Improving Medical School Curricula and Roma Access to Health Care in Hungary

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Policy paper

Abstract

During the communist regime and after its fall a continuous decrease of the social and health conditions of the Roma minority can be witnessed in Hungary, which is a phenomenon supported by sociological research (Puporka-Zádori, 1998; Gyukits, 1999; Kemény-Janki-Lengyel, 2003; Babusik, 2004). Current central government legislation on the improvement of the living and health standards of disadvantaged social groups such as the Roma aims at supporting equal access to quality healthcare services and preventive programs.

Changing the discriminatory attitude of healthcare providers towards Roma patients; moreover, the modification of graduate and post-graduate education for medical personnel in relation to the socio-economic background, health status and cultural characteristics of the Roma minority are included in strategic programs of the Ministry of Health as well. Despite these goals the access of Roma people to quality health care still meets with difficulties.

This policy paper aims to analyze the implementation of government legislation related to the health conditions of Roma people and the education of healthcare providers at medical schools for successful cooperation and communication with patients of this minority. At the final part of my paper I offer policy recommendations for decision makers in the given field in order to improve the curricula of medical schools in terms of cross-cultural training and the health status of the Roma minority by proper access to quality healthcare services.

1. Introduction

Health should not be considered as a condition of absence of diseases. One definition of health according to the World Health Organization (WHO) includes the following: "the capacity for each human being to identify and achieve his/her ambitions, satisfy his/her needs and be able to adapt to his/her environment, which should include decent housing, normal access to education, adequate food, stable job with regular income and sufficient social protections".[1] The Roma in Hungary and the whole Central and Eastern Europe are in the position of suffering the worst health conditions (Ringold, 2000).

As a result, it can be concluded that the morbidity and mortality indicators of this minority are generally worse than of the majority population in Hungary (Babusik, 2004). However, the Roma as a significant social group within the whole population of Hungary are often forced to face negative discrimination from majority members of society due to their unique culture besides their existing economical, social and regional disadvantages. According to the 2005 survey of the World Health Organization the average years of life expectancy for Hungarians is 68 for males and 77 for females[2]. This means a relatively poor health status in the European scene considering the geopolitical conditions of Hungary. However, behind the low average there are significant geographical and social differences. At villages with a population lower than 1000 the life expectancy of males is 50% lower than in big cities[3]. As the vast majority of Roma live at such locations, we can conclude that the phenomenon significantly affects these people.

Hungary's population has been in decline for the past several years. In 1975 there were 10.5 million people who lived in the country and in 2003 this number was reduced to 10.2 million. This is not always the case with the Roma population; however, where the life expectancy is very low. Roma tend to live on average 10 years less than non-Romas (Doncsev, 2000b). Moreover, the Roma populations are younger than other groups, because of the significantly higher birth rate, despite of the fact that infant mortality rate among Roma communities in Hungary is about double the national average (European Commission, 2004). The 1991 census in Hungary registered 142.693 people as Roma in the country. When this data is contrasted with that provided by other sources, it differs substantially. In 1993 the representative data collection on private households conducted by the Central Statistical Office (KSH) recorded 394.000 Roma in Hungary. The World Facts Report of the Central Intelligence Agency (CIA) states that the structure of Hungarian society consists of Hungarians (92.3%), Roma (1.9%) and other or unknown (5.8%). According to the 2001 census 190.046 people reported themselves as Roma; however, some researchers estimate

[1] Towards a New Public Health, Ottawa Conference, WHO, Geneva, 1986
[2] World Health Organization (2005) World Health Report
[3] Dr Kincses, Gy. (2006). 'Stone in the Soup of Healthcare' In *Népszabadság*, 30th January

their number to be between 450.000 and 600.000[4]. The discrepancy among different sources partly relies on the fact that some researchers consider people to be of Roma origin, who declare themselves as Roma; while according to others, those people belong to this minority, who are considered as Roma by their environment[5].

Evidence shows that social environment such as income, type of work and social networks are major determinants of health (Lavis and Sullivan, 1999; Wilkinson, 1996). Váczi (1989) also claims the health status of the Roma in Hungary correlates with health indicators of social groups most affected by poverty. It is difficult to untangle the complex social, cultural and economic factors contributing to the poor health status of the Roma, but unemployment and poverty are definitely higher in this group compared to mainstream society.

During communist times a huge proportion of unskilled Roma people were employed in the manufacturing industry; however, most of these factories being unproductive were closed down after Hungary's transition to market economy. After the break-down of the communist system most of these unskilled Roma people became unemployed working previously as manual laborers. As a result, in post-transition years the unemployment rate was considerably higher among the Roma (35,8%) than among the non-Roma (11,2%) (Speder, Habich,1997). The rate of unemployed Roma people is presently estimated ten times higher than the national average (Human Rights Watch, 2002), which means a major decline in the status of this minority on the Hungarian labor market during the previous years. Therefore, the real danger concerning this minority is more a poverty than an ethnicity issue. The vicious circle of marginalized social status, being stigmatized for it and insufficient self-advocacy skills might result in lack of motivation for social mobility. Still the gaps in health status between the Roma and majority population reflect official discrimination and marginalization of this minority from members of mainstream society. In other words, the problems affecting the health of the Roma population are mostly of social origin; however, the cultural element of the problem should not be disregarded. The reasons for this are complex. It is very difficult to address the issue of Roma culture and draw general conclusions, as this minority consists of different subgroups having distinct cultural characteristics. As a conclusion, eliminating biases and discriminatory attitude in mainstream society towards Roma is of primary importance in the process of their social integration.

