schools.

The designation of school children into physical education groups is one of the school doctor's responsibilities within the framework of providing health care at schools. Unfortunately, medical examinations preceding this classification are conducted superficially, without assessing the real physical state of the child. During this screening, not all children with physical disabilities or handicaps are selected to designate them into therapeutic physical education or simplified PE classes, thus they do not receive therapeutic treatment. Therapeutic physical education works in an effective and organized manner in those educational institutions where school doctors and district nurses are employed full time. In most cases, there is no direct link between the school doctor and the physiotherapist. It would also serve the child's healing if the school doctor, the district nurse, the physical education teacher and the parents cooperated continuously. Many children referred to therapeutic physical education do not receive adequate care because they do not have access to physiotherapy within the framework of pedagogical services: due to the lack



of an adult company who could see the child to the location where physiotherapy organized at the sub-regional level, or because of the late afternoon time this service is provided. It would help solving the problem if the municipality maintaining the school could provide therapeutic physical education or physiotherapy within the institution and several times a week, and it could ensure their supervision by specialized doctors.

*The Commissioner found that in the case of those children who do not receive physical education care that corresponds to their health conditions because of the lack*

*of institutional, material, and human resources, the right to the highest possible standard of physical and mental health provided by the Constitution is violated, and this problematic practice breaches the prohibition of unfavorable discrimination.*

*The investigation also revealed that in the field of physical education provided at schools the professional supervisory system to guarantee the quality of care is missing, and no related professional protocols are available. In their absence the physical education teachers do not know the professional criteria on basis of which they could measure the children's physical condition or the time they should spend on this activity mandatorily. This uncertainty constitutes a violation of the requirement of legal certainty following from the principle of rule of law.*

## 2.4.

### Problems Related to Kindergarten Care for Children Infected with Hepatitis B

In the summer of 2010 a child, who was infected with Hepatitis B virus and had a legal relationship with a kindergarten, was taken back there by his mother, after a two-year long intermission, with a medical certificate in hands. On his very first day at the kindergarten the manager of the institution sent him back home. In his opinion the kindergarten could not take the responsibility for his spreading the infection. The manager would let him back to the kindergarten if a hepatology expert or the epidemiological authorities confirmed in writing that the child was not contagious.

Meanwhile, both the manager of the kindergarten and the parents turned to the regional chief medical officer. The chief medical officer informed the parents in writing on the questions they asked as well as the kindergarten that *according to law it is not possible to prohibit Hepatitis B virus carriers or anyone with a chronic disease from living in a tight community, and there is no reason for this separation from a professional point of view either.* He also offered to provide an information session to the kindergarten staff and the parents as well as to vaccinate those who request it. Following this, a representative of the epidemiological authority went to the kindergarten to inform the staff and the parents on this disease and the kindergarten asked the parents to declare if they want the vaccine or not but they refused it. Instead, the parents committed themselves in writing to take their children to another kindergarten if it is officially approved that the child infected with Hepatitis B could attend a kindergarten.

The parents of the child turned to the mayor and the notary to stand against the measures of the kindergarten's manager that he hadn't put in writing. Both addressees suggested to the parents to ask for the dispensation of the child from compulsory kindergarten education, based on his special situation, and offered the help of a kindergarten teacher. The parents didn't agree with the recommendation of the local government and turned to the Education Office.

The Education Office stated in its letter to the parents that it had no right to start any legal action in this special case but in their opinion, based on all the information they could collect, it was compulsory for a five-year old child to spend four hours daily in a kindergarten and this obligation could not be met due to the manager's act to force him to leave the kindergarten. The Office brought the free choice of education institutions to the parents' attention. Therefore they would regard it practical to choose a new kindergarten for their child, where his special needs could be taken into consideration and where they could devote an increased attention to the boy that he needed due to his chronic disease.

The mayor explained in his answer to the ombudsman that his goal was to keep the kindergarten intact and that he felt impossible to match one child's interest against that of the other 43 children's. The notary had informed the Commissioner that the child still had a legal relationship with the kindergarten, but his parents had already met the obligation of compulsory education by registering the child in another kindergarten for the school year of 2011–2012.

Based on the circumstances revealed, the Commissioner shaped up his view according to which, in accordance with the law, the doctor who had detected the disease took actions to seclude the contagious patient for the period of the virulence. The patient suffering from contagion must be quarantined at home, at his residence or at the inpatient care unit of a hospital. The patients suffering from a contagious disease that is specified in the *decree on epidemic diseases* needs to be quarantined and treated solely in an inpatient care unit of a hospital or in an assigned medical clinic. The doctor who had detected the disease needs to take actions to quarantine the patient and to determine, illness by illness, if the patient and his or her relatives need to be quarantined. The decree on epidemic diseases includes the following provision on Hepatitis B carriers: There is no need to put the relatives of the patient under epidemic surveillance. The measures taken on basis of the diagnosis of hepatitis infectiosa (e.g. ban of work, restraint from socializing etc.) must be repealed immediately.

The Commissioner pointed out that in his long term experience it anomalies in relation to several constitutional rights – right to dignity, right to the highest possible standard of physical and mental health, the child's right to protection and care, ban on discrimination as well as the principle of constitutional state and the failure of state's engagement to protect the basic rights – if not the doctor who had detected the disease

but someone else e.g. an institution takes an action on the seclusion of the patient with infectious disease, partly because these people have no authorization to take such an action, and partly because this question is strictly medical.

On the basis of all the above, the Commissioner is on the opinion that the manager of the kindergarten, by his action to exclude the child from the kindergarten, violated the rule of law and legal certainty, the child's right to dignity, protection and care, and the prohibition of discrimination.

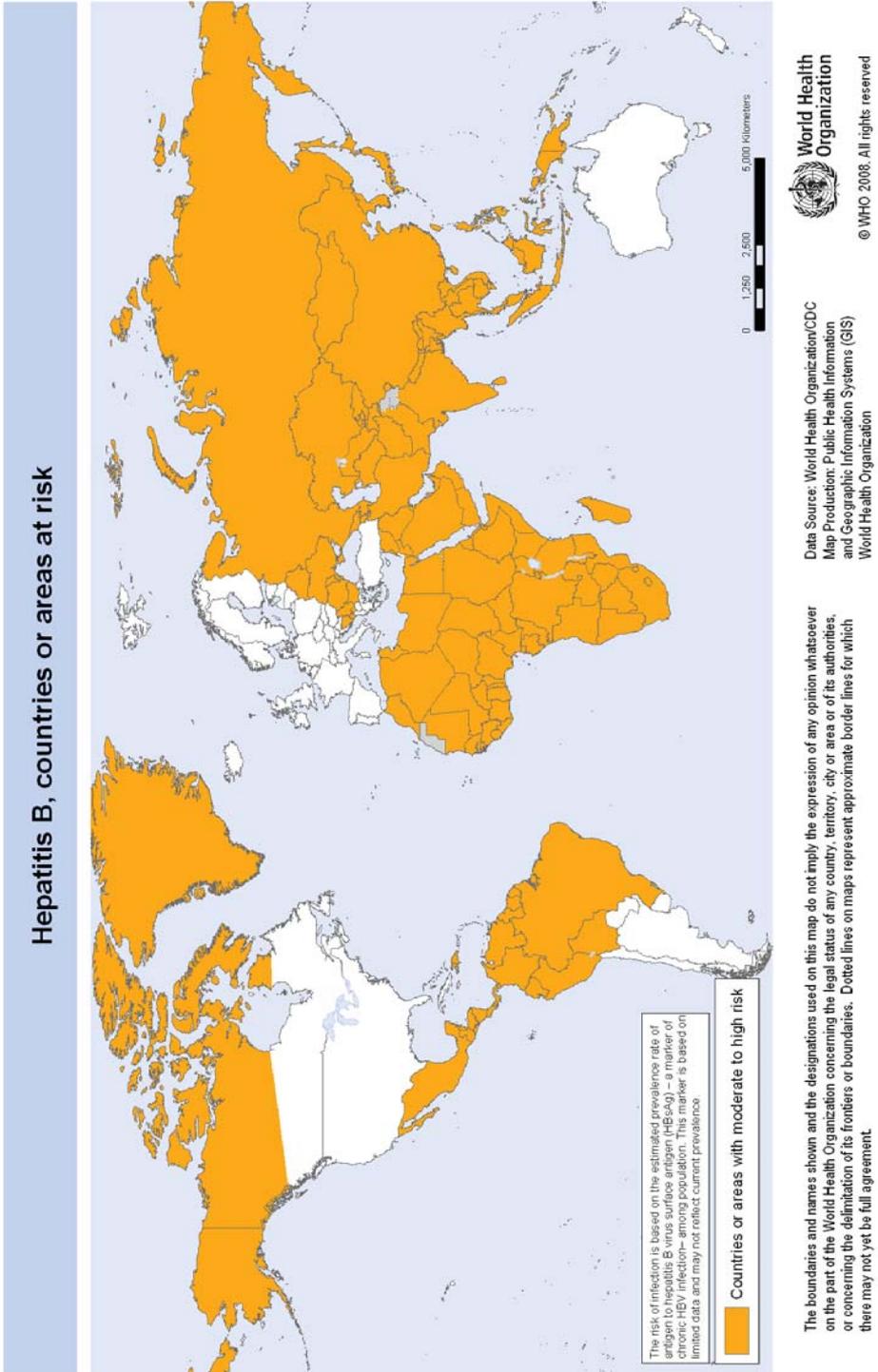
The Commissioner examined if it met the regulation on the participation in compulsory kindergarten education. Parents can decide if they want to take the kindergarten education up to the age of five. The parents' possibility to decide ends then. The child is obliged to spend four hours daily in a kindergarten from the year he/she has his/her fifth birthday. The aim of this obligation is to prepare the child for community life and for starting the elementary school.

Parents can ask for exemption from compulsory kindergarten education. The manager of the kindergarten can only make this decision if the parents ask for it. They can submit this petition if they want to. To make the use of this option is a possibility for the parents and the child. In the commissioner's opinion the manager, for his decision, needs to consider if it is necessary for the child to go to the kindergarten to be able to enter the school or for his normal socialization or not. He cannot make his decision considering personal or majority interests harmed or economic reasons, not even further operation of his establishment.

Taking all the above into consideration the answer which was given to the parents is unacceptable because the parents' request were not studied worthwhile as the encroachment on their right caused by the management of the kindergarten was not remedied but made it more serious by agreeing on the procedure of the establishment.

The ombudsman laid down that the organizations that monitored the catering of the child in the kindergarten (the mayor and the notary sustaining the kindergarten) failed to protect the basic rights in relation to the human dignity, the child's right to protection and care, the ban of discrimination, the principle of rule of law and the failure of its task of protecting objective basic rights.

The Commissioner studied the procedure of the Education Office and in his opinion the organization kept under authority control if the regulations on equal treatment – besides others – were kept. According to that all children in public education had the right to receive similar quality



care as others comparable to them under the same circumstances. When a person feels to be treated unfavorably due to the state of his/her health compared to another person or group in a comparable situation, it is regarded as a bias

Based on all the above the ombudsman stated that the Education Office hadn't act upon its range considering the merit of the case *and he hadn't consider the client's case according to the rules of public administration.*

To remedy all incompleteness they discovered, the ombudsman asked the minister to ensure that the Education Office's measures meet the regulations and initiated the regional bureau to start a review on what happened in the kindergarten.

To avoid similar cases the ministry informed the commissioner on measures they had taken on providing information.

## 2.5.

# Maladministration in Psychiatric Care

### 2.5.1.

## Deficiencies of Psychiatric Care for Children

### *The Reasons for Initiating the Investigation and Its Main Findings*

The Commissioner's investigation revealed that the children's state of mental health is more and more critical; the number of children struggling with learning difficulties and behavioral disorders is increasing steadily. During last year and the first half of this year, several children and young people below the age of 24 have attempted to commit or committed suicide. Currently, the care for children in acute crisis situation is not provided adequately, only some 60 to 70 child psychiatrist work in Hungary.

*In the opinion of the Association for Child and Adolescent Psychiatry*, the provision of psychiatric care for children and young people is severely underdeveloped. According to the recommendation of the World Health Organization, the number of psychiatrists for children and young people within a member state should be 20 percent of the number of psychiatrists for adults. Although in Hungary the number of psychiatrists for adults is already very low – not even close to the European standards – the number of children's psychiatrists is less than its 10 percent. In spite of this statistical data, children's psychiatry is not listed by the ministry among the medical professions facing severe shortage of resources, while psychiatry (for adults) and pediatry is.

Moreover, as the president of the association informed the Commissioner, specialist doctors work in a very uneven geographical distribution. Health care providers facing severe difficulties seek to reduce the number of doctors across the board, if possible; there is a moratorium on new recruits in most hospitals and clinics, and thus it is not in their interest at all to create jobs in areas where they do not even have a prescribed obligation to provide care. The number of doctors specialized in children's psychiatry

does not depend primarily on the reduction or shortening of the time for medical training (which could not be shorter than four years if the medical student intends to pass a basic certificate exam), but rather on other factors, such as who finances the students' training or will they have a job after they complete the specialist training. There are two solutions to improve the situation. One solution would be that the obligation to provide psychiatric care for children is explicitly listed in the relevant laws, thus forcing the health care providers to ask for capacity slots from the National Health Insurance Fund for specialized children's psychiatry care and, on this basis, ask for residency positions from the universities. The other solution would be that residency in children and adolescent psychiatry is financed from a central source for the entire length of the residents' training.

