Constitutional Review, Volume 6, Number 2, December 2020
P-ISSN: 2460-0016 (print), E-ISSN: 2548-3870 (online)
https://doi.org/10.31078/consrev624

The Role of Constitutional Courts in Promoting Healthcare Equity: Lessons from Hungary

Mária Éva Földes*
The Hague University of Applied Sciences, The Hague, The Netherlands
e.m.foldes@hhs.nl

Received: 6 March 2020 | Revised: 12 October 2020 | Accepted: 26 November 2020

Abstract

This paper explores whether constitutional litigation contributes to sustaining the equity element of the right to health. Equity entails a fair distribution of the burden of healthcare financing across the different socio-economic groups of the population. A shift towards uncontrolled private healthcare provision and financing raises equity challenges by disproportionately benefitting those who are able to afford such services. The extent to which equity is enforced is an indicator of the strength of the right to health. However, do domestic constitutional courts second-guess, based on equity, policy decisions that impact on healthcare financing? Is it the task of constitutional courts to scrutinize such policy decisions? Under what conditions are courts more likely to do so? The paper addresses these questions by focusing on the case of Hungary, where the right to health has been present in the Fundamental Law adopted in 2010 and the Constitutions preceding it. While the Hungarian Constitutional Court has been traditionally cautious to review policy decisions pertaining to healthcare financing, the system has been struggling with equity issues and successive government coalitions have had limited success in tackling these. The paper discusses the role of constitutional litigation in addressing such equity concerns. In doing so, it contributes to the discussion on the role of domestic constitutional courts in the protection of social and economic rights.

Keywords: Right to Health, Constitutional Litigation, Healthcare Equity.

* Lecturer at the European and International Law Program and member of the research group Changing Role of Europe of The Hague University of Applied Sciences, former assistant professor at the University of Vienna, Austria, Institute for European Integration Research and former post-doctoral researcher at Tilburg University, The Netherlands, Department of European and International Public Law and Tilburg Law and Economics Center. She holds a PhD and an MA degree from Central European University, Hungary and an MA degree from the University of Leuven, Belgium.

I. INTRODUCTION

Equity in access to healthcare is an essential element of the right to health[1] and an indicator of healthcare systems' performance.[2] It means that access to healthcare is based on medical need rather than ability and/or willingness of patients to pay for healthcare services and goods.

Health and healthcare-related rights are stipulated in many domestic constitutions around the world. A study that reviewed the entire corpus of contemporary national constitutions and constitutional documents (195 in total), concluded that 69% of them contained provisions on healthcare.[3] The findings also revealed that the status and strength of such provisions differed across the countries: only 41% of the contemporary domestic constitutions contained a justiciable right to healthcare, i.e., an individual right enforceable via domestic courts and subject to legal remedy. The remaining 28% stipulated healthcare as a non-binding aspirational goal and/or principle guiding the design and implementation of state policies.

Much has been written about the factors that influence the constitutional entrenchment and justiciability of the right to health. Country features such as legal tradition and regional location,[4] and healthcare system features such as organization and the financing model,[5] have been found relevant for the inclusion of a judicially enforceable right to health in the constitution of a country. Studies have identified a link between the financing model of the healthcare system and the impact of health rights litigation on equity. Adopting a comparative law and healthcare system approach, such research has shown that healthcare systems financed predominantly through social health insurance are more likely to have a judicially enforceable right to health compared to tax-funded systems.[6] However,

---

1 United Nations Committee on Economic, Social and Cultural Rights (CESCR), General Comment No 14, The Right to the Highest Attainable Standard of Health, UN Doc. No E/C.12/2000/4 (2000).

2 World Health Organization, "The world health report" : 2000 : Health systems : improving performance. World Health Organization, 2000. https://apps.who.int/iris/handle/10665/42281 (last accessed on 14 November 2019).

3 Courtney Jung, Ran Hirschl and Evan Rosevear, "Economic and Social Rights in National Constitutions," *American Journal of Comparative Law* 62, no. 4 (2014): 1043-1098.

4 Jung, Hirschl, and Rosevear, "Economic and Social."

5 Colleen M Flood and Aeyal Gross (eds.), *Comparative Health Rights at the Public/Private Divide* (Cambridge: Cambridge University Press, 2014).

6 Flood and Gross, *Comparative Health Rights*.

scoping reviews conclude that evidence concerning the impact of health rights litigation on equity remains inconclusive in the context of a shortage of systemic comparative analysis of within-country or cross-country cases.[7]

This paper intends to contribute to the discussion on equity in healthcare by focusing on the related role of domestic Constitutionazl Courts. The focus of the analysis will be on the element of healthcare financing, with equity understood as entailing a fair distribution of the healthcare financing burden across the different socio-economic groups of the population.

The paper addresses these issues by drawing some lessons from the case of Hungary. Hungary has been chosen as a country with a system of social health insurance, a financing model that has been found in the above-cited literature as linked to a judicially enforceable right to health at domestic level.[8] Having ratified the relevant international instruments on social and economic rights, Hungary has committed itself to respect, protect, and fulfill equity as an essential element of the right to health. As an EU Member State, it has committed itself to safeguard equity in healthcare as a fundamental value shared by all European countries. Nevertheless, the Hungarian healthcare system has been struggling with persistent equity challenges although the public scheme includes a statutory right to full cost coverage for most services provided within its framework. In the context of the equity challenges, the paper examines whether the financing model of social health insurance is linked to a judicially enforceable right to health, and whether health-rights litigation has been conducive to equity in the Hungarian case. Health-related rights have indeed been incorporated in successive domestic constitutions of Hungary and natural and legal persons have repeatedly invoked these rights to challenge government measures with an equity impact. Analyzing the jurisprudence of the Hungarian Constitutional Court, the paper explores the justiciability of the health rights stipulated in the constitution and the role of constitutional litigation in safeguarding equity in healthcare.

---

7 Tatiana Andia and Everaldo Lamprea, "Is the Judicialization of Health Care Bad for Equity? A Scoping Review," *International Journal for Equity in Health* 18 (2019): 61-67.

8 Flood and Gross, *Comparative Health Rights*.

The paper starts with an overview of the concept of equity as enshrined in the international human rights regime. Related political commitments of European Union Member States are also outlined. The discussion then moves to the link between the financing model of the healthcare system and the role for and impact of health rights litigation on equity. Findings of studies adopting a comparative law and healthcare system approach are reviewed towards this end. Afterwards, the paper zooms into the case of Hungary. Following a brief overview of the country's healthcare system with focus on the financing model, the analysis proceeds to the health-related provisions of the successive Hungarian constitutions and their interpretation by the Constitutional Court. Relevant decisions delivered by the Constitutional Court between mid-1990s and 2018 will be reviewed towards this end.