Several reports conducted to analyze the underlying factors behind the improper access to quality health care of the Roma reveal discriminatory cases. Separate wards kept for Roma patients and pregnant Roma women at hospitals, or forced sterilization (ERRC Report, 2004) are reoccurring issues in the widespread forms of discrimination against this

[4] Havas, G. & Kemény, I. & Kertesi, G., *Kritika,* 1998/3

[5] See more on the debate:
Ladányi, J., & Szelényi, I: 'Who is Roma'? In *Kritika,* 1997/3; and Kertesi, G: 'About the Possibilities of Empirical Research on the Roma', In Replika, 1998/3. In this paper I consider those people of Roma origin, who consider themselves as Roma.

minority at Hungarian healthcare institutions. In my views these issues can be addressed the most efficiently from the perspective of medical education. More specifically the sensitization of future healthcare providers is of crucial importance towards the characteristics of poverty and cultural differences related to ethnicity through interethnic contents built in medical curricula.

In this policy paper I intend to give an account of the implementation of current legislation on Roma access to health care and possible modification of medical school curricula in the interest of successfully achieving policy goals. The method applied includes the overview of current legislation on the given issue, analysis of statistical data related to the health status and social conditions of the Roma. I also analyzed research conducted in the field and made interviews with government representatives, staff of medical schools and healthcare institutions, medical students, Roma people, representatives of the civil sector and experts in Roma health.

In my paper, after examining the present changes in legislation and current policy on Roma integration, I will examine the implementation of these tools in order to reveal to what extent they are able to promote the access of Roma people to quality health care and their health status; moreover, to reduce discriminatory practices applied at healthcare institutions against them. I will also give an account of what elements are missing from the present legislation concerning Roma health issues and analyze the underlying reasons why government initiatives are doomed to failure in case they lack wide-ranging public acceptance. I also intend to explore the curricula of medical schools in the interest of tracking contents specially included for sensitizing future healthcare providers towards social and cultural issues, such as poverty or minority existence. Additionally, after reviewing such initiatives in other countries, I wish to present successful examples to educators in medical issues in the interest of teaching professionals to deal sensitively with ethnic minorities in general. Finally, in the last chapter based on my research findings I formulate policy recommendations to promote more efficient legislation on access of Roma people to quality health care.

2. Current Legislation on Roma Health Care

In the Hungarian welfare system the health sector has been among the areas most needing reform after 1989, the fall of the former socialist regime. Before the change a substantial improvement in public health status took place between World War II and the 1960s, mainly because of the increasing living standards due to the positive changes in the social and economic conditions of the country.

From the 60's onward a serious decline appeared in the quality of the healthcare system, arising from the fact that the communist ideology kept the state responsible for both financing and providing health services. The system was not flexible enough to adapt to the healthcare needs of the population; therefore, until the 1980s mostly quantitative goals were satisfied including the extension of recovery periods and the number of hospital beds (Füzesi, Ivády, Kovácsy, Orbán, 2005).

The present organization of the public health system was framed during the transition period. Hungary has already passed the most difficult phases of political transition and has accumulated experience in the course of preparing for fulfilling Community obligations and requirements. The right to a healthy environment, to income maintenance through social security, and to an optimal level of psychical and mental health is set in the Hungarian Constitution besides appointing the government as responsible body for social welfare and healthcare provisions.

As already mentioned the current social security system adapted in Hungary is a result of the historical development and most recent responses to the challenges of the economic and social transition. Eventually it became more pluralistic with divided responsibilities instead of placing all responsibilities on the state. The hierarchical relationships among different stakeholders moved towards contractual ones. However, according to Gyukics (1999) in a market-based healthcare system formed as a result of transition, disadvantaged Roma people mostly have access to medical services of lower quality due to their social drawbacks.

The National Public Health Program was accepted by the Parliament in 2001 containing specific elements to improve the access of disadvantaged people to quality healthcare services. It regulates the improvement of the living conditions of the Roma and aims at supporting the equal access of disadvantaged social groups to quality healthcare services and preventive programs. Changing the discriminatory attitude of healthcare providers towards Roma patients; moreover, the modification of graduate and post-graduate education for medical personnel in relation to socio-economic background, health status and cultural characteristics of the Roma minority are also important elements of the program. However, such contents in curricula at medical institutions are still relatively rare in general; additionally, it is difficult to identify measurable improvement in the health status of Roma people since this policy was launched.

The Decade of Health Government program aims at improving the health status of the whole Hungarian population. The main priorities of the initiative are based on the most important problems related to the health conditions of society. Specifically targeted area is the improvement in health conditions of the most disadvantaged social groups including the Roma. While developing the program, experiences from the national and international health scene were taken into account; moreover, cost efficiency was among the most important

aspects. In order to enhance the reform process, the Government aims not only to consolidate and modernize the current healthcare system but to carry on its financing reform. According to Government plans, the most important objectives are the improvement of the health conditions of the population, the increase of life expectancy at birth, and the facilitation of the quality of life determined by health. The program was adopted by the entire consensus of Parliament and its implementation started in April 2003.