*This view is shared by the Hungarian Psychiatric Association.* The president emphasized that there are major concerns in Hungary about the emergency psychiatric care provided to children and adolescents. Younger children showing directly threatening behavior are admitted to pediatric wards, while the age group between 14 and 18 are admitted to adult psychiatric wards. In the view of the president, in the same way as large pediatric care centers operate, it should be ensured that an experienced child psychiatrist is available for consultation to assist the care of psychiatric patient children admitted to either the pediatric wards or the adult psychiatric wards.

The president of the Association for Child and Adolescent Psychiatry also informed the Commissioner that according to the 2010 report of the regional chief physicians in many subregions with a population over 100,000 child psychiatrist resident positions are not created, not even at the larger clinics, because this type of specialized care is not considered important and there is no legal requirement to provide care and fill in positions in this field.

*In the area of inpatient care, a serious general lack of capacity can be observed.* There are five psychiatric wards for children and adolescents (two of them in Budapest) that meet the quality requirements and where a comprehensive child psychiatry team provides patient care. In the Trans-danubian regions or in the North Hungary region there is no such psychiatric ward. Thus, in these areas it is not possible even to train child psychiatrists locally. After closing the National Psychiatric and Neurological Institute, the thirty bed capacity psychiatric ward for children and adolescents was admitted by a children's hospital in Budapest – but the age limit was set at 14 here, therefore there is no emergency psychiatric care for adolescents aged 14 to 18, which had existed under the former system of psychiatric care.

During the survey of the current situation in providing psychiatric

care for children and young people, it turned out that the specialization of child psychiatrist is not listed among the professions in shortage even though there are only 60–70 psychiatrist doctors in the field and their average age is quite high. Many of them continue their practice after retirement and there is a region where the only available child psychiatrist is 72 years old. According to a 2009 report of the Commissioner's office, out of the 64 doctors specialized in children's psychiatry, ten had a medical practice abroad and ten more did not work in their profession. During the following two years, fourteen more doctors earned certification in children's psychiatry but several experienced specialists have left the country.

*The number of institutions providing inpatient psychiatric care is extremely low and their availability varies greatly across the different regions. In the Western half of the country there is no active inpatient psychiatric care for children at all. In this half of the country children patients of psychiatric care are placed either in pediatric wards or treated together with adult psychiatric patients, without the specialist supervision of a child psychiatrist or a medical consultation. The situation is the same in the region of North Hungary.*

There are very few institutions in which the conditions of emergency care are provided and the county level public health administrations do not have records on the location of emergency care units, thus they cannot regulate this issue. As a result, providing care for children patients is often completely random and unpredictable.

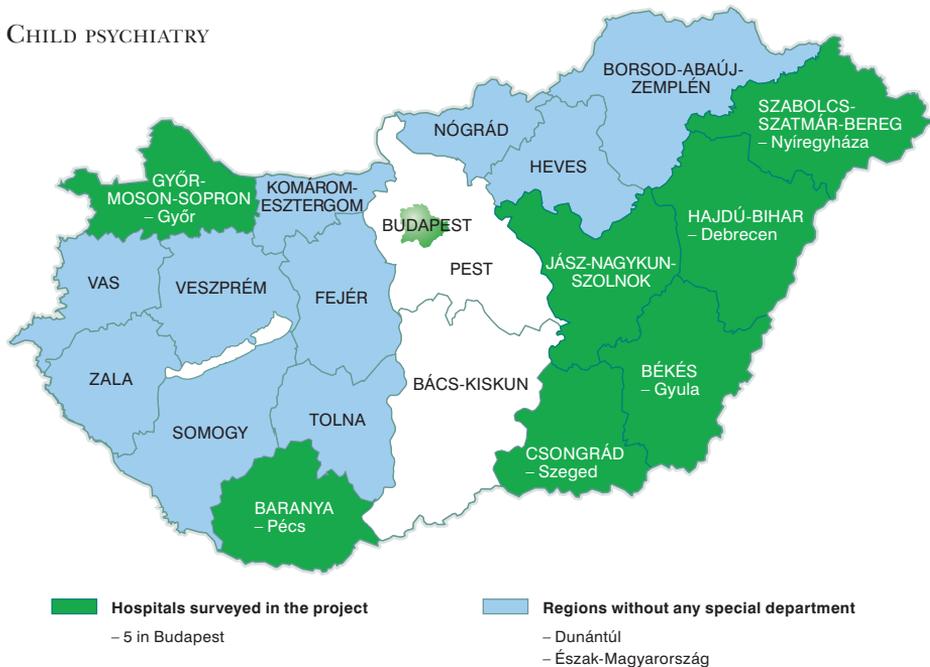
The Commissioner has determined that *all these violate the rights to health and to health care, the right to self-determination following from the right to human dignity, as well as the principle of equal opportunity.* In the report, the ombudsman called upon the minister responsible for social affairs and health care to

- take determined and coordinated action to ensure that the lack of access to inpatient and emergency child psychiatric care is eliminated in the regions of Hungary affected by this phenomenon;
- take measures to create the necessary conditions for increasing the number of child psychiatrists and, in the current situation, reclassify child psychiatry as a profession in shortage;
- examine what kind of government measures could ensure the elimination of the deficiencies observable in the provision of the necessary conditions for parental presence at the psychiatric wards for children and young persons;
- order the Chief Medical Officer to keep record of the institutions

that provide emergency psychiatric care for children and ensure the preparation of the procedures for emergency referral in line with real data and

- take action to ensure that the National Health Insurance Fund keeps a consistent and credible record of the active child psychiatrists and confirm if the places of providing psychiatric care for children in Hungary are all listed under the same professional code number reserved for child psychiatry.

#### CHILD PSYCHIATRY



#### 2.5.2.

#### The Special Rights of Psychiatric Patients

In relation to the encroachment of the rights of psychiatric patients, the following three typical problems may be identified:

1. *problems* related to the title and execution of ordering an emergency patient transport;
2. in case of emergency compulsory admission, *omissions* related to the objective deadline of ex-post notification of the court;
3. *disregarding* the procedures laid down for the application of restraining measures.

*Problems Related to the Title and Execution of Ordering Emergency Compulsory Admission*

According to the *Act No. CLIV of 1997 on Health Care*, if a psychiatric patient manifests a *directly threatening behavior* and this can be thwarted only by immediate compulsory admission to institutional psychiatric care, the doctor discovering such behavior must take immediate measures to transfer the patient to a suitable psychiatric institution. If necessary, the police might take part in the process of compulsory admission.

*Threatening condition* is a general term that is also used by the Health Care Act: the act makes numerous references to it (e.g. in the chapter on patients' rights or during determining the rules of emergency rescue), but in the chapter on the medical treatment and health care of psychiatric patients, it is not mentioned. Among the provisions of this act related to the rights of psychiatric patients only the concepts of *threatening behavior* and *directly threatening behavior* are mentioned. The primary reason for this is that the difference between the legal consequences connected with these terms is significant.

1. *Threatening condition*, as a general term, denotes a condition that *would present a direct threat* in the lack of taking immediate measures. The applicable measure may be anything; therefore it denotes a general intervention.
2. In comparison, *threatening behavior* is a *special* term that is applicable explicitly in the case of psychiatric patients. It denotes *behavior*, a certain activity or a lack of activity, which *may presumably present a serious threat* to life, health, or bodily integrity, but emergency compulsory admission to psychiatric care is still not justified.
3. *Directly threatening behavior* is also term that is used specifically in relation to psychiatric patients, which *presumes high likelihood* or almost certainty. In other words, it denotes active behavior, or the lack of it, which *presents an immediate and serious threat* to life, health or bodily integrity.

It is clear that a measure limiting someone's personal freedom may be, and should be, carried into effect only in case all conceptual elements of a *directly threatening behavior* are present (even in those cases when this measure is necessary to protect the patient's life, health, or bodily integrity from himself or herself). It is important that these conditions are conjunctive: the patient's behavior should present a direct and serious danger *during compulsory admission*. Therefore, a mere likelihood that a

person might be dangerous is not enough; the patient should present a direct and serious threat in order to trigger these measures. In the cases of applying the most restrictive measures on personal freedom, law requires the high probability of the occurrence of a similarly grievous action as a compelling constitutional justification for such measures.

The national chief medical supervisor for psychiatry has investigated such a case and he states that, on grounds of expert opinions and the details of the case, the patient's directly threatening behavior was verifiable.

It infringes upon the fundamental right to personal freedom and, in connection with it, to human dignity of the patients compulsorily admitted to a psychiatric institution if emergency compulsory admission is ordered by the prescriber only in the case of encountering directly threatening behavior (when all necessary conditions are present) and this fact is not recorded in a verifiable way in the medical documentation.

#### *Omissions Related to the Objective Deadline of Ex-Post Notification of the Court*

According to the Health Care Act, as mentioned above, if a psychiatric patient manifests a directly threatening behavior and this can be thwarted only by immediate compulsory admission to institutional psychiatric care, the doctor discovering such behavior must take immediate measures to transfer the patient to a suitable psychiatric institution. If necessary, the police might take part in the process of compulsory admission. The act also determines that within 24 hours after the admission of the patient, director of the psychiatric institution seeks to verify the justification of compulsory admission by notifying the court before the mandatory institutional psychiatric treatment of the patient can be ordered. The court, in turn, has to come to a decision within 72 hours after receiving the notification, and before the decision is made the patient can be kept under temporary detention.

The above rule clearly prescribes when the court should be notified: it should be done within 24 hours following the admission of the patient – and not the day after admission or the first work day after admission. The strict deadline is a legal guarantee stated in the Health Care Act and its purpose is to reduce the limitation of the patient's personal freedom to the shortest possible time before the court comes to its decision.

This deadline is frequently breached when the compulsory admission takes place on a Friday or during long holidays lasting several days. By

failing to comply with the provision stated in the act on the deadline of notifying the court, the health care institutions *caused an anomaly in relation to the right of the complainants to their personal freedom.*

### *Disregarding the Procedures Laid Down for the Application of Restraining Measures*

According to the Health Care Act, the personal freedom of a patient



may be limited by any means (by physical, chemical, biological methods or procedures) only in the case he or she manifests threatening or directly threatening behavior. This limitation may last only as long as it is, and may have an extent or character that is, inevitably necessary to thwart the danger. The law stipulates that the pa-

tients' rights representative and the patient's legal proxy or authorized representative shall be notified, without delay, on ordering any restraining measure, and if such interventions take place they have to be documented and justified in detail.

A ministerial decree contains the detailed rules on documentation and on the restrictive measures applicable during the admission of psychiatric patients into institutional care. A supplement to this decree is the form that should be filled out whenever a restraining measure is taken. In accordance with the provisions of the Health Care Act, the decree also states the rules of notifying the patients' rights representative and the patient's legal or appointed proxy. In addition, the psychiatric patient under the effect of the restrictive measure may notify other persons, if this does not endanger the aim of the measure. If the patient is unable to exercise this right, the person he or she wishes to notify on the restraining order is to be contacted by the psychiatric institution.

It is a widespread problem that this supplement of the decree is not filled out properly. In a case investigated by the ombudsman in 2010, for example, the section on notifying the patients' rights representative was left blank, thus the representative was not notified immediately as it is prescribed by law. The sections following the notification of the patients' right representative are also missing, thus it is not clear if the patient's legal or appointed proxy, or any other person the patient wanted to inform, was in fact notified. Moreover, it was also not obvious from the form if the head in charge was duly informed (and, if yes, when).

The above ministerial decree states that the psychiatric institute shall work out a detailed protocol on the rules of ordering and applying restrictive measures. This protocol shall include:

- a) the rules of ordering restrictive measures, taking the work schedule of the institution into consideration;
- b) the maximum duration of the specific forms of restrictive measures;
- c) the rules of monitoring connected to the specific forms of restrictive measures;
- d) the rules of lifting the restriction;
- e) the rules on the rights and duties related to the restrictive measures; and
- f) the detailed rules of exercising the right to complain.

The decree also prescribes that the document containing the protocol should be made public for the psychiatric patient, the patient's legal or appointed proxy, and the employees of the institution by putting it up in a clearly visible place.

In the investigated case, the psychiatric institution did not have a protocol; therefore it could not be made public. On basis of the attached medical documentation, it could also be established that neither the patients' rights representative, nor the authorized person was notified immediately after the restrictive measures were taken during the psychiatric care. (The documentation also did not have any information on the person the patient might have wanted to notify because there was no trace of it.)

Thus, by failing to provide adequate documentation on the restrictive measures and to notify the persons and institutions prescribed by law, the health care institutions *caused an anomaly in relation to the right of the complainants to human dignity and to fair procedure*. Failing to produce the protocol stipulated mandatorily by the ministerial decree, in itself, *violates the requirement of legal certainty following from the principle of rule of law and is capable to constitute the direct threat of infringing the right to human dignity and to personal freedom*.