It is important to note that, apart from constitutional litigation, several other mechanisms have been put in place in Hungary to enforce the statutory health-related rights guaranteed within the public, compulsory system of social health insurance. One such mechanism is the Equal Treatment Authority, a state agency with a mandate to investigate and sanction violations of the non-discrimination rule in healthcare. Another is the system of patients' rights representatives who work in healthcare facilities operating in the public system. They address patients' complaints, assist them with information provision, and advise them on rights enforcement.[9] Yet another mechanism is the Office of the Commissioner for Fundamental Rights (Ombudsman's Office), which investigates citizens' complaints and may initiate general or specific measures for redress. Hospital ethical committees and supervisory councils are also present in the system. Contribution of these various mechanisms to health equity has been discussed elsewhere[10] and is beyond the scope of the analysis included in this

[9] On the establishment and responsibilities of patients' rights representatives in the Hungarian system, see Judit Sándor, "Ombudspersons and Patients' Rights Representatives in Hungary," in *Protecting Patients' Rights? A Comparative Study of the Ombudsman in Healthcare*, ed. Stephen Mackenney and Lars Fallberg (CRC Press, 2002), 55-76.

[10] For further discussion on the role fulfilled by these mechanisms in the system, see Mária Éva Földes, "Addressing Equity in Health Care at the Public-Private Intersection: The Role of Health Rights Enforcement in Hungary," in *The Right to Health at the Public/Private Divide: A Global Comparative Study*, ed. Colleen M. Flood and Aeyal Gross (Cambridge: Cambridge University Press),229-232, 2014.

paper. Instead, this paper focuses specifically on the constitutional complaint mechanism and the justiciability of the health-related constitutional provisions.

The analysis ends with conclusions on the role of Constitutional Courts with focus on the following points: Should Constitutional Courts second-guess, based on equity, state action on healthcare financing? Is it the role of Constitutional Courts to perform a corrective function if state action is not conducive to equity? In doing so, the paper intends to contribute to the broader discussion on the role of domestic constitutional courts in the protection of social and economic rights.

II. EQUITY IN THE INTERNATIONAL HUMAN RIGHTS REGIME AND ON THE EUROPEAN AGENDA

The CESCR General Comment No. 14[11] on the normative content of Article 12 of the International Covenant on Economic, Social and Cultural Rights[12] conceptualizes equity as part of economic accessibility/ affordability of healthcare. The latter is an essential element of the right to the highest attainable standard of health enshrined in the Covenant. This element requires that payment for healthcare services, goods as well as services related to the underlying determinants of health, is affordable to everyone. Importantly, equity requires that lower-income households and socially disadvantaged groups in general, do not pay proportionately more of their income for health services and goods than higher-income households do. State Parties to the Covenant must respect, protect, and fulfill equity in healthcare regardless of the financing and organizational model of their domestic healthcare system.

Equity is also present in commitments made by European Union Member States to safeguard the fundamental values and principles of European healthcare systems. The health ministers in the Council of the European Union endorsed the shared value of equity, defined as equal access ensured according to need and regardless of ability to pay.[13] All EU Member States have committed themselves

[11] UN Committee on Economic, Social and Cultural Rights (CESCR).

[12] International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 22001 (XXI), U.N. GAOR, 21st Sess., Supp. No 16, U.N. Doc A/6316, 993 U.N.T.D. 3 (1996).

[13] Council of the European Union, "Council Conclusions on Common Values and Principles in European Union Health Systems", *Official Journal* C-146/1-3: 2006.

to achieve equity in healthcare regardless of the financing and organizational features of their respective domestic systems. Adopted in the form of Council Conclusions, this joint commitment was a response to case law developments in the field of cross-border healthcare that threatened to diminish the political control of national governments over decisions concerning the mechanisms used to finance and deliver healthcare services and goods.[14] Although the Council Conclusions lack a legal enforcement mechanism, they constitute commitments with political weight that have proven effective in paving the way for initiatives on patient rights in cross-border healthcare, quality of care, cross-country cooperation in rare diseases, and health.[15]

In 2017, the equity agenda received a fresh impetus with the inter-institutional proclamation and signature of the European Pillar of Social Rights.[16] Equity is enshrined in the Pillar through the commitment of EU Member States to ensure everyone's right to timely access affordable preventive and curative healthcare of good quality, and everyone's right to affordable long-term care services of good quality.[17] The implementation of the Pillar is primarily left to the national governments and the social rights set forth therein serve as a reference framework for country-level healthcare reforms. While the Pillar does not contain directly enforceable rights, EU institutions have committed themselves to further its implementation through a number of instruments including action to update, complement, and better enforce relevant EU law.[18]

---

[14] On the political responses to the cross-border care case law, see Dorte Sindbjerg Martinsen, "Conflict and Conflict Management in the Cross-border Provision of Healthcare Services," *West European Politics* 32, no. 4 (2009): 792-809; Mária Éva Földes, "Health Policy and Health Systems: A Growing Relevance for the EU in the Context of the Economic Crisis," *Journal of European Integration* 38, no. 3 (2016): 295-309; Mária Éva Földes, "Member State Interests and European Union Law: The Case of Health Policy and Health Systems," in *Between Compliance and Particularism: Member State Interests and European Union Law*, ed. Márton Varju (Springer, 2019), 213-232, 221).

[15] See, for a discussion of such impact, Scott Greer, Nick Fahy, Sarah Rosenblum, Holly Jarman, Willy Palm, Heather A. Elliott and Matthias Wismar, "Everything You Always Wanted to Know about European Union Health Policies but were Afraid to Ask," 2nd edition (World Health Organization, Health policy series 54, 2019).

[16] European Parliament, Council of the European Union and European Commission. Proclamation of the European Pillar of Social Rights at the at the Social Summit for Fair Jobs and Growth in Gothenburg in Sweden on 16 November 2017. See "European Pillar of Social Rights," European Parliament, access 6 November 2019, https://ec.europa.eu/commission/sites/beta-political/files/social-summit-european-pillar-social-rights-booklet_en.pdf.

[17] Eurpean Parliament, Council of the. See Principles 16 and 18 of the European Pillar of Social Rights, respectively.

[18] European Commission, Establishing a European Pillar of Social Rights, 26.4.2017, COM (2017), 250 final.

As shown above, equity has found its place in international and European commitments. However, the proof of the pudding is in the eating: is equity also present in national level commitments? Is it an element of a judicially enforceable right to health entrenched as such in domestic constitutions? And, what factors make this more likely to happen? The following part of this paper reviews the findings of research exploring the relevance of one particular factor: the financing model of the domestic healthcare system.

III. THE ROLE AND IMPACT OF THE RIGHT TO HEALTH: RELEVANCE OF THE FINANCING MODEL OF THE HEALTHCARE SYSTEM

Research adopting a comparative law and healthcare system approach has revealed a link between the financing model of the healthcare system and the role for the right to health and health rights litigation at domestic level. A global comparative study carried out to explore this link[19] categorized countries into three "baskets" based on their financing model and specifically, the differential roles envisaged for public and private financing. These three baskets included, respectively: (1) countries (mostly high-income) that aimed at universal healthcare coverage and relied on public, tax-based financing as a defining characteristic of the system; (2) social health insurance/managed competition systems in (mostly high-income) countries that also aimed at universal healthcare coverage and were predominantly financed through mandatory health insurance via non-profit, public or for-profit, private sickness funds, and (3) public/private systems in a number of (predominantly) middle-income countries. The latter category included countries that either lacked universal healthcare coverage or had a two-tier system where an impoverished, publicly funded scheme existed alongside a privately financed scheme accessible only to those people who could afford such private payments.[20]

[19] Flood and Gross, *Comparative Health Rights*.