The Medium Term Package on the Improvement of the Life Circumstances and Social Status of the Roma Minority was passed in 1999 and modified in 2001. The wide-ranging program contains measures to provide equal rights for the Roma, improve their quality of life and their living conditions, and develop their physical and mental health, besides providing chances for equal education and marketable job opportunities to promote their social integration. However, lack of systemic data on the impact of certain health policies on the Roma means a general problem in the realization of these programs.

Monitoring is insufficient from the Government's side and studies conducted mostly by non-governmental organizations on policy implementation do not reveal a general, systemic picture on the situation. According to the existing resources the process of policy implementation does not seem to function effectively considering the real needs of this minority. Most of the problems affecting the health circumstances of the Roma are still unsolved in practice, a large proportion of Roma people often do not have proper access to quality health services and their social status does not seem to improve either.

The 2002-2006 Government Program accepted by the new cabinet was created in the name of democratic, European values celebrating diversity recognizing the equal rights of people residing in Hungary. It entitles a specific section for the improvement of the living conditions of the Roma declaring that the social status of this minority is the result of a dramatic process in society instead of merely an ethnical issue. The document places special emphasis on the social protection of the Roma, the improvement of their educational standards and living conditions, the preservation of their culture and identity, the development of communication between majority and Roma members of the population; moreover, combating discrimination against them.

The 100 Steps Government Program of the present cabinet launched in 2005 sets out 21 areas for change in the area of health care. The program aims at decreasing the significant differences in access to quality health care by recognizing the differences and difficulties in GPs work due to regional differences. The elements affecting the Roma are the increase of salary linked to GP positions in the most disadvantaged regions of Hungary, where GP posts have been unfilled for a significant period of time. Besides nominative financing GPs are eligible for according to the number of their registered patients in their local community, the

new regulation allocates extra financing[6] to GPs operating at disadvantaged regions of the country.

There is a budget available for grants to be nominated to GPs undertaking a permanently unfilled GP position. However, some experts in medical issues strongly question the efficiency of such incentive programs and doubt the possibility of significant increase in the filled GP positions at such locations. The reason for their doubts is the assumption that a relatively minor increase in salary will not sufficiently attract GPs to fill these positions if their attitude towards Roma people remains the same. Therefore, there is more need for programs aiming at sensitizing medical personnel for disadvantaged social groups on both gradual and post-gradual level.

The strategic aims of the Hungarian government described above are in tune with the health promotion approach of the European Union; moreover, the wide-ranging Roma Decade Program launched by governments from 8 countries in the region. The cooperating countries intend to achieve long-term goals in the period between 2005 and 2015. The priority areas of improvement in relation to the general life conditions of the Roma are education, housing and employment besides health. The general program goal is raising the inclusiveness of health systems in participating countries. There is strong focus on the expansion of access to health care by breaking down barriers between Roma communities and healthcare providers. Hungary's priority in the initiative is increasing the number of Roma nurses, district nurses, doctors, and social workers through scholarships.

There are still no significant achievements as a result of the program and it is difficult to predict its efficiency in the long run. However, due to insufficient monitoring, it is uncertain if the Hungarian Decade Action Plan or the process of our EU accession has been realized by significant contribution to the promotion of Roma health until now. According to a study conducted by the Open Society Institute[7] the Hungarian government is being critiqued on international level for the inconsistency of monitoring Roma programs launched. Additionally, it reveals several weaknesses in Decade Action Plans including little participation of Roma in their creation, lack of specificity in the description of activities and monitoring; moreover, insufficient mainstreaming of the Decade's cross cutting themes of discrimination, gender and poverty.

3. Social Conditions Affecting Roma Health

From the factors affecting health education, economical status, economical activity and living conditions have a dominant role. These determinants influence the appearance of both

[6] From the 1st July, 2005 by the modification of the 43/1999 (III.3) Government Order.

[7] Mediating Romany Health, Policy and Program Opportunities (2005) Open Society Institute Network, Public Health Program

physical and mental illnesses. Risk factors affecting health appear in a joint manner strengthening each other resulting in and maintaining a health status very difficult to handle.

According to a 2001 survey of the National Institute for Health Development, from the risk factors, smoking, insufficient nourishment and the lack of preventive activities are issues affecting health status with high appearance among the Roma. Mortality rates are double among the Roma than the average population, while the most frequent illnesses causing death are cardio-vascular diseases and illnesses of liver.[8] Another study conducted on 166 subjects on a long-term basis in a ghetto-like Roma community in Hungary reveals, from the group involved in the study, most people died at the age of 30-50. Mortality and morbidity rates were much higher among women and illnesses of kidney and lungs were more frequent among them. The most typical illnesses of male members of the community were cardiovascular and kidney diseases (Szirtesi, 1998).

Government efforts to promote Roma health often fail to confront the social structures which shape health in the first place: inequity and discrimination in education, employment, and housing; poor access to clean water and sanitation; lack of social integration; minimal political participation; poor access to food and disparities in income distribution (Marmot, Wilkinson 1999; Berkman, Kawachi 2000). As a result we can conclude that health indicators mentioned above are primary results of the low socio-economic status of Roma people in society and cannot be improved without poverty reduction and social integration of this minority. Moreover, government programs targeting social mobility of the Roma should not disregard, but need to take into consideration the complex cultural characteristics of this group.