### *Deficiencies of the Professional Review*

In relation to the problems detailed above, it could be stated that the legal requirements are unequivocal and clear; their implementation and enforcement do not call for any particular interpretation. It is also obvious that in the investigated cases the legal guarantees related to this special range of patients were not complied with. In the investigations of the

Health Insurance Supervisory Authority and the competent professional authority, the task of the experts acting in the case is to assess the issues related to the medical profession and to see if the relevant professional protocols and the standards of care are complied with. Besides this, the Supervisory Authority also checked if the legal provisions ensuring the enforcement of patients' rights are complied with – but this investigation was unfinished because the Supervisory Authority was closed down. All ongoing procedures were transferred to the competent professional authority, the chief medical supervisor for psychiatry.

The chief medical supervisor for psychiatry stated that the hospital did not break rules or committed omissions in this case. The Commissioner found that the competent professional authority, during its procedure, disregarded some of the provisions of the Health Care Act relevant for the enforcement of patients' rights. For example, it departed from the clearly stated formulation of the law (“within 24 hours”) and used a qualitatively different phrase (“within the time and in the way allowed”) in the investigation and this condition, which is *not* in accordance with the law, was the basis of declaring the appropriateness of the procedure. Concerning the application of restrictive measures, although he inspected its documentation, but did not find the documentation lacking and therefore could not state that the patient's rights were infringed upon.

The unlawful operation of the health care provider was not recorded in either case; therefore the competent professional authority did not take any further action (for example, did not formulate recommendations for avoiding future omissions), and did not notify the maintaining institution that the conditions are not suitable for complying with the legal requirements. By his arbitrary interpretation of the law during the investigation of the case, which led to the disregard of the above mentioned clear rights infringements, the national chief medical supervisor for psychiatry caused anomalies in relation to the requirement of legal certainty following from the principle of rule of law.

## FINDINGS AND RECOMMENDATIONS

From the above it is clear that the omissions infringed the fundamental right to personal freedom – and, in connection with this, the right to human dignity – of the persons compulsorily admitted to a psychiatric institution. The omissions caused anomalies in relation to these persons'

right to fair procedure and to the requirement of legal certainty following from the principle of rule of law.

According to the Basic Law, in the Republic of Hungary, “every person shall have the right to freedom and personal safety. No person shall be deprived of his or her liberty except for statutory reasons or as a result of a statutory procedure. ... Any person suspected of and arrested for committing any offence shall either be released or brought before a court as soon as possible. The court shall be obliged to give such person a hearing and to immediately make a decision with a written justification on his or her acquittal or conviction.”

The Constitution follows international examples in regulating the right to personal freedom, the conditions of limiting this right, the special guarantees in case of depriving a person of his or her freedom, and the legal consequences applicable in case of violating this fundamental right. The Constitution recognizes and protects the right of all natural persons to freedom and personal safety and this fundamental right may be limited only for statutory reasons and as a result of a statutory procedure. A special guarantee in case of depriving someone from his or her freedom is the right to be brought before a court (*habeas corpus*).

In relation to the fundamental right to freedom, the Constitutional Court pointed it out in a 2000 decision that “enforcement of [this] right can be examined in assessing the constitutionality of all state measures that actually affect personal freedom [...] The right to personal freedom can be invoked on the merits in assessing the constitutionality of any statutory regulation restricting free movement and locomotion. [...] The constitutionality of restricting such rights can be assessed on basis of the requirements applicable to any restriction of fundamental rights. [...] The provisions of the [Health Care Act] on psychiatric patients undoubtedly influence the enforcement of the right to personal freedom specified in Article 55 para (1) of the Constitution.”

According to the Constitutional Court, it is a constitutional requirement concerning the restriction of personal freedom that the restriction should be compliant with the criteria of necessity and proportionality. It should be clear that psychiatric patients, obliged to undergo institutional psychiatric treatment as a result of their threatening condition and behavior, do not lose their fundamental rights because of this. The starting point of contemporary constitutional law is that compulsory institutional treatment of psychiatric patients is one of the most severe forms of restricting personal freedom. In relation to this, the Supreme Court of the United States stated in a number of decisions that compulsory psychiatric

treatment is a more severe restriction of personal freedom than imprisonment, considering the use of psychotropic substances during treatment and the stigmatizing character of a mental disorder.

Ordering compulsory treatment in a psychiatric institution, also with respect to its legal justification, is special in that it is directed towards medical treatment and not punishment. The constitutional condition of applying interventions that restrict personal freedom is that the psychiatric patient presents a direct and serious threat to oneself or others and, because of the lack of full disposing capacity, he or she is unable to make a decision alone on the necessary medical treatment.

According to the Constitutional Court, “it can be established on the basis of the European Convention of Human Rights and the judicial practice of the Court’s case-law as well as the international documents mentioned that in the case of mental patients, the endangerment of the patient himself or of the public may justify the restriction of personal freedom and mandatory psychiatric medical treatment. Both the international documents and the case-law of the Court focus on procedural guarantees, namely that the restriction of liberty on the grounds of mental illness should not be arbitrary and it shall be limited to the necessary degree and duration.”

The *highest procedural guarantee* of the right to personal freedom is that without a court decision following a procedure prescribed by law, no one can be deprived of his or her liberties and, as a general rule, *the court should make its decision in advance*. If, for some legitimate reason, it is not possible for the court to rule on the deprivation of someone’s freedom in advance (thus, in the case of a psychiatric patient demonstrating threatening behavior), then it follows from the Constitution that the person detained *should be brought to court as soon as possible*. Individuals should receive adequate protection against the decisions made by the authorities in violation of their fundamental rights – and this protection is realized through the *obligatory and immediate court control* of the detentions initiated previously, without a court decision.

The Constitution provides only for the procedure of bringing those persons to the court that are suspected of and arrested for committing a criminal offence, but the right to personal freedom applies to persons living on the territory of the Republic of Hungary even outside of criminal procedure. Therefore the guarantees necessary for the enforcement of the right to personal freedom should be *ensured also for the cases of detention outside of criminal procedure*.

According to the Constitution, the detainees “shall either be released

or brought before a court *as soon as possible*” and the judge must “make a decision ... *immediately*”, without delay. The Basic Law of Hungary, therefore, does not provide a concrete deadline for bringing someone to the court. Instead, it delegates the determination of the details of this to the legislative level: in this case, the rules are specified in the Health Care Act.

In the practice of the European Court of Human Rights, it is always the specific circumstances of the individual case that *determine what constitutes “without delay”* – but bringing the patient to court after more than four days of detention is unlawful even in extraordinary situations. The deadline has to be determined in a way not to hinder the activity of the law enforcing authorities and the detention should last only as long as it is necessary to prepare for the court procedure. This duration should not be longer than three to four days even in extraordinary cases. Weekend days and holidays are included in the deadline in almost all European states. The enforcement of a fundamental right is well worth the establishment of a “weekend duty” system of courts and authorities entitled to order the deprivation of freedom.

Therefore, the limitation of personal freedom ordered or executed without legal guarantees, or in the face them, *violates the right to personal liberties*. In case the psychiatric institution sustains detention but *fails to bring the patient to the court*, or does not bring him or her to court in compliance with the legal requirements, then it induces the violation of the right to personal freedom as acknowledged by Article 55 (1) of the Constitution. It is the constitutional obligation of the authority that sustains detention to bring those persons to court that have been deprived of their freedom without a court order.

With regard to the above the Commissioner has taken the following measures:

1. *called upon the Chief Medical Officer* to initiate measures in order to ensure that inquiries into the patients’ complaints are conducted in accordance with law, in the form of a substantive and not only formal review of whether the health care service providers comply with the norms relevant for them;
2. *called upon the health service providers targeted by the inquiries* to act in accordance with the relevant legal requirements during their provision of psychiatric care; to comply with all documentation and notification obligations in relation to the limitation of the patients’ personal freedom; and to comply with the legal requirements



placed in an observation room and was administered parenteral injection as a constraint measure, which was duly documented.

Thus, the court ordered the monitoring of the complainant's mental condition. However, the concrete professional content of the monitoring, as that of the compulsory treatment too, is unclear at the legislative level. At the same time, it is evident that monitoring and treatment have two different meanings; treatment being a much broader concept than monitoring.

By ordering the monitoring observation, the court obliges a person to enter in a psychiatric institution for a specified period of time and to stay there for the monitoring of his or her mental condition. Nevertheless, the legislation does not specify what exactly the obligation of "staying at the institution" covers in a given case. Since, in practice, the court does not make a decision on this issue, it is left to the physician's (professionally based) discretion if the patient is required to stay in the hospital during the whole period of observation, or may return home after the necessary observation, examination, testing, and so on, is done. Thus, for example, during the weekends or other holidays, when there is no specialist in the institution to conduct the monitoring observation, the patient's staying at the institution might be unnecessary.

The existence of different directions of interpretation is confirmed by another petition, in which the complainant objected that the assigned health care institution interpreted the court's injunction on a one-month long mental condition monitoring session in such way that the patient was released and could return home for the periods between which the particular examinations were carried out and, in this way, the patient actually spent only a few days at the institution instead of one month.

Since the concrete professional content of the monitoring is unclear, it can be stated – in agreement with the opinion of the National Psychiatric Center – *that the law enforcing health care staff may have serious difficulties in deciding, based on the legislation in force, what kind of interventions and restricting measures can be applied in case of the accused persons referred for the monitoring of their mental condition.* On this issue, the Code of Criminal Procedure provides simply that during the monitoring of mental condition the freedom of the psychiatric patient may be restricted only in accordance with the provisions of the Health Care Act. However, the provisions of the code of criminal procedure are not adequately harmonized with those of the Health Care Act, for the latter one states that *only patients that manifest threatening or directly threatening behavior can be restricted in their personal freedom by applying any*

*method* (by physical, chemical, biological or psychiatric techniques or procedures).

Thus, according to the narrow interpretation, no restrictive measures could be taken, except when the monitored person manifests threatening or directly threatening behavior. In such case the provision of the Health Care Act on emergency medical treatment would apply, according to which the head of the psychiatric institute shall initiate, by notifying the court, the ordering of compulsory medical treatment at a psychiatric institution. This, however raises a further dilemma, namely that while the monitoring of the mental condition is ordered by the criminal court, the compulsory treatment is ordered by the civil court, in the framework of a non-litigation procedure. The details of the relationship between the two types of court procedure are not clarified either on the level of legal regulations.

*The code of criminal procedure therefore does not elaborate the kind of restrictive measures that can be taken during the observation in the case of persons referred to mental condition monitoring, or to prevent the incidental unauthorized leave of the accused person.*

In contrast to the monitoring observation, compulsory medical treatment is ordered in case of threatening or directly threatening behavior and, when it happens, the institution is authorized to carry out psychiatric treatment as well, including the application of chemical or biological restraints. The concerned person must undergo the treatment deemed to be necessary for professional considerations even against his or her will, at the cost of breaking his or her will.

No doubt, legal regulations have several deficiencies in this area. Nevertheless, according to the view of the Commissioner, if the condition of the patient referred for mental condition monitoring makes necessary the application of chemical or biological restraints – namely the patient manifests threatening or directly threatening behavior – the institution shall apply the Health Care Act, which means that it has to initiate at the court the ordering of compulsory medical treatment in a psychiatric institution. In the lack of all these, the institution has no lawful authorization for the treatment.

Based on the Health Care Act, if a psychiatric patient manifests a directly threatening behavior and this can be prevented only by an immediate compulsory admission to institutional psychiatric care, the doctor discovering such behavior must take immediate measures to transfer the patient to a suitable psychiatric institution. If necessary, the police might take part in the process of compulsory admission. The act also deter-

mines that *within 24 hours* after the admission of the patient, the head of the psychiatric institution should seek to verify the justification of compulsory admission and the medical treatment by notifying the court before the mandatory institutional psychiatric treatment of the patient can be ordered. *The court, in turn, has to come to a decision within 72 hours* after receiving the notification, and before the decision is made the patient can be kept under temporary detention.

In the ombudsman's view *the corresponding provisions of the Health Care Act can be applied without any problems*, also in the case of patients referred for mental condition monitoring, regardless of the fact that the relationship between the two court procedures (the criminal court ordering the mental condition monitoring, the civil court deciding on the compulsory medical treatment) is indeed not sufficiently regulated. In the case of the complainant the court ordered the monitoring of his mental condition, therefore it *did not authorize treatment*, including biological or chemical restraint.

Based on the adequate interpretation of the fundamental constitutional right to human dignity and personal freedom, and in light of the existing legal guarantees, the range of procedures that the institution may initiate is strictly limited, also in cases similar to the investigated one:

1. If the patient manifests threatening or directly threatening behavior that makes the application of biological or chemical restraint necessary, then the head of the institution shall initiate without delay, in compliance with the Health Care Act, the ordering of the emergency or compulsory medical treatment, in the absence of the patient's capacity of discretion and, consequently, in the lack of his or her consent.
2. If the patient, however, does not manifest threatening or directly threatening behavior, and simply does not want to stay at the psychiatric ward and does not want to accept that his or her hospitalization, then the application of chemical or biological restraints, even in compliance with the law in force is, in the ombudsman's view, offending and should not be allowed.