[20] "Public" in this category meant systems funded by tax finance as well as those partially funded by mandatory social health insurance or mandatory private insurance. See Colleen Flood and Aeyal Gross, "Litigating the Right to Health: What Can We Learn from a Comparative Law and Health Care Systems Approach," *Health and Human Rights* 16, no. 2 (2014): E62-72.

Although no causal relation was proven, findings revealed disparate roles for the right to health and health rights litigation within the three categories outlined above. Specifically, it was found that healthcare systems financed predominantly through social health insurance were more likely to have a judicially enforceable right to health within the public scheme, compared to tax-funded healthcare systems. Arguably, the design and structural features of social health insurance as a financing model, provide the necessary preconditions for health rights litigation. One such feature is the possibility to base individual claims on insurance contracts concluded between financiers and individuals. Another feature is the entrenchment of health-related rights and a basic "health basket" in statutes and the use of formal decision-making processes to establish the content of this health basket, guaranteed to everyone within the public scheme as part of a contract of insurance. The financing model of social health insurance is argued to be in itself conducive to a stronger role for the right to health and health rights litigation within the system. (This is in comparison with tax-financed public systems, which were found to usually not have a judicially enforceable right to publicly funded healthcare, with some notable exceptions like in Canada[21]). Furthermore, a constitutional right to healthcare was introduced in middle-income countries with two-tier systems where a publicly funded but under-resourced scheme co-existed with a privately financed scheme solely affordable to a small part of the population. In these countries, social and economic rights were included in the constitution as part of the agenda to remedy the retrogressive effects of gross inequities existing in the society.[22]

A number of studies have explored the impact of health rights litigation on equity. Although scoping reviews concluded that evidence on such impact was inconclusive due to the shortage of systematic comparative analysis of within-

[21] Colleen Flood, "Litigating Health Rights in Canada: A White Knight for Equity?" in *Comparative Health Rights at the Public/Private Divide*, ed. Colleen Flood and Aeyal Gross (Cambridge: Cambridge University Press, 2014), 79-106.

[22] Colleen Flood, "Litigating Health Rights." See also Colleen Flood and Aeyal Gross, "Introduction: Marrying Human Rights and Health Care Systems: Contexts for a Power to Improve Access and Equity," in *Comparative Health Rights at the Public/Private Divide*, ed. Colleen Flood and Aeyal Gross (Cambridge: Cambridge University Press, 2014), 1-18.

country or cross-country cases,[23] some findings are noteworthy. A quantitative study conducted in Brazil concluded that judicialization of healthcare did not benefit the most disadvantaged parts of the population but on the contrary, it facilitated the concentration of health resources in municipalities with higher socioeconomic status.[24] Other studies revealed that the impact of health rights litigation changed over time. In this respect, a recent shift towards more regressive effects has been found for example, in case of access to pharmaceutical products.[25] Some commentators warned about the negative impact of overusing health rights litigation to reinforce specific individual claims (e.g., for high-priced health services and goods), on state efforts to achieve the broader solidarity and fair distribution goals of public health systems.[26] Concerns have been voiced about undue distortions in the allocation of public funds in favor of the wealthier groups of the population who have the resources to litigate and enforce individual claims to expensive treatments.[27]

As shown by the studies outlined above, a focus point of the current debate is the link between the financing model of the healthcare system and the role of the right to health and health rights litigation at domestic level. Another question is the impact of health rights litigation on equity. The following parts of this paper contribute to this debate by examining these questions in the case of Hungary. To this end, it is first necessary to discuss the financing model of the Hungarian healthcare system and point out the challenges to equity. Afterwards, the analysis moves to the right to health in the public, mandatory healthcare system. The health-related provisions of the successive Hungarian constitutions are discussed next as interpreted by the Hungarian Constitutional

[23] Andia and Lamprea, "Is the Judicialization," note 8. *See also* Claudia Marcela Vargas-Pelaez, et al., "Judicialization of Access to Medicines in Four Latin American Countries: A Comparative Qualitative Analysis," *International Journal for Equity in Health* 18 (2019): 68.

[24] Luciana De Melo Nunes Lopes, Lopes et al., " "(Un)Equitable Distribution of Health Resources and the Judicialization of Healthcare: 10 Years of Experience in Brazil," *International Journal for Equity in Health* 18 (2019): 10.

[25] Claudia Marcela Vargas- Palaez et al., "Right to Health, Essential Medicines, and Lawsuits for Access to Medicines - A Scoping Study," *Social Science & Medicine* 121 (2014): 48-55.

[26] Everaldo Lamprea, "Colombia's Right-to-Heath Litigation in a Context of Health Care Reform," in *Comparative Health Rights at the Public/Private Divide*, ed. Colleen Flood and Aeyal Gross (Cambridge: Cambridge University Press, 2014), 131-158; Everaldo Lamprea. "The Judicialization of Health Care: A Global South Perspective," *Annual Review of Law and Social Science* 13 (2017): 431-449.

[27] Flood and Gross, *Comparative Health Rights*.

Court. The analysis continues with a discussion on the impact of health rights litigation in the Hungarian context and draws some broader conclusions on the role of Constitutional Courts in promoting the equity agenda in healthcare.

IV. THE HUNGARIAN HEALTHCARE SYSTEM

Hungarian legislation provides for a social health insurance system with compulsory membership. Opting-out of the public, compulsory system is not allowed but individuals may purchase additional, voluntary, private health insurance. The public scheme aims at universal coverage and provides a statutory right to full cost coverage for most healthcare services provided within its framework. Subsidized goods include prescription medicines in outpatient care and medical devices.[28]

4.1. The Financing Model

The Health Insurance Fund (hereafter: The Fund) was created in 1993 as a single public fund operating nationwide and originally separated from the central government budget. Financing for this Fund is sourced from employers and employees whose contributions are calculated as percentages of salary income and additional income. Parliamentary Act LXXX of 1997 on Persons Entitled to Social insurance Services and Private Pension and the Financing of These Services[29] regulates the contribution rates and the entitlement conditions within the public scheme. It also sets an obligation for the government to cover, from taxes, the shortfall in the revenues of the Fund. Furthermore, Parliamentary Act LXXXIII of 1997 on Services of Compulsory Health Insurance[30] stipulates an obligation for the Hungarian state to take responsibility for ensuring healthcare irrespective of the revenues stemming from social health insurance – which has meant, in practice, a

[28] For the overview of the organization and financing of the Hungarian healthcare system and the analysis of the politics of healthcare reforms, see Földes, "Addressing Equity in," note 11.

[29] Act LXXX of 1997 on Persons Entitled to Social Insurance Services and Private Pension and the Financing of These Services (1997. évi LXXX. törvény a társadalombiztosítás ellátásaira és a magánnyugdíjra jogosultakról, valamint e szolgáltatások fedezetéről) (Hung.).