There is a severe lack of access to quality health care of the Roma population, not only because of cultural insensitivity or sometimes discriminatory attitude of medical personnel towards them, but due to regional inequalities as well. Roma communities are usually situated at segregated settlements, while most Roma live at deprived and socially disadvantaged regions of Hungary. According to a representative survey conducted in 2003 Roma people often lack proper medical treatment due to geographical reasons based in segregated settlements with significant distance not only from local hospitals, but often from the office of the closest GP in their area[9]. Further results of the survey show that settlements with multiple disadvantages do not offer local practitioner services directly. They also tend to lack other basic institutional services. In settlements, where there is no GP, the number of

[8] National Institute for Health Development (2001) *Roma felnőtt népesség egészségállapota, egészség magatartása és a romák valamint az egészségügyi szolgálatok közötti kapcsolat vizsgálata* (The Health Status of the Adult Roma Population, Health Behavior and the Analysis of the Relationship between the Roma and Health Services) Report

[9] Differences in Access to Primary Healthcare – Structures, Equal Opportunity and Prejudice – The Results of an Empirical Study, Hungarian Delphoi Consulting, 2003

Roma among the general population tends to be significantly higher; therefore, the inhabitants of these communities suffer multiple disadvantages with the lack of local and assessible health care.

4. Stereotypes of Healthcare Providers on the Roma

Roma people in Hungary have traditionally been targets of ethnic prejudice. The sometimes stereotypical social characteristics[10] existing on the Roma population are unfavorable for mainstream society. These prejudices are deeply rooted and transmitted through generations; therefore, are difficult to identify and change. When assessing public opinion about the Roma, not only cultural differences, but the deep socio-economic barrier between the Roma and non-Roma determines the origin of anti-Roma feelings. According to a representative survey taken among Hungarian citizens in 1992 and 1993, 60% of the respondents would mind if Roma people moved into their neighborhood and 64% of them would mind if their child married a Roma (Kostma, 1999). These numbers reveal very strong hostility against this minority in Hungarians, which is present on different segments and layers of society.

Social inequalities, the Roma need to face, are relatively often supplemented by negative, biased attitude of medical personnel at different healthcare institutions. These notions originate from different stereotypes on Roma people, due to insufficient information and lack of objective data on cultural differences, poverty and related issues including ethnicity.

A clear distinction can be identified between 2 types of discrimination in healthcare: when a person, due to their Roma origin, does not have access to a certain health service; while the other type is when a Roma person experiences concrete discrimination during receiving health service. As a result, a number of cases can be recognized, when a certain type of discrimination takes place in health care:

- insufficient access to GPs or medical specialists,
- the supposition of healthcare providers that a Roma patient cannot afford to pay gratuity money[11] for the medical service,
- negative discrimination in antenatal care
- improper access to preventive treatments.[12]

[10] Roma people are less educated, more likely to be unemployed and poorer then members the majority society (Fábián, Z. & Fleck, Z., 1999)

[11] Gratuity money is a widespread phenomenon in Hungarian health care by patients' directly giving money to medical personnel for their services as a symbol of gratitude; though, it is illegal to accept such benefits by avoiding tax-paying. Due to the private manner of these habits, it is very difficult to detect such cases of corruption.

[12] National Institute for Health Development (2001) Roma felnőtt népesség egészségállapota, egészség magatartása és a romák valamint az egészségügyi szolgálatok közötti kapcsolat vizsgálata (The Health Status of the Adult Roma Population, Health Behavior and the Analysis of the Relationship between the Roma and Health Services) Report

As already mentioned above, different drawbacks present in the state of health are deepened by the existing discrimination against the Roma in health care, which can be well demonstrated by the following case. According to a 2004 report of Amnesty International, a Hungarian hospital provided separate accommodation for Roma women in the maternity ward, which is one of the widespread forms of discriminatory cases in health care affecting the Roma.

Another survey conducted by the European Roma Rights Center (ERRC) in 2004 reveals the same type of discrimination at another hospital, where pregnant women were also placed in separate rooms from the non-Roma and experienced different forms of discrimination from nurses and doctors at the hospital on a regular basis. In the same year the ERRC and the Legal Defence Bureau for National and Ethnic Minorities (NEKI) jointly filed a complaint against Hungary with the United Nations Committee on the Elimination of Discrimination against Women (CEDAW) relating to an illegal sterilization of a young Hungarian woman of Roma origin. The patient was asked to sign forms giving her consent to the operation, without an explanation on the outcome of the process.

A survey already cited, measuring Roma people's perception on the attitude of medical personnel towards them reveals that 44,5 % of Roma patients experience some level of hostility from their GP, which rate is significantly higher than in the case of medical staff at hospitals[13]. One reason for the difference can be the fact that GPs provide more frequent medical services to patients in general than e.g. doctors at hospitals. When Roma were asked about their experiences on access to medical services, 20,7% already experienced the denial of the local GP visiting and providing service to an ill adult patient on night or weekend duty. Additionally, 11,3% of the respondents experienced the same phenomenon in the case of their children being ill. The situation is the worst at ghetto-like, segregated, geographically isolated Roma settlements. At such locations 40% of patients claimed to have experienced the same, while 18,6% of the total Roma population of the country lives in a settlement without a GP.