*In conclusion, the Commissioner found that the health care institution – by applying chemical and biological restraints without the observance of the legal guarantees provided in the Health Care Act (such as notification of the court without delay) and by the arbitrary interpretation of these rules – caused an anomaly in relation to the complainant's right to human dignity and personal freedom.*

The Commissioner has called upon the *general director of the hospital*

- a) to ensure that, according to the law, the use of any biological or chemical restraining measure should be avoided in the institution during the *monitoring of the mental condition*;
- b) to make sure that in the case of a patient's *directly threatening behavior*, the hospital acts strictly in view of the relevant legal requirements: in each case it complies with the documentation and notification obligations related to the restriction of a patient's personal freedom and, in the case of an emergency psychiatric treatment, with the legal requirements related to the notification of the court; and
- c) to work out a detailed protocol on the rules of ordering and applying restrictive measures as prescribed in the ministerial decree and put it up in a clearly visible place.

The Commissioner also called upon the minister responsible for health to take coordinated action together with other ministries to initiate the amendment of the Health Care Act and the Code of Criminal Procedure for the following purposes:

- a) to determine, unequivocally and clearly, by dissolving the observed controversies, the minimum standards necessary for the protection of fundamental rights in relation to the exact duration of monitoring mental condition; the protocols to be followed in the case the observed persons manifest threatening or directly threatening behavior; and the possible interventions and restraining measures that can be applied;
- b) to create high-security forensic units for the patients with directly threatening conditions (and for their environment) as well as – in case it is justified and follows professional protocols – for the monitored patients to ensure that they remain safe during their hospitalization.

#### 2.5.4.

#### Significance of the Threatening Condition: The Aggressive Patient – The Aggressive Home-Care Patient

It is a fact beyond dispute that sick people are in a vulnerable position. This statement is also true in the case of patients with psychiatric disorders. They need assistance in protecting their human dignity and in enforcing their right to self-determination and health. In some of his activities, the Commissioner has already been paying special attention

to monitoring aspects of the fundamental rights of social and health care provided to people with disabilities and to psychiatric patients.

The thorough examination of the institutional treatment and care of aggressive psychiatric patients has been justified by the fact, that during the last year, several complaints have been received from parents of young patients with psychiatric disorders who have asked for assistance in the residential placement of their children. The complainants reported that they were unable to find – neither near their homes nor sometimes even anywhere in the country – a medical institution or nursing home that could provide long-term care for their aggressive special-needs children exhibiting (directly) threatening behavior.

The minister responsible for social affairs pointed out that the legal rules in force do not allow the admission of aggressive psychiatric patients to psychiatric care institutions. Currently the treatment and care of these patients takes place within the health care system of Hungary in psychiatric wards given that there are no so-called high-security units, except for the Forensic Psychiatric Mental Institution appertaining to the penitentiary system. In his view, such “civilian” high-security units provided with special personal and material conditions could ensure a context which would be safe for both the aggressive psychiatric patients and health care workers, while meeting medical care criteria. The ministry plans the implementation of a new high-security unit with a double-gate entry system, equipped with three times 15 beds, operating as part of a new national institution with the specific purpose of treating and caring for aggressive psychiatric patients.

The number of severely violent patients who need long-term placement cannot be determined at present, as patients’ conditions may vary or improve in function of their treatment and the passing of time. For the time being, the Minister considers this number of beds both necessary and sufficient. The current welfare system is designed in such a way that the long-term institutionalization of psychiatric patients is not the task of the health system, but is almost exclusively the duty of the social welfare system. The treatment and care provided within the social institutions is not enough for a certain portion of psychiatric patients who require long-term medical care. This is recognized in the case of psychiatric patients who have committed criminal acts, and who receive long-term treatment in the Forensic Psychiatric Mental Institution. However, no adequate psychiatric institutions are available for those aggressive patients who have not (yet) committed criminal acts on account of which they could be sent to the Forensic Psychiatric Mental

Institution, but would need long-term preventive treatment. A considerable legal uncertainty may be experienced among the law enforcement bodies as regards the practice of dismissal from a psychiatric nursing home of psychiatric patients under urgency or compulsory psychiatric treatment. More detailed and clear regulations are needed because the dismissal of the patient from the institution, or the refusal to so, leads to a situation when the law enforcement bodies need to decide upon the restriction of the patient's fundamental constitutional right.

The legal basis for compulsory treatment is the threatening behavior. Under the law, the patient must be dismissed from the institution if the patient's medical treatment is no longer justified. This provision is very difficult for medical experts to interpret, especially because no medical treatment qualifiers are specified. Patients who (would) require compulsory medical treatment as a rule have mental disorders which require lengthy and often lifelong medical treatment. When the statute is interpreted in this light, the patient may in principle be kept in the institute for a very long time, provided that this is also approved by the court review. However, long-term institutional care has organizational, institutional and financial limitations.

The current legislation stipulates only the procedures to be used as a restrictive measure, but does not specify whether compulsory medical treatment may go beyond the restrictions or not. The significance of the above is that, based on these laws, restrictive measures may only be used to avert (directly) threatening conduct. The legislation does not provide guidance as to what healthcare workers can do once the (directly) threatening conduct has ceased.

The Commissioner has previously dealt with the problem described above when he investigated a psychiatric nursing home in a Hungarian town. This institution treated its most problematic patients in its Department No. 7, which still has an extremely large number of patients – that is 33 patients struggling with disabilities, mental illnesses, addictions or any combinations of these. The main purpose of creating the department was that patients who are difficult to handle, require greater control, supervision and endanger other patients would be placed there, as they just cannot integrate into the normal community due to their state and condition.

One of the patients, who has been living in the institution since 1996, has a moderate mental disability. Previously he lived in at least 20 different institutions where he received treatment and took part in development programs but his low tolerance, intellectual deficit, impulsive

behavior, and uncontrollable outbursts of rage thwarted his development and treatment. As a constant threat not only to caregivers, but also to his fellow patients, he had to be separated and lives alone in a room furnished with bolted-down furniture. The institution is still looking for a place of treatment that would suit his condition. Attempts to transfer him have been made on several occasions, but without success so far.

In this report, the Commissioner reached the conclusion that currently Hungary has no treatment institution which would provide treatment for acute, aggressive psychiatric patients who show violent behavior repeatedly.

The court orders the compulsory institutional medical treatment of the psychiatric patient who displays threatening conduct, but for whom no emergency medical treatment is justified. The process of ordering the compulsory medical treatment is initiated by the specialist physician of the mental health care institution establishing the necessity thereof, by informing the court. The physician recommends a psychiatric institution to perform the medical treatment. The court shall review the compulsory institutional medical treatment every 30 days. The institution shall dismiss the patient compelled to undergo compulsory institutional medical treatment if the patient's medical care is no longer justified.

In accordance with the provisions of the Social Care Act, it is only chronic psychiatric patients who, at the time of their admission, are not in a threatening condition and due to their health condition and social situation are not capable of self-care even with assistance, may be admitted to psychiatric nursing homes. A claimant whose underlying disease determined by the physician is severe antisocial personality disorder, with a personality disorder rendering him/her incapable of coexisting with others may only be admitted to the psychiatric patients' nursing home if the institution is also able to provide treatment in connection with the claimant's underlying disease.

If the recipient of the medical service requires emergency medical treatment due to his/her health status, the medical officer responsible for the health care provider shall initiate the patient's psychiatric medical care.

Pursuant to the provisions of the Social Care Act, the recipient of the service of the social institution providing personal care has a right to the full range of services provided by the social institution with regard to his/her social situation, health or mental state, and to benefit from

the individual treatment and the services of the social institution on the basis of his/her special situation or condition. The requirement of equal treatment must be upheld during the provision of social services. The institution shall perform its services in full and comprehensive compliance with the constitutional rights of the treatment recipients by paying particular attention to their rights to life, human dignity and physical integrity, physical and mental health. Based on the provisions of the above legislation, the differences between the two forms of care – treatment in a social nursing home or hospitalization in a psychiatric ward – may be summed up as follows:

The patient may only receive compulsory hospital treatment if the patient exhibits threatening or directly threatening behavior. The psychiatric wards of hospitals carry out medical treatments and patients must undergo these treatments if the patients are threatening (or may threaten) the life, physical integrity or health of others or of their own.

No patients in a threatening condition or requiring acute hospital treatment may be admitted to the nursing home. Only those psychiatric patients may be admitted to these institutions who are incapable of self-care even with assistance, or if there is no person who could provide such assistance. Those patients whose underlying disease is severe antisocial personality disorder, or a personality disorder making them incapable of living in a community, may only be admitted to the nursing home if the institution is also able to provide treatment in connection with the claimant's underlying disease.

*The Commissioner's report found that neither the Health Care Act nor the Social Care Act provide for the long-term care and/or institutional nursing care of those psychiatric patients who temporarily do not exhibit threatening or direct threatening behavior due to the hospital treatment but in whose cases this behavior periodically recurs, even despite the medication recommended by the specialized physician, and who accordingly need special care.*

Consequently, in accordance with the above, it is also the constitutional right of aggressive psychiatric patients to have access to adequate health care - not only in the psychiatric wards as part of the compulsory institutional medical treatment, but also during their long-term institutional care. The question is whether any institutions providing long-term care and/or special health care for psychiatric patients with recurrent threatening behavior related to their health status exist in Hungary at all.

During the inspection of the institutional care provided for psychiatric patients, the ombudsman found that the legislation in force does

not offer clear and unequivocal guidance as to which institutions should provide long-term care for psychiatric patients exhibiting aggressive behavior, how long their institutional medical treatment should be, or when they can be released from the psychiatric ward. The report also pointed out that the statutory provisions are silent as to which institutions are suitable for providing long-term care for aggressive psychiatric patients.

Pursuant to the data of the investigation conducted by the ombudsman in this matter some of the social nursing homes, such as the Kiskunhalas nursing home, attempt to provide care and treatment for aggressive psychiatric patients, but they fail to provide the care which would suit their condition. Moreover, they need to take serious efforts to protect the physical integrity of the rest of the patients or to prevent the patient from committing acts of self-harm. Providing decent living conditions for these patients in these nursing homes is almost impossible.

The question arises whether it is the exclusive task of the social sector to provide long-term institutional care for patients who temporarily exhibit recurring (direct) threatening behavior or whether the effective contribution of the health care system is also necessary for ensuring that psychiatric patients who need lifetime care would receive care appropriate to their status. *The relevant legal rules in force do not provide a clear answer to this question. As a consequence, there is currently no institution in Hungary which would be suitable for caring for these patients – in some cases, for the rest of their lives.*

The Commissioner established that the existing legal framework infringes upon the rule of law and the principle of legal certainty arising therefrom. At the same time, the total absence of the long-term residential care institutions is contrary to the requirement of equal treatment, and infringes on the right to human dignity and health of the affected people, including the right to health care.

Therefore, the Commissioner calls upon the Minister to develop the legal framework of the long-term institutionalization of aggressive psychiatric patients by concurrently determining the personal and material conditions, and to clarify the legal provisions concerning the compulsory institutional medical treatment in the interest of a uniform application of the law. The Commissioner also calls upon the Minister to take firm steps for the implementation of institutions providing long-term residential care for psychiatric patients exhibiting threatening behavior, that have special conditions of operation that can provide for the adequate health care of patients.

NUMBER OF PSYCHIATRIC PATIENTS BY COUNTY, IN 2008  
(SOURCE: NATIONAL HEALTH INSURANCE)



## 2.6.

### Aspects of the Right to Health Care from the Side of the Patients

#### 2.6.1.

##### Status Report on Patients' Rights – Enforcing and Protecting the Rights of Patients in Hungary

At the beginning of 2011 the Commissioner received numerous complaints from citizens in which the complainants objected the procedures of the National Public Health and Medical Officer Service (Állami Népegészségügyi és Tisztiorvosi Szolgálat, ÁNTSZ). They claimed that their petitions originally submitted to the Health Insurance Supervisory Authority (Egészség-biztosítási Felügyelet, or EBF), in which they had objected the activity of health care providers, were not investigated with due care.

The different cases are similar in certain patterns that typically characterized the procedures of the different units of ÁNTSZ, as testified by the copies of the documents attached to the complaints lodged to the Commissioner's office. One such pattern is passing the case from one regional institution to another, citing that the case is not within their powers or competence, thus slowing down the procedure. Another pattern is to cite the law on complaints, but without any substantive justification. The complainants objected in numerous cases that the various units of ÁNTSZ rejected the original complaint without substantive investigation on grounds that it had been lodged more than one year after the problem arose. In its letters combining the notification of rejection with providing practical information, ÁNTSZ did not make any reference to legal sources and gave a general advice to the complainants to turn to the court or to the ombudsman for "judicial remedy".