[30] Act LXXXIII of 1997 on Services of Compulsory Health Insurance (1997. évi LXXXIII. törvény a kötelező egészségbiztosítás ellátásairól) (Hung.).

yearly injection of tax-based resources due to the chronic shortfall in the Fund's revenues.

The system was struggling over two decades with the challenges of strengthening social health insurance. The Fund was constantly facing revenue shortage issues and successive government coalitions had limited success in meeting these challenges. After 2010, the national government launched a centralization process including the integration of the Fund into the central government budget.

Although social health insurance is still dominant as a financing model, the Hungarian system has been shifting towards a more mixed model with elements of tax-based financing and notably, a growing share of private, out-of-pocket financing. The OECD estimated that in 2018, Hungary spent 6,6% of its GDP on healthcare, which is below the OECD36 average of 8,8%.[31] In 2017 (the latest year for which comparative data are available on health expenditure by type of financing), 61% of total health expenditure was financed by compulsory social health insurance, 8% by government schemes, 2% by voluntary health insurance schemes, and 27% by out-of-pocket payments.[32] The share of out-of-pocket payments is higher than the OECD36 average of 21%.

4.2. Persisting Challenges to Equity

The Hungarian healthcare system is designed to ensure financial protection of the population through the public, compulsory, social health insurance scheme with universal application. However, as shown by the OECD figures indicated above, the share of private, out-of-pocket financing of healthcare is significant at population level. Out-of-pocket payments constitute a regressive way of healthcare financing because they impose disproportionately higher burdens on low income groups who are thus more likely to face the risk of unmet medical need.

[31] OECD, *Health at a Glance 2019: OECD Indicators* (Paris: OECD Publishing, 2019), 153, https://doi.org/10.1787/4dd50c09-en.

[32] OECD, *at a Glance 2019, 157.*

Apart from private financing, private provision of healthcare has also been on the raise. In 2013-2015, the total capacity of licensed, privately financed outpatient care exceeded that of the publicly funded.[33] Private, for-profit healthcare providers operate alongside the public, compulsory, social health insurance scheme. This poses equity challenges because a shift towards uncontrolled private healthcare provision and financing disadvantages low income groups.

The share of Hungarian households with catastrophic healthcare expenditure has been high and on the rise: in 2014, it reached 21,6%. Catastrophic healthcare expenditure as a healthcare system performance indicator, generally refers to out-of-pocket spending for medical treatment that exceeds a certain share of a household's income and threatens the household's financial ability to meet its subsistence needs.[34] Data show that such expenditure is most common among the two lowest income quintile groups of the Hungarian population.[35] Although unmet need in healthcare is relatively low at population level (it affected 7% of the total population in 2014), the risk of unmet need among disadvantaged groups exceeds manifold the population average.[36]

One should also mention the persistence of informal (illicit) fees charged in the public, compulsory, social health insurance scheme. Studies have documented that patients regularly pay such fees although they should be able to access healthcare free of charge at the point of delivery, based on their statutory rights. Such illicit fees are most common in hospital care and certain forms of outpatient care, and government measures have had limited success so far in tackling them.[37] Informal payments remain widespread

[33] OECD, *Health at a Glance 2019,* 25.

[34] For the definition of this indicator, *see* Sharifa Ezat and Yasmin Almualm, "Catastrophic Health Expenditure among Developing Countries," *Health Research Policy and Systems* 4, no. 1 (2017).

[35] National Healthcare Services Center. *Health System Performance Assessment 2013-2015* (Állami Egészségügyi Ellátó Központ, *Magyar Egészségügyi Rendszer Teljesítményértékelési Jelentése 2013-15*) (December 2016), 25, https://mertek.aeek.hu/jelentes-2013-15.

[36] National Healthcare Services Center, *Health System Performance*, 26.

[37] Petra Baji, Petra Baji, et al.,"Informal Payments for Healthcare Services and Short-Term Effects of the Introduction of Visit Fee on These Payments in Hungary," *The International Journal of Health Planning and Management* 27, no. 1 (2011): 63-79.

and pose serious threats to equity. A study examining the distribution of the burden of informal payments across income groups concluded that Hungarian people with low income paid proportionally more for publicly provided healthcare through informal payments (compared to those with higher income).[38] Informal payments persisting in the Hungarian public scheme have been ranked among the most regressive in international comparison.[39]

V. THE RIGHT TO HEALTH IN THE HUNGARIAN SYSTEM

Health-related guarantees have been present in the Hungarian Constitution since 1949, with various status and strengths. The constitution in force between 1949 and 1989, i.e., during the years of state-socialism, only stipulated a workers' right to health, derived from the right to work and with content focused on occupational health and safety.[40] This constitution was substantially amended in 1989 marking the transition from state-socialism to democracy.[41] The amendments introduced a number of health-related provisions including the right to the highest attainable level of physical and mental health (Article 70/D), the right to social security (Article 70/E), and the right to a healthy environment (Article 18).

The current constitution, named Fundamental Law of Hungary, was adopted in 2011 and came into force in January 2012.[42] Although the Fundamental Law also contains a right to health, the "highest attainable" element was removed from its formulation. The current Article XX contains a "right to physical and mental health", guaranteed to everyone.[43] It also includes an obligation for

[38] Agota Szende, Anthony Johr Culyer, "The Inequity of Informal Payments for Health Care: The Case of Hungary," *Health Policy* 75, no. 3 (2006): 262–271.

[39] Szende and Culyer, "The Inequity."

[40] The Constitution of the People's Republic of Hungary, Act XX of 1949 (1949. évi XX. törvény, a Magyar Népköztársaság Alkotmánya) (Hung.), adopted on 18 August 1949.

[41] Act XXXI of 1989 on the amendment of the Constitution (1989. évi XXXI. törvény az Alkotmány módosításáról) (Hung.), adopted on 23 October 1989, in force until 31 December 2011.

[42] The Fundamental Law of Hungary (Magyarország Alaptörvénye), adopted on 25 April 2011, in force since 1 January 2012.

[43] The Fundamental Law of Hungary, Article XX (Magyarország Alaptörvénye).

the Hungarian state to "promote the effective application" of this right. The state must fulfill this obligation "through an agriculture free of genetically modified organisms, by ensuring access to healthy food and drinking water, by organizing safety at work and healthcare provision and by supporting sports and regular physical exercise as well as by ensuring the protection of the environment".[44] Furthermore, the Fundamental Law contains a right for everyone to a healthy environment, a related prohibition of transport of pollutant waste into the territory of Hungary for the purpose of disposal, and an obligation for anyone who cause damage to the environment, to restore it or bear the cost of restoration.[45] It also stipulates entitlement to assistance in case of illness, maternity, invalidity, disability and other risks outside the individual's control, in conditions further specified at the statutory level.[46] The nature and extent of social measures are determined at the statutory level, and the Fundamental Law includes a requirement for the legislator to take into account "the usefulness to the community of the beneficiary's activity" when making such determinations. It is noteworthy that, unlike the previous constitution in force until 2011,[47] the current Fundamental Law no longer includes a right to social security. The rights' language has been replaced by a weaker language of aspirational goals set for the state. Accordingly, the state should "strive to provide social security to all of its citizens", implemented through a system of social institutions and measures. This change has reduced the possibilities to invoke this provision during litigation, since social security is no longer formulated as a legally enforceable fundamental right.