Another survey reflects the satisfaction of Hungarian society in general, regardless of ethnic affiliation, with the attitude of healthcare providers[14]. According to this study, only 10% of subjects have experienced negative attitude from the side of or problems in communication with medical personnel. However, 74% of respondents think there are inequalities present in the quality of services in the healthcare system severely affecting poor people. In the respondents' views this phenomenon the most significantly affects Roma people besides the homeless, the elderly and those, who are not willing to offer gratuity

[13] Differences in Access to Primary Healthcare – Structures, Equal Opportunity and Prejudice – The Results of an Empirical Study, Hungarian Delphoi Consulting, 2003
[14] Szonda Ipsos (2004) Opinions on Health Care Reform in the Hungarian Public, 2004

money to medical personnel. As a conclusion, it is more frequent among the Roma to experience problems in cooperation and communication with healthcare professionals than among mainstream members of society.

Though there are numerous reports known on discriminatory acts of healthcare providers towards the Roma, remedy is usually available neither in the courts, nor through any other mechanism. Therefore, besides the improvement of the institutional background of the healthcare system, specific steps are needed to sensitize medical personnel towards cultural and ethnic differences and guarantee equal rights in health care for the improvement of Roma peoples' health status.

5. The Curricula of Medical Schools

The present state of medical education requires extensive reform. There are no efficient selective mechanisms built in the system, in other words all students accepted at the medical school and successfully preparing for and passing their exams can become a practitioner regardless of their social sensitivity. According to the opinion of practicing healthcare providers I collected data from, proper selective mechanisms revealing attitudes, social competencies such as empathy, the ability and willingness to communicate and cooperate with patients in a clear, open and tolerant manner; moreover, full respect of patients' rights would select the most suitable future professionals to the profession. However, medical universities and colleges, such as other higher-educational institutions receive normative support according to the number of students they have enrolled. The implementation of selective systems in medical education are doomed to failure until normative government support of universities depend on the number of students they have (Jákó, 2003).

Considering higher education on an international dimension, due to globalization and the free movement of capital, universities have become extensively dependent on the labor market and the economic factors behind it (Appadurai, 2000).This phenomenon became intensely significant after the Hungary's joining the European Union following the requirements of the Bologna process. In the hard competition among universities providing quality work force in significant quantities to the common labor market these institutions are forced to follow the conditions set by global economic trends. Therefore, any selective mechanisms built in the system reduce the opportunities of universities in the global competition; thus, it is not in their interest to imply any systems to select the most suitable students for the profession.

As a result of the process described above, a growing proportion of medical personnel educated in Hungary migrate to more developed countries in the interest of finding better paying positions and higher life standards. The most popular destinations of this, so-

called ‘brain-drain’, process is Western Europe and the United States of America. These countries with more developed welfare systems welcome highly qualified medical personnel and are able to offer better compensation for their work. Due to this process an increasing proportion of the most highly qualified medical personnel educated in Hungary end up in foreign medical institutions. According to a 2005 survey of the Hungarian Hospital Association, there is a dramatic shortage of doctors nationwide.[15] This ratio is 15-20%; however, according to the report, the number of those who decide to leave the profession and choose another, better paying job in Hungary is higher than those, who work in other countries as doctors.

The curricula of medical schools often lack practice-oriented elements related to social disadvantages, poverty and ethnicity in the interest of sensitizing future healthcare providers towards such issues. According to my research findings, topics linked to social disadvantages, poverty and ethnicity are included in the curricula of Hungarian medical schools mostly on a theoretical basis. Students lack first-hand, real experiences with people of different social and cultural background in order to prepare them for the challenges of the profession. 66,6% of the students I collected data from by interviews and focus group discussions from 4 Hungarian universities and 3 colleges find medical education too much theory and outcome based with strong focus on technical issues. Therefore, according to their views, medical curricula often do not focus enough on the humanistic side of the medical profession. This might result in disappointment and confusion from the side of the students by the time they actually start their medical practice. However, understanding different value systems, being able to communicate and cooperate with people regardless of their social and ethnical origin, facing the characteristics of poverty and its endless, often hopeless circle are features future medical personnel need to acquire in order to understand and fulfill the real needs of each individual patient.

Neményi (1998) emphasizes the integration of ethnical contents into medical schools’ curricula and stresses the importance of initiatives for the improvement of communication between healthcare providers and the Roma minority. Additionally, courses should be developed and introduced that provide information on the health status and social problems of the Roma. As a consequence, the curricula of medical schools need to be filled with both theoretical-factual and practical, life-like features of cultural and social contents.