On grounds of these problems and complaints, the Commissioner launched a number of inquiries in parallel with each other because of the suspicion that the principle of rule of law, the requirement of legal cer-

tainty and the right to fair procedure following from it, as well as the right to effective judicial remedy, were violated. In response to the similarities of these cases of complaint, the ombudsman published a comprehensive report that provided a summary of general statements and proposals for taking measures in relation to the enforceability of patients' rights. Besides launching the investigation, the Commissioner also turned to the state secretary responsible for health affairs and to the Chief Medical Officer in order to receive information on how the successor organizations of the Supervisory Authority distribute the range of responsibilities and competences between them and how are these regulated – thus, to find out what was the rationale behind the different procedures and decisions objected by the complainants.

*Anomalies Related to the Handling of Complaints Received from the Health Insurance Supervisory Authority*

The report emphasizes that the Supervisory Authority, as a government agency, acted according to the rules of administrative procedure and its decisions could be challenged by judicial review. The task of this Authority was to investigate complaints, petitions, and requests in relation to the use of health care services by persons who are insured within the state health insurance system. According to law, the Authority may inspect if the health care providers fulfill their obligations and impose fines, if necessary. The Parliament, however, repealed the Act on the Health Insurance Supervisory Authority and discontinued the operations of the Authority by ensuring partial legal succession.

The ongoing cases were taken over by the regional directorates of the legal successor National Public Health and Medical Officer Service (ÁNTSZ) and after January 1, 2011, the county-level public health authorities. However, these authorities were not entitled to conduct official investigations against the health care providers or to make a decision challengeable before a court. The regional directorates of ÁNTSZ and later the public health authorities could communicate with the complainants only in the form notification letters providing information, citing the provisions of the law on complaints. The Chief Medical Officer and the state secretary responsible for health affairs both acknowledged that the competent bodies of ÁNTSZ handled the complaints taken over from the Supervisory Authority not as complaints to be investigated in the framework of an official administrative procedure but only as public service notifications. The Chief Medical Officer also in-

formed the Commissioner that by interpreting the law on complaints, it created special protocols for the bodies under its jurisdiction.

The Commissioner emphasized that the creation of transitional provisions resulted in a severe legislative omission that had an effect on the enforcement of the fundamental rights of the complainants. This, in turn, led to an emergency situation for the authorities applying the relevant laws. The legislator provided only for the transfer of functions and cases but did not determine how and in what kind of procedure the cases should be judged by the legal successor agencies. In the administrative cases transferred to the legal successor that had not been closed by the Supervisory Authority, it was not possible to continue the administrative procedure, thus they were interrupted without substantive, legally assessable closure (injunction or decision).

According to the ombudsman, the complainants turning to the Supervisory Authority rightfully expected that their cases would be judged by the successor agencies in an official, administrative procedure, which would be closed by a legally binding decision – and their complaints would not be reclassified as public service notifications. The Commissioner emphasized that it is not in accordance with the requirement of legal certainty and the right to fair procedure that, when the operations of a state authority are discontinued, the complainants are suddenly not provided the possibility to seek remedy after the case was already opened and under investigation. It is also a deficiency of the transitional provisions that the complainants turning to the Supervisory Authority are deprived of their right to judicial remedy and the possibility of bringing the case to court.

The Commissioner pointed out that in connection with the transferred complaints the legal successor agencies were not entitled by any legal provision to apply the law on complaints or to develop a special protocol. The complainants lodged their complaints to the Supervisory Authority with the intention to seek individual remedy and not to submit a public service notification. Moreover, in a significant number of cases the administrative procedure was well on its way (e.g. an independent expert opinion or the opinion of the public health institution was already collected). The report emphasizes that when the Chief Medical Officer and the competent regional chief medical officers discovered the legislative omission, they decided to judge the cases of complaint transferred to them on grounds of the law on complaints, and by this they caused anomalies in relation to the right of the complainants to fair procedure and judicial remedy.

*Enforceability of Patients' Rights, Remedies for the Encroachment of Their Rights, and the Institutional System of Protecting Rights*



In his report the Commissioner emphasized that it is a person's fundamental right to be able to make decisions related to his or her health condition and to consider the alternatives in connection with his or her illness and the treatment or the mitigation of the effects of the illness. However, for such decisions to make it is necessary to be adequately informed, because in the lack of relevant information the patient cannot make a satisfactory decision. The ombudsman also pointed out that the patient is, by default and as a result of his or her condition, not in the position to terminate his or her medical treatment citing the right to self-determination or to ask for information about the illness and the effects of the treatment not previously disclosed to him or her. At the same time, the patient is forced to endure, in a physical sense, all risks that the treatment might entail.

The report also revealed that one of the primary conditions of practicing certain fundamental rights, such as the right to self-determination in health care following from the right to human dignity, is its enforceability: in the case of an individual legal injury, the patient is entitled to initiate the judicial remedy of this grievance and the substantial investigation of the case in front of the appropriate enforcement bodies. In relation to the protection of the patients' rights, therefore, it is a necessary but not sufficient condition to declare the individual rights in a special statutory catalogue. At the same time, the creation and operation of appropriate general – or, in certain cases, special – rights protection agencies should also be ensured.

In connection with this, Commissioner emphasized that there is no high quality health care service without enforcing patients' rights. The availability of law enforcement agencies which are impartial and independent, especially from the public health institution providing health care, as well as the accessibility of calculable law enforcement procedures are in the interest of all stakeholders. The report argues that, while the doctor–patient relationship is otherwise subject to private law, the condition of being ill and being in the vulnerable position of a patient creates an asymmetric legal and informational relationship that needs to be

regulated legally. Even after the treatment is finished, the patient might not be always able to enforce compliance with the rightful guarantees that are in his or her interest.

Furthermore, besides the basic requirement of impartiality applied in the assessment of the complaints, special expertise is required to judge the rationale or justification of the decisions of the medical profession so that it can be assessed if the doctor committed any failure in relation to the objected care or treatment or if the health care institution itself has fulfilled the applicable statutory requirements (for example, if the treatment was fully conducted “in the interest of the patient”).

In addition, the report gives a summary list of institutions and procedures serving the enforcement of patients’ rights on grounds of the legal regulations in force

#### *Complaints Addressed to Health Care Providers and the Maintaining Institutions*

The report notes in connection with the enforcement of patients’ rights that the Health Care Act determines that the patient has the right to lodge a complaint at the public health institution or its maintaining institution about the health care service provided. The public health institution and its maintainer, in turn, are obliged to investigate the complaints and inform the patient in writing about the results of the investigation as soon as possible but within a maximum of 30 workdays. The detailed rules of such investigation are contained in the internal rules of the health care provider. The Commissioner states that in relation to the investigations of the public health institution and its maintaining institution, the requirement of independence and impartiality cannot be enforced, therefore ensuring this avenue of lodging complaints, in itself, is not satisfactory. Nevertheless, it is still an important way of seeking remedy, especially when the health care provider or the maintaining institution acknowledges the reasonability of the complaint and is able to remedy it locally and relatively quickly.

#### *The Patients’ Rights Representatives*

The Act No. CLIV of 1997 on Health Care provides for the institution of the patients’ rights representative whose basic task is to protect the rights of patients as determined by law and to assist them in their learning about these rights and the enforcement of these rights. The patients’

rights representative helps the patients to access medical documentation and to formulate their complaints. Based on a written authorization by the patient, the patients' rights representative may make a complaint at the director of the health care provider or at the maintaining institution, and may act in the patient's name. It is the duty of the patients' rights representative to call the attention of the manager or the maintaining institution to the observed unlawful practice or to other deficiencies and to make proposals concerning the elimination of these practices. In case these acts are unsuccessful, the patients' rights representative is entitled to notify the competent persons or bodies. The law also specifies that the patients' rights representative has the right to enter the territory where the health care provider operates, to have access to relevant documentation, and to formulate questions to health care employees.

The Commissioner noted here that the patients' rights representative has the qualifications suitable for judging the relevant professional issues, but his or her role is restricted to the provision of information, to mediation and to making proposals. Therefore, due to the specific legal position of the patients' rights representative, he or she is not entitled or authorized to remedy the violation of some right or to make decisions, and does not have any official licenses. The existence of this legal institution is indispensable in the counterbalancing of the asymmetric legal (and especially the informational) relations – however, it can only complement but cannot replace the bodies entitled to make decisions.

### *The Role of Courts in Protecting Patients' Rights*

The Constitution states that claims arising from the infringement on fundamental rights, and objections to the decisions of public authorities regarding the fulfillment of duties, may be brought before a court of law. In connection with seeking remedies for the injuries related to patients' rights and health care service, the possibility of pursuing a claim before the court is fundamental and primary: today, a patient or a person using health care services may file a civil suit citing infringement of personal rights. Pursuant to the Civil Code, personal rights are infringed especially in the cases of violating the requirement of equal treatment, the right to human dignity and the freedom of conscience, the right to bodily integrity and health, or in the case of unlawfully limiting personal freedom. According to the Civil Code, a person whose inherent rights have been violated may have make claims under civil law, depending on the circumstances of the case, thus demand a court declaration of the

occurrence of the infringement and file charges for punitive damages in accordance with the liability regulations under civil law.

The report of the Commissioner pointed out that lawsuits initiated against the health care providers on the ground of the violation of personal rights (claims for damages) place undue burdens on the victims as the civil law litigation requires long time, it is expensive (as it requires obtaining and presenting medical and other expert opinions) and during the legal procedure the victim has to prove the legal violation (in case of a claim for damages: the causation and the extent of damage). Although expert opinions, in principle, ensure that courts shall deliver well founded decisions, the above-mentioned asymmetrical relation between the parties may not necessarily be balanced out in the civil law litigation procedure: as the health care institution, which presumably committed the infringement of the patient's right, still remains in a more favorable position. In the opinion of the Commissioner, and it is no less important, the prolonged legal procedures are disadvantageous not only for the patient but also for the health care providers. Pursuing a claim before the court cannot serve the purpose of preventing future infringements; thus today the legislator clearly seeks to provide the parties with mediation procedures so that extra judicial agreement can be reached.

### *The Ombudsman's Role in Protecting Patients' Rights*

In conclusion, the report suggests that in addition to the courts, the general ombudsman, whose institution is intended to protect fundamental rights, and the data protection commissioner (e.g. in connection with the handling of health-related data) may be also suitable for investigating the complaints lodged in relation to the enforcement of patients' rights, for establishing instances of maladministration in relation to fundamental rights, such as the right to human dignity and self-determination in health care, and for taking appropriate measures. The report reveals, however, that the ombudsman and his colleagues do not have the special expertise or licenses, and the ombudsman's office does not have the human or material resources necessary to handle large number of complaints in relation to the activities of the health care providers – and there is no specific legal provision either to authorize the Commissioner to pursue this task. The report also notes that the rights protection institutions similar to the ombudsman – due to its nature, and rightly so – typically do not have the authority to make decisions; thus, in this field,

they can provide complementary rights protection solutions to the complainants turning to them.

Considering the above distribution of responsibilities, the ombudsman draws the conclusion that in order to ensure the better enforcement of patients' rights, it is necessary to create and operate independent and impartial, but not court-type institutions with administrative authority and special expertise (besides experience in constitutional and legal practice and policymaking), which are able to investigate the separate complaints lodged by individuals, and the decisions of which can be challenged before a court. The need to balance out the asymmetrical legal relations in the field of patients' rights requires the establishment of autonomous, authority-type rights protecting institutions. Further elements or pillars of enforcing rights are: pursuing claims before the court and, in a complementary function, the different ombudspersons, patients' rights representatives, and the institution of filing a complaint to the health care provider or the maintaining institution.

In the report the Commissioner pointed out that after the Health Insurance Supervisory Authority was discontinued, starting with January 1, 2011, all complaints related to the infringement of patients' rights and objecting some procedure, decision, or omission of the health care provider should be lodged to the territorially competent county-level public health authority. The county-level public health authorities shall handle the complaints as public service notifications and act in compliance with the law on complaints. The ombudsman also emphasized that exercising a general right to lodge petitions would not lead to effective judicial remedy because in these cases the authorities and bodies of the state are not required to conduct an inquiry, they might respond to this type of complaint only in the form of a simple response providing minimal information related to the case. The Commissioner stressed that in the "procedure" initiated in compliance with the law on complaints the complainant is taken as a "notifier", does not have the legal status of a client; the authority acting in the case might provide a "hearing" but it is not obliged to; and the case is closed by a simple informative written response, and not by a decision that could be challenged in a judicial review.

In his report the Commissioner concluded from the above that currently the official protection of the rights of patients is not ensured either formally or substantially: all patients' rights-related complaints lodged against health care providers are handled as public service notifications and not as complaints to be investigated in an official administrative pro-

cedure. The ombudsman emphasized that the legal situation created by the legislative omission causes anomalies in relation to the requirement of legal certainty, the right of the complainants – who suffered infringements during receiving health care service – to human dignity and self-determination in health care, as well as their right to judicial remedy.