The scope and content of the right to health within the framework of the public scheme is further determined at the statutory level. Parliament defines the benefit package at the level of broad categories, in acts with national application. Parliamentary Act CLIV of 1997 on Health[48] sets forth a catalogue of health-related

44 The Fundamental Law of Hungary, Article XX.
45 The Fundamental Law of Hungary, Article XXI.
46 The Fundamental Law of Hungary, Article XIX.
47 *See* The Hungarian Constitution in force between 1989 – 2011, Article 70/E.
48 Act CLIV of 1997 on Health (1997. évi CLIV. törvény az egészségügyről) (Hung.).

individual rights, minimum standards and procedures as well as enforcement mechanisms. Noteworthy are the right to healthcare, a corresponding duty for the state to ensure access to healthcare for everyone including low-income (and other vulnerable) groups, and a number of patients' rights in the public health system such as the right to information, confidentiality, redress in cases of harm, personal data protection, and the prohibition of discrimination.[49] Parliamentary Act LXXXIII of 1997 on Services of Compulsory Health Insurance[50] defines the in-kind and cash benefits included in the health basket, regulates exclusion/inclusion of services at the level of broad functional categories, sets the referral rules, the contracting rules, and the payment methods. Decrees of the central government and ministerial decrees determine the health benefit package at more detail by regulating, e.g., the extent of the subsidy granted for prescription medicines and medical devices and the inclusion/exclusion of benefits in the health basket.[51] The government covers from the central budget the cost of healthcare provided in the public, mandatory system for certain vulnerable groups defined at the statutory level.

As noted in the introduction to this paper, besides constitutional litigation, individuals can also use other mechanisms to enforce their statutory health-related rights guaranteed within the public, compulsory system of social health insurance. Further discussion of these various mechanisms is beyond the scope of this paper. Instead, the following section turns to the constitutional complaint mechanism and the justiciability of the health-related constitutional provisions.

---

[49] See, for further discussion of patients' rights in the Hungarian healthcare system, Mária Éva Földes, "Revisiting Patients' Rights to Information in an Enlarged Europe: A review of the Romanian and Hungarian Regulatory Framework in the Light of European Union Rules," *Orvostudományi Értesítő (Bulletin of Medical Sciences)* 83, no. 2 (2010): 134-139.

[50] Act LXXXIII of 1997 on Services of Compulsory Health Insurance (1997. évi LXXXIII. törvény a kötelező egészségbiztosítás ellátásairól) (Hung.).

[51] See Ministerial Decree No 32/2004 (IV. 26) on Criteria for Inclusion in Social Insurance Coverage of Authorized Medicinal Products and Food Supplements and on Changing Inclusion or Coverage (32/2004. (IV. 26.); Ministerial Decree No 14/2007 (III. 14.) on Inclusion in Social Insurance Coverage of Medical Aids and Coverage of Their Prescription, Supply, Reparation and Borrowing (14/2007. (III. 14.).

VI. JUSTICIABILITY OF THE HEALTH-RELATED CONSTITUTIONAL PROVISIONS: THE JURISPRUDENCE OF THE HUNGARIAN CONSTITUTIONAL COURT

The Hungarian Constitutional Court (hereafter: The Court) has interpreted the scope and content of the health-related constitutional provisions on several occasions. This section provides an overview of the Court's relevant jurisprudence and draws conclusions on the justiciability of these provisions. Justiciability requires that two conditions are met: (1) the constitutional provision serves as a basis for taking the state to court for its failure to fulfill its related obligations, and (2) natural and legal persons have legal recourse to ensure the fulfillment of their constitutional rights (usually through a mechanism for judicial review, set forth in the constitution).[52] The following section elaborates on these two conditions in the Hungarian context starting with remarks on the second one.

6.1. Curtailing *Locus Standi* for Natural and Legal Persons

Some remarks are due on recent changes in *locus standi* for natural and legal persons in Hungary. Between 1989 and 2012, any natural or legal person, *without legal interest*, was able to submit a petition to the Court requesting the constitutional review of a legal norm (*ex post* norm control).[53] Natural and legal persons have made extensive use of this possibility and frequently turned to the Court to challenge legal norms including those related to healthcare organization, financing, and delivery. Their access to the Court was, however, significantly curtailed in 2012 with the adoption of the Fundamental Law currently in force. The Fundamental Law introduced new rules on *ex post* review and reserved the right to initiate such proceedings to the Government, the Commissioner for Fundamental Rights (Ombudsman), the president of the Curia, the General Prosecutor, and one-quarter of the members of Parliament. Preliminary norm control (*ex ante* review) can only be initiated by Parliament, the President of the Republic, or the

[52] See Jung, Hirschl and Rosevear, "Economic and Social,"

[53] Act XXXII of 1989 on the Constitutional Court (*1989. évi XXXII. törvény az* Alkotmánybíróságról) (Hung.), in force until 31 December 2011.

Government (e.g., for the constitutional review of international agreements prior to their ratification).

Starting with 2012, natural and legal persons have been able to make use of the constitutional complaint mechanism only in concrete cases when their rights enshrined in the Fundamental Law were violated. At present, as a general rule, they can initiate such proceedings when their fundamental rights are infringed upon by a judicial decision and there are no other legal remedies available at national level (or all other remedies have been exhausted). The Court then reviews the judicial decision itself - not the law -, and may decide to annul it. The Court also admits cases where fundamental rights are directly violated, meaning, not by a judicial decision but by the application of an unconstitutional law, and there is no other legal remedy available. In such cases, the Court reviews the contested law and the legal consequence of the ruling can be annulment or termination of application.

6.2. Justiciability of the Constitutional Provision on Health

The Court delivered a landmark ruling on health-related rights in 1996,[54] when it was asked to scrutinize the rules set forth in Parliamentary Act LXIII of 1996 on the obligation of healthcare delivery and rules of territorial financing (hereafter: the 1996 healthcare financing act).[55] This act was adopted as a component of a reform package that intended to consolidate social health insurance, i.e., the financing model (re)introduced in Hungary after the fall of the state-socialist system. A number of petitioners including natural and legal persons, argued that the entire law was unconstitutional in itself because the new financing model violated the fundamental right to health, guaranteed to everyone as an individual constitutional right. Other petitioners contested certain provisions of the act including the specific payment mechanisms set forth therein and the powers conferred upon the Health Insurance Fund. The submissions reflected, in essence, the

[54] Alkotmánybíróság (AB) [Constitutional Court], MK. 1996. (105) 54/1996. (XI. 30.) (Hung.).

[55] Act LXIII of 1996 on the Obligation of Healthcare Delivery and Rules of Territorial Financing (1996. *évi XXXII. törvény* az egészségügyi ellátási kötelezettségről és a területi finanszírozási normatívákról) (Hung.).

dissatisfaction of petitioners with the state's withdrawal from the promises of free healthcare for all and the shift towards social health insurance as the new model of healthcare financing and basis of entitlements. The submissions embodied the petitioners' attempt to turn down these healthcare system reforms via constitutional litigation.