Some initiatives already implemented in Hungary can be mentioned as good examples in the given field targeting the social sensitization of future medical personnel. In 1999 the Hungarian Soros Foundation launched a medical program called *Interethnic Training for Doctors*. From the 13 applications, submitted by different faculties of medical universities and colleges, 7 proposals were granted. As a result graduate and postgraduate

[15] Hungarian Hospital Association (2005) Report on Human Resources of Healthcare Institutions, Budapest

elective courses, moreover educational materials were developed at these institutions aiming at improving the cooperation of medical personnel with patients of Roma origin. Most of these courses have been included in the curricula of these schools on a continuous basis with a growing interest from the students' side throughout the years. While at most faculties it is an elective course, at one university it is a mandatory subject. According to the teachers, who developed and have been teaching these courses, the reason for their adaptation and long-term existence lies in the positive attitude of leading faculty members towards social issues. Thus, the importance of such courses is not questioned at their institution and there is generally a supportive environment for their sustainability.

According to the expert nominated by the Soros Foundation to conduct the monitoring process of the program, the acceptance of these programs varied by the students involved, whose interest was rather low in the primary phase. One reason for this can be the high number of mandatory courses students have to complete during their studies, so they might lack motivation to select elective courses with such contents. However, he evaluates the program successful in general, because the programs developed were rich in information on the culture of Roma people and on phenomena contributing to poverty and social disadvantages, while representatives of the schools were motivated to adapt them in the local curriculum.

As for medical education in general, according to most university teachers active in the field of cross-cultural medical training I interviewed, at higher educational institutions, there is a tense competition among different faculties to gain credits for their own courses. Therefore, oftentimes courses related to human behavior e.g. medical ethics or interethnic contents are considered to be of secondary importance after other compulsory basic subjects. Teachers and students all agreed on the fact that the success of these courses mostly depends on the social sensitivity and underlying attitude of the teacher dealing with them.

Another positive example for initiatives in inter-ethnic medical education is the so-called *Summer Camp on Empathy* program of the Semmelweis University of Budapest. In the framework of the initiative, taking place on a yearly basis, undergraduate medical students have the opportunity to experience social inequalities through outdoor and personality development training techniques. In the program there is a strong focus on issues of poverty, social exclusion and marginalization emphasized by situational and role-play activities. Participants of the camp also have the chance to visit and talk to Roma people receiving first-hand experiences on their living conditions; moreover, on the complexity of socio-cultural factors resulting in their poor health status. The program was initiated by the student's body at the university, as a common need emerged from their side to include such contents into their studies. All participants who I interviewed consider the program extremely

beneficiary for their personal and human development. All of them think their social and communicational skills improved due to the program while becoming more sensitive towards social disadvantages and cultural differences by understanding underlying phenomena contributing to social characteristics.

At most medical schools a mandatory course on communication is included at the primary phase of studies. Those students, who were satisfied with the social competencies of the teacher to hold such courses found it useful; however, those, who did not think the teacher had effective communication skills, enough empathy, sensitivity and openness towards the group were not content with it. 80% of the students did not find it practical enough with very little or no focus on information on ethnic differences or Roma people. Therefore, a significant barrier might be in the successful implementation of interethnic programs is the underlying attitude of faculty members and students.

These programs are usually adapted and supported by teachers who are already open towards the issue of cross-cultural education and find it important to promote in medical training. However, according to 66,6% of the 15 medical school teachers I interviewed the reason if they are not introduced at institutions might be due to the fact that leading medical faculty members do not place it among priority areas in the educational process. Until the adaptation of such educational content materials is only advised to medical schools by the Central Government, no one can be held responsible for not including them in the local curricula. This is true for the students as well; if the course given is not made compulsory for selection by university staff, only those students choose it, who already have some sensitivity towards the issue. While those, who do not find it important, usually do not include it in their studies, even though they should be the primary target group of such trainings.

Attitudes towards different social and cultural groups in society are inherited, passed on to the next generation at medical schools, which is a basic determinant of the ‘culture of doctors’, which often has certain elitist elements. The presence of this value system is a complex code of values and norms of behavior, which is very difficult to detect. As 75% of the 45 medical students from different universities or colleges I interviewed or made focus group discussions with have at least one parent with a university or college degree, we can conclude that most of them come from middle or upper class families, which social groups do not necessarily have frequent interactions with poor or disadvantaged layers of society. Thus, their practical, first-hand experiences related to the social background and culture of Roma people might also be limited. This can be an underlying reason for the relatively low interest from the students’ side towards issues related to poverty and social disadvantages.

6. Foreign Lessons

Research data shows that socio-cultural differences between patient and healthcare provider influence communication and clinical decision making (Smedley, Stith, and Nelson, 2003). Though cross-cultural medicine has lately gained attention in the U.S, it has been widely discussed from the 1960's, the emergence of the civil rights movement (Chin, 2000, as cited in Smedley, Stith, and Nelson, 2003). There are several ways cross-cultural contents can be integrated into the curricula of medical schools on undergraduate, graduate level and continuing medical education. Their aim is to develop certain competencies including specific knowledge, skills and attitudes. While there is no one existing way to include such issues in medical curricula, it should always be adapted to the cultural environment of the given setting.