The Commissioner emphasized, at the same time, that from a constitutional perspective it is not the termination of the Supervisory Authority that is objectionable. The legislator is free to decide what kind of organizational framework is created to perform the required task of legal protection. Handling the petitions and complaints related to the infringement of patients' rights – due to the specific character of these rights and the legal status of the persons whose rights were infringed – requires the creation of a multilayered system. The Commissioner is on the opinion that this system should incorporate an independent, specialized rights protection authority, the decisions of which could be challenged before the court. Whether this requirement is fulfilled by establishing a new institution or by the enlargement of an already existing one is typically not an issue that should be solved on the constitutional level. Nevertheless, it should be open to constitutional review if the given institution is able to ensure, with the necessary efficiency, the protection and enforcement of the fundamental rights in its competence.

### *Overview of the Situation of the Patients' Rights Representatives*

In the last section of the report the Commissioner discussed the situation of the patients' rights representatives and stressed that this institution, as a pillar in rights protection, is crucial in the practical enforcement of patients' rights and, in particular, from the perspective of providing information related to the rights of the patients and the alternatives of seeking remedy.

Already after launching the comprehensive investigation, the Commissioner learned that, in the meantime, a government decision discontinued the operation of the public foundation dealing with patients' rights. According to the information received from the state secretary responsible for health, the tasks and responsibilities of the public foundation were taken over by a new government agency. However, the government decree regulating the legal status and operation of this agency was not amended beforehand – and it did not mention the tasks related to the system of patients' rights representatives even at the time of publishing the report. Therefore it was necessary to extend the scope of the ombuds-

man's investigation because after the public foundation was terminated and as a result of other measures, in the lack of clear and unambiguous regulations, the legal status of patients' rights representatives, as well as the legal and financial guarantees of their independent operation, became uncertain. Furthermore, by the time the report was published, the Commissioner had not been informed about the planned amendments to the relevant laws, thus – on the level of regulation – only uncertainties could be recorded in relation to the institution of the patients' rights representative and the legal status of the individual patients' rights representatives.

In the report, therefore, the Commissioner emphasized that the legal situation that has developed in relation to the functioning of the institution of the patients' right representative causes anomalies in relation to the requirement of legal certainty and the right of the patients to human dignity and to self-determination in health care, because it induces the direct threat of legal injury.

## RECOMMENDATIONS

The report revealed several contradictions related to fundamental rights. In order to remedy these, the Commissioner called upon the competent minister to take action in a number of fields:

- First, the ombudsman requested the minister to initiate legislative proposals that enable the competent county-level public health authorities to make administrative decisions – which could be challenged by judicial review – in all cases of complaint that have been originated from the Health Supervisory Authority, the previous legal person, and have not yet been decided.
- Second, the Commissioner also asked the minister to ensure the legal succession by initiating the appropriate, ex-post amendment of the relevant laws and by taking other necessary measures, so that the judicial review of the decisions of the Supervisory Authority is made possible.

In order to ensure that substantive remedy can be provided for the procedures, decisions, and omissions infringing on the patients' rights, the Commissioner also recommended that by complementing the existing regulations and initiating law amendments the ministry creates an independent specialized rights protection agency with official pow-

ers that could investigate the individual complaints of the patients in an administrative procedure and make decisions that could be challenged before the court.

In relation to the functioning of the system of patients' rights representatives, the ombudsman requested the minister to amend the relevant laws and determine the legal and financial framework for this system as soon as possible so that, after the public foundation was terminated, a new central agency with a national jurisdiction can be established.

The Commissioner also *requested the Chief Medical Officer to take action* in order to ensure that in case he discovers a legislative omission in connection with the procedures of the bodies under his jurisdiction, he proceeds only after collecting information and seeking advice from the ministry responsible for the field. The Chief Medical Officer should also make sure that the investigation of the patients' rights complaints are conducted in accordance with the Health Care Act, by inspecting the compliance of the health care providers with the relevant legal norms in not only formal but also substantive terms.

*In his response, the minister*, by confirming his previous position, informed the Commissioner that in numerous cases the complainants, who turned to the Health Supervisory Authority with their petition, while it existed, also lodged the same complaint to ÁNTSZ, which was allowed by the law on complaints. According to the relevant laws in effect, it is possible to lodge a complaint even today: the procedures of the county-level public health authorities are based on their responsibility to supervise and provide professional control over the operation of the health care institutions.

The minister pointed out in his reply that in order to eliminate the problem indicated in the report, the Health Care Act was amended in a way that in relation to care provided to a patient by a health care institution, complaints can be lodged, in accordance with the law on complaints, to the health care administrative body that is entitled to issue an operating license to the health care provider affected by the complaint. The minister indicated that the amendment, on the one hand, facilitates that the complaints can be really handled as complaints and, on the other, solves all previous competence problems and jurisdictional disputes. He also noted that in response to a complaint it is possible today to initiate an official investigation within the framework of a supervisory procedure, to make a decision on the case, and to impose a so called 'health fine'.

The minister is on the position that protection of the rights of the clients of health care providers can be properly assured until the new National Pa-

tients' Rights and Medical Documentation Center (Országos Betegjogi és Dokumentációs Központ, OBDK) is established and the related problems are finally settled. He does not deem it possible to amend the transitional provisions on arranging the transfer of responsibilities to the successor agencies, nor does he think that it would serve legal certainty.

Concerning the legal status of patients' rights representatives and the protection of patients' rights, the minister stated in his response that the responsibilities of the public foundation were taken over by its general and universal legal successor, which now carries out its statutory tasks related to the employment of patients' rights and children's rights representatives.

*In his reply to the minister*, the Commissioner indicated that he can accept the ministerial response to the recommendations of the report and the justifications of this response only partially.

*In his reply to the Chief Medical Officer*, the Commissioner reiterated that the primary cause of the legal anomalies was clearly and undoubtedly the legislative omission that did not make it possible for the legal successor agencies to apply the rules of administrative procedure in their assessment of the cases transferred to them.

## 2.6.2.

### The Patients' Rights of Parents

In 2010 the Commissioner received a number of similar complaints from parents who were accommodated in the same hospital ward as their children during the hospital treatment of the latter. All complainants objected to the unworthy circumstances, finding especially injurious that at best, they could spend the night sitting on a stool next to their sick child, but they also reported a case when an expectant mother was allowed to sleep on a mattress next to the sick-bed of her child.

During the investigation the Commissioner contacted several children's clinics and a few county and city hospitals in relation to the overnight accommodation of the parents of minors treated as inpatients in a hospital, and he also requested detailed information on financing issues.

In his argument related to fundamental rights, the Commissioner referred to the requirement arising from the rule of law, according to which the bodies vested with executive power carry out their activities operating *in the order laid down in the law, within limits* regulated in a predictable way with which the citizens can familiarize themselves. The ombudsman also

referred to an important element of the right to life and human dignity: namely, the right to self-determination. Another significant part of his argument was *the constitutional basis of the protection of children*: that every child has the right to receive from his or her family, the state and the society the protection and care required for his or her proper physical, mental and moral development. It is the obligation of the family, the state and the society to provide such protection and care. The same is required by the basic principle of child protection, that is, the enforcement of *the best interests of the child*. Along these aspects and requirements of the fundamental rights, the investigation was mainly aimed at finding out whether the enforcement of continuous contact – besides providing the possibility of having contact – is realized in the public health institutions concerned under appropriate and decent circumstances.

Pursuant to the Health Care Act, any child treated in a public health institution has the right to have at least one person with him or her; however, the Act fails to specify any minimum standards with respect to the circumstances of such stay, which means that these can be determined by the public health institutions themselves. The Health Care Act also makes it clear that the right to have contact may be exercised by the patient subject to the conditions existing in the inpatient institution, while respecting his or her fellow-patients' rights, and ensuring the undisturbed and smooth delivery of patient care. The exercising of rights is made dependent on the existing conditions, which makes the actual exercising of the declared rights relative, thus allowing significant differences between the Hungarian institutions.

The Act leaves the detailed rules of having contact to be defined in the regulations of the inpatient institution – which in itself cannot be regarded as troublesome as long as the provisions of the hospital regulations are not contrary to the contents of the framework laws and meet the statutory minimum requirements – on condition that the provisions defined therein shall not restrict the material content of the right. However, for technical and organizational reasons, it is virtually impossible to achieve that the circumstances of having contact are provided in almost uniform way and at similar standards in all hospitals and in the case of all children treated. Consequently, the circumstances of parents' overnight staying in the hospital are different depending on the technical and architectural parameters as well as the financial situation of the given institution.

The statutory rules on having contact are superficial and in practice they are only relevant as principles, but this nature of principle is not sufficient for the full and actual enforcement of the rights of patients, es-

pecially children. Compliance with the legal rules governing the creation of hospital regulations can be highly varied depending on the differences of the healing therapies of the institutions, the architectural characteristics and financial opportunities of the institutions or departments. As a result of this, it can be ascertained that the possibility of having continuous contact – beyond the actual complaints – is not ensured properly in several institutions.

The Commissioner established that it *does not violate* the right to have contact or *the human dignity of the parent entitled to stay in the institution if the hospital forbids the parent staying with his or her child to lay on other empty sick-beds in the hospital ward or room*. However, as to the restrictions in the hospital regulations concerning *the gender of the parents placed in the same room*, the Commissioner found it unjustified to generally prohibit male relatives from staying with the child. It is contrary to the right of the child if the father cannot stay with a child who is admitted later, only because a child previously admitted to the same room is accompanied by his or her mother. The moral feelings or convenience of the previously accommodated parent does not give rise to any prohibition on the presence of males. It is quite possible that the child's mother is ill, in need of care, or perhaps deceased and there is no other female relative who could stay with the child. Furthermore, if the exercising of rights is dependent on the existing material conditions – even if the wording only takes into consideration the limits of the actual conditions –, it makes the actual exercising of the declared rights relative.

However, it must be stressed that it turned out from the cooperative responses of the hospitals – which in many cases also contained constructive proposals – that the management and personnel of hospitals generally seek to provide the most relaxing and suitable accommodation possible, which effort, however, is often thwarted by the architectural characteristics of the ward (the size of the room, sanitary facilities, and so on).

The legislator's responsibility primarily lies in laying the foundation of an attitude change: it must perceive that the current situation is intolerable and, in order to eliminate it, it must transform the legal and financial environment. However, the revision may not necessarily be limited to the health laws in a narrow sense: for example, it may be realized by making it obligatory on newly opened hospitals and departments to apply *architectural solutions* which facilitate the proper realization of parents' stay in practice, and by defining minimum requirements in this respect as well as determining relevant technical (architectural and engineering) rules.

In his report, the Commissioner also contested, from the perspective of fundamental rights, the solution of regulating the scope of persons affected by the financing, since this has been defined in laws of various levels, which hinder the lucidity and clarity of the regulation, thereby violating the requirement of legal certainty following from the principle of the rule of law.

It can be stated that the financing fee used in the case of providing for a person accompanying a child covers both the accommodation and boarding of the parent. However, it has not been determined uniformly, how much of this is allocated by the hospital for the boarding of the parent, how much is assigned to the costs arising, and how much is spent on setting up and maintaining beds. The legal regulations do not determine the minimum requirements related to the accommodation of parents that hospitals should provide out of this amount. In practice this means that a hospital that only accommodates the parent on a chair – justified by any reason – may receive the full reimbursement despite the fact that the combined amount of the boarding of the parent and the overheads related to his or her presence does not reach the daily minimum amount.

The Commissioner also established that it causes an anomaly in connection with the child's right to care and protection and also a direct risk of grievance that the state does not support or reimburse the stay of parents of children older than 14 at all. However, the Health Care Act contains no definition of who is to be considered a minor and does not cite any other law as an explanation. Nevertheless, in another section the act provides that the rule in question must also be applied in the case of minors older than 16. It follows from all this that the concept of "minor" as used in this act is also applicable to children over 14 years of age. The laws in force governing financing, however, only order the financing of the stay of parents whose children are younger than 14 when their hospital treatment is started. Of course, the presence of the parent or relative in the institution also cannot be prevented in such cases. But in the absence of financing, the hospital may get into a detrimental situation if it reports the parent of a child older than 14. Based on all this, the Commissioner found an anomaly in relation to the right of children to care and protection.

The Commissioner requested the minister to initiate the drafting of the laws on the financing of persons accompanying children in a uniform statutory instrument of the same level; the financing of the stay of the persons accompanying *all patients younger than 18*; and he also requested the minister to elaborate the parameters of the minimum level of ac-

commodation (minimum standards), which must be allocated from the central budgetary sources for the accommodation of the parent and the reserves for future developments. The ombudsman recommended that the minister elaborate a regulatory environment, through which it can be realized that only such solutions can be applied during the planning and building of children's hospitals and hospital departments caring for children to be opened in the future, which facilitate the suitable, clean and hygienic stay of parents and which do not jeopardize the treatment of children. He also requested the hospitals involved to provide the possibility of staying in the hospital also for the male relatives of children admitted to the institution.

The responses of those involved have confirmed that the problem is significant and that a solution is required as soon as possible.