The Court addressed these complaints taken together in its Decision 54/1996.[56] In this ruling, it provided a comprehensive interpretation of the health-related provisions of the constitution in force at that time including Article 70/D on the right to the highest attainable physical and mental health, Article 70/E on the right to social security, and the constitutional protection of property. In essence, it argued that the constitutionality of the 1996 healthcare financing act could not be reviewed solely on the basis of Article 70/D on the right to health. As ruled by the Court, this provision, although it used a rights language, did not constitute a justiciable individual right. It merely formulated a responsibility for the state to ensure the functioning of a system of healthcare institutions and organize medical care. The state was at liberty to fulfil this responsibility as it saw fit, and within the limits of the capacity of the national economy. Article 70/D merely referred to the obligation of the state to create an economic and legal environment conducive to the fulfillment of the right to health.[57] The ruling made it clear that the Court was only willing to establish, in an abstract manner and in general terms, a minimum threshold to be guaranteed by the state. Failure to guarantee this necessary minimum could in principle lead to unconstitutionality, for example, in the extreme case of complete lack of a system of healthcare institutions and medical treatment on certain territories of the country. Beyond such extreme situations, fulfillment of state responsibilities in healthcare could not be assessed via constitutional review.[58]

[56] Act LXIII of 1996 on the Obligation of Healthcare Delivery and Rules of Territorial Financing (1996. *évi XXXII. törvény* az egészségügyi ellátási kötelezettségről és a területi finanszírozási normatívákról) (Hung.).

[57] *See also* Alkotmánybíróság (AB) [Constitutional Court], MK. 1995. 56/1995. (IX. 15.) (Hung.), at para. 260.

[58] Alkotmánybíróság (AB) [Constitutional Court], 1996, at para. 186.

As argued by the Court, "the constitutional right to the highest attainable physical and mental health could not be interpreted, in itself, as a legally enforceable individual right". Instead, this constitutional provision formulated a state responsibility, which included an obligation for the legislature to establish individual rights in certain areas of physical and mental health. In the view of the Court, the state enjoyed wide discretion in determining the financing model of the system and deciding on the entitlements and payment mechanisms. Its arguments can be further outlined as follows: Healthcare can be organized and financed in many different ways and the state is free to decide to alter the financing mechanisms and/or introduce an entirely new financing model. Nobody can claim a right to a certain model. Constitutional review is not the appropriate tool to assess the suitability of a system to guarantee healthcare entitlements. Unconstitutionality of the financing model can only be determined in extreme situations when it is unquestionable that the model is inherently unsuitable to fulfill the necessary minimum of state responsibilities. Thus, the financing model, the payment mechanisms, the functioning of the institutions and the organization of healthcare, cannot be contested via constitutional complaints as they fall outside the scope of the Constitution and constitutional review (save in extreme situations).

In subsequent decisions, the Court has repeatedly confirmed its reluctance to review the financing choices of the state on the basis of the constitutional provision on health. It did so when dismissing a submission that challenged co-payments such as flat-rate visit fees and hospital daily fees, charged in the public scheme.[59] Flat-rate co-payments constitute an equity issue because they are regressive and usually associated with an increased risk of unmet medical need.[60] Nevertheless, the Court refused

[59] Alkotmánybíróság (AB) elnöki végzés [Decision of the President of the Constitutional Court], MK. 2007. 179/I/2007. (IV. 6.) (Hung.).

[60] Gregoire Mercier, Jenica Pastor, Valerie Clément, Ulysse Rodts, Christine Moffat and Isabelle Quéré, "Out-of-Pocket Payments, Vertical Equity and Unmet Medical Needs in France: A National Multicenter Prospective Study on Lymphedema," *PLoS ONE* 14, no. 5 (2019): e0216386. https://doi.org/10.1371/journal.pone.0216386.

to second-guess the introduction of such co-payments and dismissed the submission arguing that the constitution did not guarantee free healthcare.

Recently, the Court confirmed its restrictive interpretation of the right to health in a ruling delivered in 2018.[61] In this case, a group of 25 petitioners (natural and legal persons) made yet another attempt to use the constitutional complaint mechanism against the financing rules set in the public scheme by challenging a related government decree.[62] The Court dismissed the submission and reiterated that the health provision of the Fundamental Law stipulated a constitutional responsibility for the state the fulfillment of which would not be reviewed by the Court save in extreme cases when a minimum threshold is not reached.[63] To date, the Court did not provide further guidance for the establishment of this minimum threshold; it merely repeated its earlier example discussed above (i.e., the total lack of healthcare institutions and medical care on certain territories of the country). It did, however, add further clarifications to the state responsibilities stemming from the constitutional provision on health: it established that the state had the duty to ensure that each Hungarian citizen insured within the public scheme had effective, *de facto* access to primary care by being assigned to a general practitioner. This is a basic constitutional duty of the state, and general practitioners contracted within the public scheme are indispensable for fulfilling it.

It is thus clear that the right to health, set forth as such in successive Hungarian constitutions, has not been interpreted by the Court as a judicially enforceable individual right. Instead, the Court has interpreted it as a state responsibility the fulfillment of which is *not to be assessed via constitutional review* - save in extreme circumstances when the state fails to meet a minimum threshold not fully defined by the Court to this date.

[61] Alkotmánybíróság (AB) [Constitutional Court], MK. 2018. 3197/2018. (VI. 21.) (Hung.).

[62] Petitioners challenged Government Decree No 43/1999. (III. 3.) on Detailed Rules Concerning the Financing of Healthcare Services from the Health Insurance Fund (Az *egészségügyi szolgáltatások Egészségbiztosítási Alapból történő finanszírozásának részletes szabályairól szóló* 43/1999. (III. 3.) Korm. Rendelet) (Hung.).

[63] Alkotmánybíróság (AB) [Constitutional Court], 2018, at para. 20.

6.3. The Right to Healthcare Derived from the Constitutional Provision on Social Security

While the Court ruled that the constitutional provision on the right to health did not constitute a legally enforceable individual right, it simultaneously held that *the right to healthcare exercised within the public, compulsory social health insurance system did constitute a real individual (fundamental) right*. However, the constitutional basis of this individual right was not the health article of the constitution but the one on social security and the constitutional protection of property. If the element of social insurance plays a determining role, reduction or termination of service provision should be reviewed in the light of property protection.[64]

As interpreted by the Court, the constitutional article on social security unconditionally requires that nobody is left without healthcare due to the shortfall in the financing of the Health Insurance Fund. Thus, the financing model of the healthcare system is only constitutional if the state effectively covers from the central government budget, the costs of healthcare services and goods guaranteed at statutory level when those costs exceed the revenues of the Fund. Therefore, the system is only constitutional if it guarantees the effective exercise of right to healthcare within the public, compulsory scheme, based on the constitutional right to social security.