Access by minority groups to the same standard of health care is a matter of growing concern in the United States as well. From the 1960's and 70's U.S. government legislation began to focus on the representation of African-Americans and other minorities in the health professions. According to Byrd and Clayton (2002) the reason behind the new policy was the assumption that minority health professionals would improve access of these minorities and the poor to health services based on their cultural connections and willingness to serve them. Jaynes and Williams (1989) support this argument in their report by claiming that more than 80% of the clients of African-American physicians involved in the study were from the same ethnic group. Byrd and Clayton also argue that African-American health professionals had important policy agenda in the wake of the Civil Rights Era and strongly advocated for better access to quality health care for their ethnic group. As a result of government attempts to correct minority underrepresentation in health care, the number of students from different minority groups at medical schools rapidly grew between 1965 and 1970 with the peak of 75% of African-Americans accepted applying to medical school in 1969. Therefore, the growing proportion of medical staff with minority background at healthcare institutions contributed to better access for patients from these social groups to quality health care.

Medical schools in the U.S. already have good practices for cross-cultural education in order to sensitize healthcare providers towards different minorities and cultural groups. These models are also applicable for adaptation to the Hungarian setting when dealing with the Roma. The Department of Social Medicine at Harvard Medical School in Boston offers 15 courses on socially related issues in the 2005/2006 school year, from which 13 are required. 9 of the courses directly deal with socio-cultural differences and competence, equity and human rights in health care, moreover health ethics on a national and international dimension. Therefore, undergraduate students have the opportunity to face the realities of social segregation, ethnic discrimination and inequalities in health care as a result of socio-cultural differences.

The strategic priorities of the American Medical Student Association, consisting of 60.000 physicians-in-training as members countrywide, are fighting for universal health care, eliminating health disparities, advocating for diversity in medicine and transforming the culture of medical education. The Humanistic Medicine Action Committee of the Association is dedicated to raise awareness on the importance of focusing medical care on the needs of each individual patient. Additionally, the organization advocates for the acceptance of underrepresented communities; moreover, empowers medical students to give a voice to these individuals in the health care setting. Throughout their programs they are dedicated to fight inequalities, promoting diversity, and facilitating change for marginalized populations having representatives at several medical schools countrywide. The Association is also entitled to educate the medical community about the biases and discriminations these individuals face within the healthcare system. Being exposed to such contents by the time of entering the medical profession, medical students participating in such programs will presumably understand cultural differences and social inequalities related to ethnicity more than those who do not become involved in such initiatives during their studies.

7. Shortcomings of Present Legislation on Health Care

National health policies relevant to minority inclusion include increasing the tolerance level and conflict handling abilities of healthcare providers due to the high number of conflicts taking place between Roma patients and healthcare personnel. This tendency, according to the Roma Integration Directorate of the Government Office for Equal Opportunities in Hungary, requires a thorough overview of medical schools' curricula and cross-cultural training in the educational programs of medical schools. Therefore, according to the program it is of utmost importance to clearly emphasize the complexity of social disadvantages in medical education. Moreover, future health service providers need to be faced with the realities of poverty and social problems through direct, first-hand experiences as part of their education in order to be sensitive enough towards social and ethnic background of patients.

However, the Central Government has not implied any measures in the legislation on the inclusion of cross-cultural contents into the curricula of medical schools. Such courses exist at institutions, where faculty members find the issue of particular importance; however, their adaptation is not compulsory. There is urgent need for reform in this area as future healthcare providers need to be sensitized and open towards communicating and cooperating efficiently with people regardless of their social and ethnical background.

While in the Hungarian healthcare system operational costs are covered by social security and investments by local communities, a significant part of staff wages goes to medical personnel from the pocket of patients. This part of the health budget is not covered

by insurance, it is illegal by avoiding tax-paying, but is indirectly tolerated by authorities. According to a survey conducted in 1998 by the Social Research Informatics Center (TÁRKI) 5-6 patients from 10 directly give money to the GP. It is estimated that only in the year of 1998 within the 95% confidence interval of 24 billion and 42 billion forints (112 billion-196 million USD at the 1998 average rate) were given to medical personnel as gratitude money. From this sum doctors received 29 billion forints, while the rest of the money was given to the rest of the staff. It is assumed that such donation raise the doctors' salary by 150%.

Gratitude money is very widespread in the Hungarian healthcare system. It is very difficult to detect; therefore, no significant measures have been taken to reduce its importance. According to my findings healthcare providers seem dependent on it due to the fact that they are underpaid by the healthcare system and the sum they directly receive from their patients supplements their rather low income. Hungarian healthcare providers earn an average of 168.000 forints monthly[16], less than the average salary of full-time employees in 2005, which is 186.000 forints[17]. The practice of offering such reward to healthcare personnel has become part of the Hungarian medical culture, therefore those, who are not able to provide such compensation are in danger of receiving medical care of lower quality. Thus, this is another factor presumably having a significant effect on Roma people representing a layer of society severely struck by poverty.

Another shortcoming of the present healthcare legislation is the lack of proper monitoring on the implementation of reform programs. Similarly to other government departments the health sector is highly influenced by politics in Hungary. In the past 4 years 3 ministers were nominated to reach visible rapid achievements in the healthcare system. However, strong political influence resulting in frequent changes of personnel in decision making positions function as obstacles in the implementation of wide-ranging, effective and systemic programs to find real solutions for the existing problems. Additionally, there is no constant evaluation program implied in the system implementation realized by bodies independent from the government[18] offering objective feedback on these initiatives. This means a common barrier to measuring the efficiency of the Government's Roma-related programs in general.