## 2.7.

### Aspects of the Right to Health Care from the Service Provider's Side

#### 2.7.1.

##### The Health of Members of Law-Enforcement Bodies



It is widely known that, in our society, restrictions on the constitutional rights of members of law enforcement bodies are only allowed if those restrictions are necessary for the body employing the law enforcement professionals to function in a state governed by the rule of law. The Ombudsman considered it impor-

tant to bring to the surface the problems related to the enforcement of fundamental rights also in the area related to the health and the mental and physical state of members of law enforcement bodies. He therefore reviewed – in the framework of an *ex-officio* investigation – the laws on the procedure for the medical panel reviewing the health fitness of law enforcement professionals, and their application in practice.

The direct aim of his examination was to establish whether the legislation governing the health fitness review procedure for members of the law enforcement bodies is consistent with the principle of the rule of law, as well as with the requirements of legal certainty, non-discrimination and *equal treatment*; furthermore, whether any abuse can be established in connection with the right to human dignity or *social security*.

*In his investigation, the Ombudsman made enquiries to the heads of all bodies affected by this issue.*

The designated hospital has been engaged in the first instance examinations of professional and contract soldiers since 2007.

The reviews are undertaken by professionally recognized and highly experienced military medical professionals, appointed from among the staff of the institution. Where a further specialized medical examination or in-patient treatment is required to decide on the health status or fitness for service of the person examined, this is provided for by the out-patient clinic and specialized out-patient units, as well as the in-patient wards and senior specialists of the hospital. The review panels operating in the hospital are not entitled to award the following classifications: “unfit for military service,” “unfit for service as a member of law enforcement bodies” and “unfit for current service.”

In the health care institute entitled to decide on appeals, the tasks of the medical panel reviewing the health status of members of the professional and contract military staff are to review the fitness examinations of the staff of the Hungarian Army and the law enforcement bodies; making proposals for healthcare leave in the event of health deterioration due to accident or illness; authorizing healthcare leave or to decide on fitness; and to conduct review procedures.

The National Police Headquarters emphasized in its submission that, on the issue of health, mental or physical fitness for service or for a position, it must be decided under a review procedure if, due to an illness or an accident, the member of a law enforcement body: has lost his/her service capacities to such a degree that he/she is permanently unable to conduct his/her tasks and despite a longer therapy no satisfactory improvement in his/her condition can be expected or his/her health impairment is such that he/she seems to be unfit to carry out his/her function/position.

Detailed rules for the examination of fitness for military service are laid down in a ministerial decree. It provides that, if the health status of a soldier has changed to such a degree (as a result of an illness, surgery, or an accident) that it fails to comply with the health fitness requirements applicable to him/her, a review of his/her fitness must be initiated.

### *Findings and Conclusions of the Ombudsman*

The service incumbent on the members of the law enforcement bodies, requiring greater capacities, requires efficient selection during recruitment. Properly conducted admission screening may help to avoid employing an unfit person – in health terms – as a member of law enforcement bodies. A good admission selection system may also help to reduce the number of injuries in later training and exercises, and, later on, the number of health impairments.

As such, health fitness (or unfitness) examinations represent a significant step in the process of becoming a member of a law enforcement body, because this makes it possible to screen out those suffering from an illness or a disability (assuming that such healthy people are capable of carrying out their tasks as any member of a law enforcement body). Physical and mental fitness checks are closely related to this but are separate from the medical examinations.

As such, in order to enforce the requirements for service and for a position, the fitness of the personnel for service as members of law enforcement bodies (their health and mental and physical state) must be examined and assessed, both prior to the establishment of the service relationship and also during the service (hereinafter: fitness examination). Health fitness is evaluated by a doctor, mental fitness by a psychologist, and physical fitness by a person with a physical education or sport professional qualification or a person with fitness and load carriage ability knowledge, taking a preliminary medical opinion into account.

With regard to law enforcement bodies, the professionals carrying out the fitness examinations do not make a proposal on the fitness or unfitness or its variations (degrees) but deliver an independent, exclusive decision. Neither the qualification of new recruits nor the classification of members of staff therefore ensures a comprehensive assessment of fitness, which *can lead to legal uncertainty and may also infringe their right to a fair procedure*. This cannot occur in the case of soldiers, since the FÜV Panel (Review Panel) does not deliver an exclusive decision over the health fitness degree of a soldier or the relationship between the soldier's health impairment and his/her service obligations but only makes a proposal regarding it. The constitutional provision forbidding discrimination enshrines the requirement of equal rights; the Ombudsman, therefore, established that the members of law enforcement bodies are equal in all service locations (whether military or law enforcement), and their legal standing, due to the restriction of certain ones of their respective constitutional rights, is equal. (All these shall not exclude that higher fitness requirements for certain positions can be provided for by the law.) In view of the above, the fact that the Review Panel delivers an independent, exclusive decision in relation to the law enforcement bodies and makes proposals in relation to military bodies *also enables the establishment of any violation of non-discrimination*.

From a different aspect, the Ombudsman pointed out, the respectively different fitness requirements related to individuals prior to admission, already in service, and with changed health status are not recognizable

either in the set of health, nor the physical, nor the mental fitness requirements in the relevant legislation. At the same time, however, it cannot be claimed of individuals applying for admission, currently in employment, or with changed health status that their health, mental and physical condition can be assessed along the same fitness criteria. In this regard *the constitutional requirement for the equal distribution of rights and the fundamental right to human dignity would not be impaired* if the legislator established different fitness criteria, subject to taking individual aspects into account to the same degree. *Moreover, the rule of law would also require* that the fitness examination of persons belonging to the above mentioned three groups should be conducted against different fitness criteria.

All health (medical) examinations/reviews are carried out by a specialist consultant. However, the relevant legislation only refers to the mandatory consultation with an occupational health specialist in a few cases, i.e. the legislator gives priority to the result of examinations carried out by a doctor specialized in a single specialty area (e.g. ophthalmologist, internal medicine specialist, neurologist). According to the Ombudsman, the mechanism would change if the panels carrying out the fitness examinations/reviews would act on the basis of the results from a detailed occupational health assessment, and additional examinations would take place only in justified cases, and in a targeted way. *This would comply with the principle of rule of law and the requirement of equal treatment.*

It clearly follows from the relevant laws that the review panels decide on the merit of the fitness. An appeal can be lodged against the first instance decision. However, a further appeal against the decision made in appeal is excluded; these decisions are enforceable. The Commissioner *considers this inconsistent with the principle of rule of law*, since it is of great significance that the person under review has no concerns that the review procedure is conducted purely on the basis of professional considerations. To solve this potential dilemma, the ombudsman considers the following as a solution: the legislator should provide for the judicial review of the decision made on appeal, since this fitness review affects the rights or rightful interests of the person under review. The issue of permitting an appeal against the decision establishing health and physical fitness by the law on the staff of law enforcement bodies but not permitting it against a decision establishing physical unfitness is also a closely related question. *This results in an abuse in connection with the right to a fair procedure and to effective legal remedy.* (It should be noted that neither the decree governing the army nor the decree governing the customs police contains any exclusion with regard to the appeal against the “Physically Unfit” classification).

The law fails to consider the members of law enforcement bodies as equal persons, even in terms of appointing the bodies competent to conduct fitness examinations/reviews. For example, the fitness examinations for applicants to the Customs Police are carried out by the law enforcement body itself, while another institution is entrusted with the task of conducting health and mental fitness examinations for the members of law enforcement bodies and the Army, and within this, the decision on appeals for new recruits, existing members applying for higher or different or special (anti-terror, personal security, etc.) positions or for foreign service. This differentiation also *gives rise to establish an abuse in relation to the principle of the rule of law, as well as to the requirements of non-discrimination and equal treatment*. In the opinion of the ombudsman, an unbiased and objective examination, compliant with the requirement of legal certainty, can only be expected from a body outside the organization itself.

In order to eliminate the abuses related to constitutional rights as revealed by him and to prevent them in the future, the Commissioner requested the Minister of Justice to consider the establishment of a modern, coherent system for the health fitness examinations/reviews for all members of the law enforcement bodies that would support the protection, restoration, and development of the staff's health, and that would increase the staff retaining ability of the bodies concerned, and the detailed preparation of their health fitness assessment methods in a coherent legal framework, with special attention to the fact that the members of both the law enforcement bodies and the Army work and live their family lives subject to significant legal and lifestyle restrictions. In his reply, the Minister only assured the Ombudsman that, when reviewing the regulations related each legal relationship, he would suggest to the affected ministries the establishment of a more coherent set of rules for their consideration.

### *The Effect of the Commissioner's Proposal*

In December 2011 the ministry submitted to the ombudsman the new draft decree on the health and mental and physical fitness of the members of certain law enforcement bodies. This draft only partly takes into account the findings of the ombudsman. According to the amendment, the proposal on the status check against differentiated and customized fitness requirements for applicants, staff and persons with changed health status is accommodated, which is compliant with the rule of law principle and ensures human dignity. Fitness examinations come within

internal competence, which the ombudsman considered appropriate for eliminating the discrimination he revealed in connection with this issue, and *the requirement of equal treatment* would be observed. *However, he considers it to be of concern that, as the main rule, first instance examinations will be carried out by the competent primary care doctors and psychologists of the law enforcement bodies, and on appeal by the doctors and psychologists appointed by the minister governing the law enforcement body.* In his opinion, the rule of law principle would require *that the latter solution would be the main rule, i.e. the minister would appoint the professional, and in the second degree another (external) body or institution would be competent.* His observation on the fact that no judicial review can be opened against the decision of the review panel is closely related to this. The ombudsman is also concerned about the lack of remedy, even following the amendment, against a potential physical unfitness examination outcome. The ombudsman maintained his findings on the fact that the joint decree is inconsistent with higher level legal acts; furthermore, the right to pass an independent and exclusive decision by the professionals examining health, mental and physical fitness on the fitness or unfitness for service and on the fitness variations (levels) can create legal uncertainty and may infringe the right to fair procedure. This latter provision fails to ensure a comprehensive assessment of fitness.

### 2.7.2.

#### Investigation in the Basic General Practitioner Care

##### *Initiation of the Investigation and Its Background*



In 2011 several complainants set out objections in their submissions with regard to general practitioners' right to practice and the operation of basic general practitioner care.

In the first case, a retiring general practitioner contacted the Commissioner on the grounds of the *public service contract related to the right to practice*. He stated that in 2004 a local government had wanted to sell the polyclinic where, amongst others, the complainant had his surgery and he was allegedly requested to buy his surgery if he did not want to pay a higher rent to the new owner. According to the complainant, other general practitioners in that town have

their surgeries in properties owned by the municipality, without the obligation to pay rent. The majority owner of the building left the property, leaving behind a debt of several million forints, and so now it only houses the surgeries of seven general practitioners. The complainant's surgery cannot be sold or let out; however, his obligations (e.g. paying utility bills) as an owner must still be met.

In the other case a complainant from the same town described *his problems in connection with general practitioner care*. According to his complaint, he has been with his current general practitioner since 1994, although outside of his district, since the practitioner accepted his registration; however, the practitioner asked several of his patients to register with a different practitioner since "he has too many patients." The complainant then called the geographically competent general practitioner, who asked him to find another general practitioner since he also "has too many patients."

The Commissioner initiated a comprehensive investigation on the grounds of suspected abuse related to the right to human dignity and equal treatment, the requirement of legal certainty and to the right to property. During the investigation he requested information from the competent minister, from the National Health Insurance Fund, from the competent authorities and from the mayor of the town.

The report separately addressed the comprehensive inquiry conducted in 2010 in connection with the anomalies in the regulation and practice related to the operation of GP practice, its characteristics and salability, as well as the summary conclusions of the Commissioner's report. In his report, the ombudsman established that the lack of the institution of compensation and the failure to legislate on the Act regulating the Practice Program brought about an abusive and contradictory situation in connection with the right to property and the requirement of legal certainty. Against this background, the ombudsman initiated the Minister of Justice to establish consistency between "operating rights" and the autonomy of the local government by initiating legislation on the institution of compensation and the facts giving rise to cases of compensation, and to initiate separate legislation on the Practice Program. In order to guarantee coherent law enforcement nationwide, the Commissioner requested the Minister for National Resources to standardize, with the involvement of the Country Medical Officer and the local governments, the practice in the field of operating rights, caused by the divergent interpretation.

Following this report, the *ministry responsible for healthcare* sent the

concept of the draft law to the Commissioner. The draft law intends to continue to use the term “right to medical practice” instead of “operating right,” which would mean the right to practice tied to a specific geographical area, to establish a uniform interpretation. As such, the right to practice is a right of material value that can be interpreted within a specific district and cannot be separated from it, on the basis of which it means the exclusive right of a general practitioner to provide primary healthcare within a specified general practitioner district.