It is noteworthy that the Court has only talked so far about the right to healthcare as a right present within the framework of the public, compulsory scheme. It interpreted the right to healthcare as a right "purchased" via the payment of insurance contributions, which must be guaranteed by the state in accordance with the requirements of the constitutional protection of property. Thus, the right to healthcare is conditional on the fulfillment of entitlement conditions. The legislative freedom of and choices made by the state will not be subjected to constitutional scrutiny unless they lead to violations of the right to healthcare exercised via social health insurance and/or violations of the right to property.

[64] See also Alkotmánybíróság (AB) [Constitutional Court], MK. 1995. 43/1995. (VI. 30.) (Hung.), at para. 195.

Although the Court upheld the right to healthcare as an individual, judicially enforceable right based on the social security article of the constitution, it nevertheless adopted a cautious approach when reviewing state decisions on the basis of this provision. It did so when being asked to review the constitutionality of the limits drawn to the subsidy of certain medical goods provided within the public, compulsory scheme.[65] Putting forward cost-containment arguments, it dismissed the submission and held that it was at the discretion of the state to draw limits to the health basket provided within the public, compulsory scheme. It also held that the constitution did not set forth any state obligation to fully subsidize a treatment.

What conclusions can we draw from this jurisprudence? A right to healthcare enforceable within the public, compulsory scheme was inferred by the Court from the constitutional right to social security. This right to healthcare constitutes an individual right that is judicially enforceable within the public scheme. This is in line with the findings of commentators who argue that features of social health insurance such as existence of insurance contracts, are conducive to a stronger role for the right to health. However, one should note that the Court has interpreted this right to healthcare as confined to the public scheme and as a "purchased right" conditional on fulfillment of membership conditions. Also, the Court has been reluctant to second-guess state decisions on payment rules such as flat-rate co-payments officially charged in the public scheme despite their regressive character from the perspective of equity. Moreover, the former constitutional right to social security was replaced by a weaker provision in the current Fundamental Law. This new social security provision no longer speaks of rights and merely sets an aspirational goal for the state. It remains to be seen how the Court will interpret this provision and whether it will still infer from it a judicially enforceable right to healthcare.

[65] Alkotmánybíróság (AB) [Constitutional Court], MK. 2003. 517/B/2003. (XII. 12.) (Hung.). See also Földes, "Addressing Equity in," note 11, 226.

VII. CONCLUSION: EQUITY IN HEALTHCARE – WHAT ROLE FOR CONSTITUTIONAL COURTS?

As outlined at the beginning of the paper, studies have found that countries adopting social health insurance as a financing model are more likely to have a judicially enforceable right to health. The case of Hungary does not fully support this finding. The constitutional right to health has not been interpreted by the Hungarian Constitutional Court as a justiciable individual right. The constitutional right to social security was used by the Court as the basis of affirming the existence of a judicially enforceable, individual right to healthcare, however, this right was confined to the public, compulsory scheme.

The Hungarian Constitutional Court has repeatedly confirmed its view according to which, constitutional review is not an appropriate tool for assessing the suitability of a system to guarantee healthcare entitlements (save in extreme situations, i.e., when it is unquestionable that the model is inherently unsuitable to fulfill the necessary minimum of state responsibilities). This approach is particularly concerning because, as a result, policy decisions impacting on the distribution of the financial burden across the population groups cannot be contested via constitutional review.

Health-related rights set in the constitution should, however, make it possible – and indeed, encourage – constitutional scrutiny of such policy decisions and in particular, they should enable the review of regressive policies in healthcare financing. Regressive financing policies can lead to serious equity challenges. They result in the unfair distribution of the financing burden to the disadvantage of the most vulnerable socio-economic groups. They are associated with disproportionately higher prevalence of unmet medical need among these groups. The equity component of the right to health is meant to prevent such outcome and Constitutional Courts should use it to turn down regressive policies. This is a corrective function that Constitutional Courts should be willing and equipped to perform if state action is not conducive to equity.

Furthermore, it is the duty of Constitutional Courts to examine whether a state's actions are in line with its human rights commitments including its commitment to fulfill the right to health and equity in access to healthcare as its core element. All individuals should benefit from these state commitments, including those most in need. Similarly, all individuals seeking healthcare should be able to do so in an equitable manner, including those who obtain medical treatment in the public scheme as well as those who obtain it at private facilities operating in the country. Especially in the context of emerging two-tier systems with under-funded public schemes and private schemes operating in parallel, constitutional litigation should serve as an effective tool for challenging the resulting redistribution and access problems.

BIBLIOGRAPHY

Act LXIII of 1996 on The Obligation of Healthcare Delivery and Rules of Territorial Financing (1996. *évi XXXII. törvény* az egészségügyi ellátási kötelezettségről és a területi finanszírozási normatívákról) (Hung.).

Act CLIV of 1997 on Health (1997. évi CLIV. törvény az egészségügyről) (Hung.).

Act LXXX of 1997 on Persons Entitled to Social Insurance Services and Private Pension and the Financing of These Services (1997. évi LXXX. törvény a társadalombiztosítás ellátásaira és a magánnyugdíjra jogosultakról, valamint e szolgáltatások fedezetéről) (Hung.).

Act LXXXIII of 1997 on Services of Compulsory Health Insurance (1997. évi LXXXIII. Törvény a kötelező egészségbiztosítás ellátásairól) (Hung.).

Alkotmánybíróság (AB) [Constitutional Court], MK. 1995. 43/1995. (VI. 30.) (Hung.).

Alkotmánybíróság (AB) [Constitutional Court], MK. 1995. 56/1995. (IX. 15.) (Hung.).

Alkotmánybíróság (AB) [Constitutional Court], MK. 1996. 54/1996. (XI. 30.) (Hung.).

Alkotmánybíróság (AB) [Constitutional Court], MK. 2003. 517/B/2003. (XII. 12.) (Hung.).

Alkotmánybíróság (AB) elnöki végzés [Decision of the President of the Constitutional Court], MK. 2007. 179/I/2007. (IV. 6.) (Hung.).

Alkotmánybíróság (AB) [Constitutional Court], MK. 2018. 3197/2018. (VI. 21.) (Hung.).

Andia, Tatiana and Everaldo Lamprea. "Is the Judicialization of Health Care Bad for Equity? A Scoping Review." *International Journal for Equity in Health* 18 (2019): 61-67.

Baji, Petra et al. "Informal Payments for Healthcare Services and Short-Term Effects of the Introduction of Visit Fee on These Payments in Hungary." *The International Journal of Health Planning and Management* 27, no. 1 (2011).

Council of the European Union. Council Conclusions on common values and principles in European Union health systems, *Official Journal* C-146/1-3, 2006.

European Commission. Establishing a European Pillar of Social Rights, 26.4.2017, COM(2017) 250 final.

European Parliament. "European Pillar of Social Rights." Access 6 November 2019. /https://ec.europa.eu/commission/sites/beta-political/files/social-summit-european-pillar-social-rights-booklet_en.pdf.

Ezat, Sharifa Wan Puteh and Yasmin Almualm. "Catastrophic Health Expenditure Among Developing Countries." *Health Research Policy and Systems* 4, no. 1 (2017). DOI:10.21767/2254-9137.100069.