On the basis of this draft, the ministry would specify by law the mandatory content of the service contract, including the compensation obligation of the local authority. For those contracts already existing, a new contract should be entered into or amended in accordance with the mandatory content within one year at the latest. Furthermore, the draft intends to enact – respecting the autonomy of local government – that the right to practice can be acquired subject to a preliminary contract between the doctor wishing to obtain the practice right and the local government, as well as a declaration from the local government that it wishes to enter into a service contract for the provision of general practitioners’ tasks in the specified district. Under the submitted draft a practice management vehicle is to be established in order to comply with the operation obligation of the practice program, the operation and legal regulation of which would be closely linked with the regulation of the right to practice. This practice management vehicle would, *inter alia*, extend interest free loans to doctors wishing to buy and join the general practitioners’ system and, as collateral, it would be specified that in the event of non-performance the loan would be repaid from the funds remitted by the Health Insurance Fund, with an interest of twice the base rate. The practice management tasks will be carried out by a newly established institution.

*The Findings of the Report in Connection with the Regulatory Reform of the Right to Practice and the Institution of Compensation*

Referring to its report published in 2010, the Commissioner pointed out that the re-consideration of the right to medical practice can start materially with the regulation of the institution of compensation, omitted from the original scheme, as well as with the regulation of individual cases giving rise to compensation, the calculation method of the damage and the compensation procedure. The ombudsman highlight-

ed that the submitted proposal is a repayment of a constitutional debt and that its implementation would be a significant step forward, since it would make provisions for the institution of compensation. At the same time, the ombudsman also noted that he had received no information on the specific details of the implementation. The ombudsman intended to signal in his report that, as long as the lack of the institution of compensation persists, the affected people's right to property is impaired, and the abusive and contradictory legal situation regarding legal certainty also persists.

The report states that in one of the complaint cases it could not be proved that the local government had forced the general practitioners providing basic health care to purchase the surgeries. According to the documents submitted, it invited them to exercise their pre-emptive purchase rights; as such, no fundamental rights-related abuse could be established with regard to this specific complaint. According to the ombudsman, it was clear from the information received and from the legislation cited that the local government and the general practitioner carrying out the tasks were entitled to agree on the terms and conditions for providing health services, subject to compliance with the law and the financing contract, including the conditions related to carrying out renovation and maintenance and paying the premiums for property insurance. The determination of terms and conditions and rights and obligations in this bilateral agreement currently concerns the two parties.

The Commissioner stressed that in private law the full contractual freedom, based on the equality and horizontal relationship of the parties, carries serious risks in this field, which is permeated with numerous public law aspects and state and local government roles. On one hand, the local government cannot be considered as an equal contracting party, since according to the current practice and in the absence of a preliminary contract it can decide on its own, and without stating the reasons, with whom it wishes to enter into a contract. Some municipalities have a dominant position, so a situation might easily occur when, "in exchange" for their willingness to contract, they can unilaterally determine contractual terms. It is also conceivable that, relying on contractual freedom, they agree on different terms for individual districts when specifying the terms of the service contract to be concluded for that district, thus applying discrimination against certain general practitioners.

According to the Commissioner, it is necessary, going beyond the

specific case reviewed and in order to enforce the requirement of equal treatment and legal certainty and a balanced level of health care, to specify by law the minimum content of the service agreement, in order to balance the powers of the two parties in the legal relationship. The report also points out that the legislator needs to specify the owner of certain tasks within primary healthcare and the resources for their financing.

In his report, the Commissioner also mentioned that the current allocation of district establishment and amendment rights fully and exclusively to the local governments might have negative consequences, both for general practitioners working in primary healthcare and for the patients at the same time. This is because the legislation in force only specifies a number, the reaching of which can give rise to the establishment of an independent district; however, it does not mean an obligation for the local authority. On the other hand, general practitioners are required to provide care for all patients belonging to their district under their territorial service obligation, despite the fact that above a certain number and age composition of a set of patients it can mean an unfeasible burden, and it is also disadvantageous in terms of financing.

The Commissioner's investigation revealed that, in the service agreement concluded with the local government, general terms are typically used; in general, the general practitioner is entrusted by the local government with carrying out tasks specified by the law in general practitioner district 'X' of a town for an unlimited period of time. However, it is the local authority's exclusive right to amend the district borders, as well as the local authority also has decisive influence on the development of patient numbers in a district, for example through issuing spatial planning concepts or building permits.

For various reasons, patient numbers in general practitioner districts have become very different, which has several consequences: In some districts with greater patient numbers, waiting times grew significantly; however, the healthcare time per patient decreased. The problem is acute: For doctors in the districts with such large patient numbers the regulations currently in force provide no way out, so they unofficially try to direct patients "for their own good" to other doctors. The patient can then visit the general practitioner competent for the district of the patient's residence, who will be officially required to accept him, and he can even be forced to do so by the competent medical officer. However, in the absence of mandatory rules on local authorities with

regard to district establishment and amendment and without material legal guarantees, these will not lead to changes in the healthcare situation and its predictability.

The report also suggests that patients can find themselves in the same situation as with their previous general practitioner: several hours of waiting time, minimal care time per patient, and an exhausted doctor and specialist staff. According to the ombudsman, it is therefore true that, formally, every patient will belong somewhere (i.e. formally will receive basic health care), but this does not mean quality patient care. In his report on the investigation, the ombudsman established that, in the absence of a law regulating with guarantee local government tasks and powers in terms of district establishment and amendment, not only is the requirement of legal certainty impaired but this long-standing legal situation also causes an abuse in connection with the right to healthcare.

#### *The Actions of the Ombudsman and the Replies of the Bodies Concerned*

In order to remedy the situation revealed and in order to facilitate uniform law enforcement nationwide, the Commissioner requested the minister responsible for healthcare to regulate in detail the institution of compensation in connection with the general practitioners' practice as soon as possible through initiating legislation and the amendment of legal acts and through taking other necessary measures. The ombudsman also requested urgent action on specifying by law, subject to respecting the contractual freedom principle and in clear and transparent terms, the mandatory minimum content of and guaranteeing framework rules for service agreements, thus supporting the necessary coherence of their content. Finally the ombudsman requested the minister to regulate clearly, subject to respecting the autonomy of the municipalities and following the introduction of the institution of compensation, the obligations regarding the establishment and amendment of primary healthcare districts for quality patient care.

In his reply to the report, the minister informed the Commissioner that addressing the problems revealed has started; the detailed debate on the amendment of the relevant law is already underway in Congress. According to the minister's announcement "*the draft, with the agreement of the professional organizations, addresses the institution of right to practice, regulates the mandatory content of the service agreements, establishes the institution of the practice management vehicle, and in certain cases*

*establishes compensation obligation for local governments – pro rata with their cost bearing capacity – as well as the basis for compensation.”*

The competent minister forwarded the draft Government proposal on the amendment of certain health insurance- and healthcare-related Government decrees that already contained – in accordance with the Commissioner’s report – the basic rules for practice licensing and the operation of the practice management vehicle.

# Concluding Remarks

During the last four years in the Dignity Project series, we focused on the enforcement and enforceability of the fundamental rights of vulnerable social groups in such a complex way and clear methodology that had not been previously used in the Commissioner's investigations. If we add the long-term project of studying children's rights from a variety of perspectives, then the intention is even more obvious: the code of fundamental rights and the research on different vulnerable groups have shaped the repertoire of the ombudsman's work in a distinctive way, in response to the societal expectations of ensuring the enforcement of the rule of law.

In 2008 the predicament of homeless people was the focus of the first Dignity Project. With our 2009 project, titled Dignity Differently, we intended to facilitate the recognition of the dignity, equal rights, and equal opportunity of persons living with disabilities. In 2010 we examined the situation of the elderly and the social, legal, and sociological aspects of old age in the project titled Dignity for the Elderly. And in 2011 we investigated and analyzed the enforcement of patients' rights, the various unresolved structural problems of the health care system, and interpreted the most important aspect: the relationship of trust between the doctor and the patient.

The main reason to initiate a long-term research on children's rights was that the child of the present is to become the open, tolerant, adult citizen of the future society. Thus, the child's legal knowledge, sensibility, and awareness, the capacity to enforce his or her own rights, and of course his or her mental and physical condition, determine how these abilities and capacities will work out when he or she becomes an adult in a couple years or not much more than a decade. Moreover, through addressing the problems of children we can reach out to the parents, to the pedagogues, or to the whole adult society.

The complaints and objections, recommendations and initiatives that affect children's rights are usually submitted to us by adults. This is why the main target group of our inquiries is the society of children. Our aim therefore is to ensure that the fundamental rights of the child are not just abstract concepts or meaningless frameworks for the children but living tools by which they could develop an active relationship with the legal, moral, and ethical movements and currents of their environment. We also seek to ensure that they are aware of the difference between public and private life, and the significance of their difference, that they know the limits of their possibilities and able to ask meaningful questions related to their various troublesome problems that are not – yet – discussed in the school books.

The enforcement of children's rights also depends on the knowledge and experience of the various professionals, experts, and legislators. This is why it is very important to envision a competent and able adult society that recognizes, respects, and protects the rights of the children. And this is why this special protection of children, which is provided by numerous international conventions and declared by the Basic Law of Hungary, is such a great challenge in the 21st century, in the new generation of the structure of human rights.

Mapping the enforcement of children's rights in Hungary inevitably touches upon many areas of social policy: from providing health care through making life easier for the disabled to performing various educational and cultural tasks. But it also reveals problems in the institutional system of providing health and social care or in relation to the strength of the economy or the sustainability of protecting our environment.

The situation of children within the health care system is a special world. The child is not a small adult but what he or she really is: a growing, changing, sensitive, and therefore vulnerable and protectable person.

The technological advances of the late 20th and early 21st century have not left the classic doctor–patient relationship untouched. From the beginning of life – expecting a child and preparing for birth – to the final stage of existence, life has become a series of decisions with great significance. If the child is ill and requires hospital treatment, the simplest tonsil removal requires at least three days in hospital. It feels like an eternity for the parent who spends that three days sitting on a stool next to the bed – but because of “the utmost interest of the child” (cf. UN Convention on the Rights of the Child) or simply the

culturally coded parental role complaining is out of question: what is most important is that the child is recovering fast.

But what can an aging parent do if her or his child is well into adulthood but whose mental (psycho-social) illness does not allow him or her to go to school or work, whose psychiatric care is unresolved, whose treatment is erratic, who becomes more and more aggressive, who makes the life of his or her parents unbearable, whose state-of-the-art therapeutic care cannot be provided within the treatment capacities of inpatient hospitals, or whose long-term placement in a well equipped mental institution is practically impossible because of the endless waiting lists? The long years of waiting destroy the life of not only the patient but also his or her family, and it eats up the time recommended for proper rehabilitation.

Is it clear for the parent raising a disabled child that a simple dental treatment or even a control examination might turn into a minefield if the doctor is not specifically trained, for example, in providing care for the autistic child? Or what would be the adequate therapeutic method for the autistic person admitted into hospital for a routine intervention that is in line with the professional rules and ethical norms when the autistic child bursts into an unexpected attack and there is no relative nearby who could help or no available medical professional who is specialized in diagnosing autism spectrum disorders?

To live as a homeless person today requires elaborate survival strategies. This circumstance does not make it possible for the homeless to spend the necessary time on recovery after some illness or medical treatment. One year on the street is two to five years in normal life. For the sick, ill – and most often very ill – homeless persons the most important health care service provided is averting the immediate life threatening condition (ambulant care, detoxication, treatment of frost-bites, etc.). After such emergency situation there is not much hope for living a healthy life.

We could continue listing the troubles and deficiencies in providing health care, or the complaints about the operation of the health care institutions, and add that health care system tests all of its participants, not only the patients but also the doctors and residents. We can see that trust between the patients and doctors, and between health care providers and the maintaining institutions, continues to erode and this makes the future very uncertain in this field.

The vulnerability of patients continues to increase. General practitioners in basic care and the doctors of large hospitals have made the same oath about healing their patients but the structural situation is quite different in the two cases. What helps better the patient in the process of healing: the personal engagement of the general practitioner or the impersonal professionalism of the hospital specialist? Doctors may be vulnerable because of the structural problems but the situation of the patients is much more difficult.

In the very asymmetrical personal relationship between the patient and the doctor we need to see how much the language of rights can help. At least it can contribute to a paradigm shift that results in the recognition and acknowledgement of patients' rights, to the transition from paternalist to partnership relations, and consequently to a better chance of recovery for the informed patient.

We have dealt with many other issues during our one-year program but we could not include them in this report because the investigations are still ongoing. We continue our research on the circumstances of end-of-life decisions, on the practice and acceptability of living will, or on the current situation of hospice services in Hungary. The contours of the future of residency are also unclear: it is not simply a matter of revising the system of medical education and training; in our accelerated life there are also more and more complex demands that traditional and modern medicine and medical science has to keep up with. In the near future we will also launch an investigation on one of the most special form of psychiatric care, the Forensic Psychiatric Mental Institution (IMEI), its role and significance, and the anomalies of its operation. The types of health care that the psychiatric patients of social care institutions need in their threatening condition are also not regulated and it is unresolved where such patients could receive adequate medical assistance.

The field of health rights is surely much wider than the self-limiting scope of the Commissioner's patients' rights investigations. We presented specific issues in this summary of our activities to the audience of young democracy with a developing human rights culture. The role of the state is significant in this development but without the health awareness and legal critical attitude of its citizens, it would be difficult to institutionalize patients' rights on the basis of human rights principles.