Flood, Colleen. "Litigating Health Rights in Canada: A White Knight for Equity?" In *Comparative Health Rights at the Public/Private Divide*, edited by Colleen Flood and Aeyal Gross. Cambridge: Cambridge University Press, 2014.

Flood, Colleen and Aeyal Gross. "Litigating the Right to Health: What Can We Learn from a Comparative Law and Health Care Systems Approach." *Health and Human Rights* 16, no 2 (2014): E62-72.

Flood, Colleen M. and Aeyal Gross. "Introduction: Marrying Human Rights and Health Care Systems: Contexts for a Power to Improve Access and Equity." In *Comparative Health Rights at the Public/Private Divide,* edited by Flood, Colleen M. and Aeyal Gross. Cambridge: Cambridge University Press, 2014.

Flood, Colleen and Aeyal Gross, ed., *Comparative Health Rights at the Public/Private Divide.* Cambridge: Cambridge University Press, 2014.

Földes, Mária Éva. "Revisiting Patients' Rights to Information in an Enlarged Europe: A review of the Romanian and Hungarian Regulatory Framework in the Light of European Union Rules." *Orvostudományi Értesítő (Bulletin of Medical Sciences)* 83, no. 2 (2010).

Földes, Mária Éva. "Addressing Equity in Health Care at the Public-Private Intersection: The Role of Health Rights Enforcement in Hungary." In *The Right to Health at the Public/Private Divide: A Global Comparative Study*, edited by Colleen M. Flood and Aeyal Gross. Cambridge: Cambridge University Press, 2014.

Földes, Mária Éva. "Health Policy and Health Systems: A Growing Relevance for the EU in the Context of the Economic Crisis." *Journal of European Integration* 38, no. 3 (2016).

Földes, Mária Éva. "Health Policy and Health Systems: A Growing Relevance for the EU in the Context of the Economic Crisis." *Journal of European Integration* 38, no. 3 (2016).

Földes, Mária Éva. "Member State Interests and European Union Law: The Case of Health Policy and Health Systems." In *Between Compliance and Particularism: Member State Interests and European Union Law*, edited by Márton Varju. Springer, 2019.

Government Decree No 43/1999. (III. 3.) on Detailed Rules Concerning the Financing of Healthcare Services from the Health Insurance Fund (Az *egészségügyi szolgáltatások Egészségbiztosítási Alapból történő finanszírozásának részletes szabályairól szóló* 43/1999. (III. 3.) Korm. Rendelet) (Hung.).

Greer, Scott et al. "Everything You Always Wanted to Know about European Union Health Policies but were Afraid to Ask," 2nd edition. World Health Organization, Health policy series 54, 2019.

International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 22001 (XXI), U.N. GAOR, 21st Sess., Supp. No 16, U.N. Doc A/6316, 993 U.N.T.D. 3 (1996).

Jung, Courtney, Ran Hirschl and Evan Rosevear. "Economic and Social Rights in National Constitutions." *American Journal of Comparative Law* 62, no. 4 (2014).

Lamprea, Everaldo. "Colombia's Right-to-Heath Litigation in a Context of Health Care Reform." In *Comparative Health Rights at the Public/Private Divide*, edited by Colleen Flood and Aeyal Gross (Cambridge: Cambridge University Press, 2014).

Lamprea, Everaldo. "The Judicialization of Health Care: A Global South Perspective." *Annual Review of Law and Social Science* 13 (2017).

Lopes, Luciana De Melo Nunes et al. "(Un)Equitable Distribution of Health Resources and the Judicialization of Healthcare: 10 Years of Experience in Brazil." *International Journal for Equity in Health* 18 (2019): 10.

Martinsen, Dorte Sindbjerg. "Conflict and Conflict Management in the Cross-border Provision of Healthcare Services." *West European Politics* 32, no. 4 (2009).

Mercier, Gregoire et al. "Out-of-Pocket Payments, Vertical Equity and Unmet Medical Needs in France: A National Multicenter Prospective Study on Lymphedema." *PLoS ONE* 14, no. 5 (2019): e0216386. https://doi.org/10.1371/journal.pone.0216386.

Ministerial Decree No 32/2004 (IV. 26) on Criteria for Inclusion in Social Insurance Coverage of Authorized Medicinal Products and Food Supplements and on Changing Inclusion or Coverage (32/2004. (IV. 26.) (ESzCsM rendelet a törzskönyvezett gyógyszerek és a különleges táplálkozási igényt

kielégítő tápszerek társadalombiztosítási támogatásba való befogadásának szempontjairól és a befogadás vagy a támogatás megváltoztatásáról) (Hung.).

Ministerial Decree No 14/2007 (III. 14.) on Inclusion in Social Insurance Coverage of Medical Aids and Coverage of Their Prescription, Supply, Reparation and Borrowing (14/2007. (III. 14.) EüM rendelet a gyógyászati segédeszközök társadalombiztosítási támogatásba történő befogadásáról, támogatással történő rendeléséről, forgalmazásáról, javításáról és kölcsönzéséről) (Hung.).

National Healthcare Services Center**.** *Health System Performance Assessment 2013-2015* (Állami Egészségügyi Ellátó Központ, *Magyar Egészségügyi Rendszer Teljesítményértékelési Jelentése 2013-15*). December, 2016.

OECD. *Health at a Glance 2019: OECD Indicators*. Paris: OECD Publishing, 2019.

Sándor, Judit. "Ombudspersons and Patients' Rights Representatives in Hungary." In *Protecting Patients' Rights? A Comparative Study of the in Healthcare*, edited by Stephen Mackenney and Lars Fallberg. CRC Press, 2002.

Szende, Agota *and* Anthony Johr Culyer. *"*The Inequity of Informal Payments for Health Care: The Case of Hungary.*"* *Health Policy* 75, no. 3 (2006).

The Constitution of the People's Republic of Hungary, Act XX of 1949 (1949. évi XX. törvény, a Magyar Népköztársaság Alkotmánya) (Hung.).

The Amendment of the Constitution, Act XXXI of 1989 (1989. évi XXXI. törvény az Alkotmány módosításáról) (Hung.).

The Constitutional Court, Act XXXII of 1989 (1989. *évi XXXII. törvény az* Alkotmánybíróságról) (Hung.).

United Nations Committee on Economic, Social and Cultural Rights (CESCR), General Comment No 14, The Right to the Highest Attainable Standard of Health, UN Doc. No E/C.12/2000/4 (2000).

Vargas-Pelaez, Claudia Marcela et al. "Right to Health, Essential Medicines, and Lawsuits for Access to Medicines - A Scoping Study." *Social Science & Medicine* 121 (2014).

Vargas-Pelaez, Claudia Marcela et al. "Judicialization of Access to Medicines in Four Latin American Countries: A Comparative Qualitative Analysis." *International Journal for Equity in Health* 18 (2019): 68.

World Health Organization. *The World Health Report: 2000 : Health systems: improving performance*. World Health Organization, 2000. https://apps.who.int/iris/handle/10665/42281 (last accessed on 14 November 2019).