[16] Hungarian Hospital Association (2005) Report on Human Resources of Healthcare Institutions, Budapest
[17] Hungarian Central Statistical Office (2005/1) Report on Economy and Society
[18] The monitoring body set up in 2003 to measure the efficiency of the Government's Roma programs belongs to the Roma Integration Directorate of the Government Office for Equal Opportunities operating within the Ministry of Youth, Family, Social Affairs and Equal Opportunities; therefore, it is not independent from but highly influenced by politics.

8. Conclusion

Roma people in Hungary are regularly subjected to discrimination at healthcare institutions. The existence of this phenomenon is party due to lack of preparation at medical schools for the realities of the profession to acquire skills necessary for the proper communication and cooperation with patients from different ethnic and cultural groups. The education at medical schools is mainly theoretical and technical-sided with minor emphasis on practice-oriented subjects. Therefore, medical students are not able to prepare for the challenges of the profession by the time they need to face phenomena and conflicts connected to cultural differences and social disadvantages in their everyday work. Consequently, there is a great responsibility on teachers of medical schools in including inter-ethnic contents in studies and forming attitudes by developing skills in students necessary for successful communication and cooperation with disadvantaged social groups.

Lack of central legislation on cross-cultural courses in medical school curricula results in the infrequent operation of such programs at educational institutions. Moreover, such contents often lack enough attention from curriculum designers. Until the government develops only recommendations to medical schools on the given issue, no systemic changes can be expected in medical education and only those institutions will employ them where faculty members are already open towards the subject. Medical schools, healthcare institutions and medical personnel are heavily under-supported on a general basis; therefore, initiatives in cross-cultural medical education and quality healthcare are doomed to failure as long as no general provisions are launched for the comprehensive improvement of the financial conditions and quality of services at medical schools and healthcare institutions.

Besides legislation reform, the perception of healthcare providers needs to be changed on people with different ethnic and cultural background on postgraduate level as well. Moreover, it is of utmost importance that representatives of disadvantaged social and cultural groups, such as the Roma enter medical schools and become healthcare providers, moreover instructors at medical schools. This way, receiving the social prestige of this profession, they would have the opportunity to change the perception of society on the Roma; moreover, the attitude of medical students as future healthcare providers towards social disadvantages and cultural differences.

9. Policy Recommendations to Promote Roma Access to Quality Health Care

- Changing the current legislation and make the application of cross-cultural courses compulsory at medical schools on all levels
- Creating post-graduate regularly applied, practical oriented, cross-cultural training programs for the sensitization of medical staff working in healthcare
- Strengthening the cooperation of medical universities with the civil sphere in order to enable Roma NGOs, Roma advocates and NGOs operating in the field of health care to develop and launch courses at medical schools with self-experimental activities on culture, ethnicity, poverty and other social disadvantages
- Launching special incentive and grant programs offered to Roma students in order to enter medical education
- Encouraging medical schools to improve student bodies' self-advocacy skills and to involve them more in decision making processes
- Motivating medical schools to adapt successful inter-ethnic programs from other countries to sensitize medical students towards minority groups and socially disadvantaged people
- Closely and consistently monitoring the implementation of government policy concerning the Roma by independent bodies without political influence
- Launching community development programs to motivate stakeholders involved in social services for the Roma on local and regional level (local and regional government, local GP and hospital, family support center, Roma and non-Roma NGOs, Roma self-government) to cooperate for efficient access of the Roma to healthcare services
- Allocate resources to hospitals to employ social workers for better cooperation with patients of different cultural background
- Building up effective measures to combat the existence of gratitude money in health care
- Creating proper conditions to motivate medical personnel to remain in the profession and in the country as labor force

References

Amnesty International Hungary (2004) Report 2004, Budapest

Appadurai, A. (2000). *Grassroots Globalization and the Research Imagination*, In *Public Culture,* 12/1, 1-19

Babusik, I (2004). '*A szegénység csapdájában, Cigányok Magyarországon-szociáli gazdasági helyzet, egészségi állapot, szociális és egészségügyi szolgáltatásokhoz való hozzáférés'* (In the Trap of Poverty, Roma in Hungary – Social and Economic Status, State of Health, Access to Social and Healthcare Services) Delphoi Consulting.

Berkman, L.F. and Kawachi, I. (eds.) (2000). *Social Epidemiology*, Oxford: Oxford University Press.

Bognár, G. & Gál, R, I and Kornai, J (1999). *Hálapénz a magyar egészségügyben*, (Gratitude Money in the Hungarian Healthcare System), TÁRKI (Social Research Informatics Center)

Byrd, W. M. and Clayton, L. A. (2002) *An American Health Dilemma Vol II. – Race Medicine, and Health Care in the United States 1900-2000*. New York, London: Routledge.

Commission Report Hungary (2002). *Minority Rights and the Protection of Minorities*

Doncsev, T. (2000b). *Measures Taken by the State to Promote the Social Integration of Roma Living in Hungary,* Budapest

European Commission Directorate-General for Employment and Social Affairs (2004). *The Situation of Roma in an Enlarged European Union*. Luxembourg: Office for Official Publications of the European Communities: 27

Fábián, Z. & Fleck, Z. (1999). 'Authoritarianism, socio-demographic variables and socialization in the explanation of prejudiced attitudes: Antisemitism and Anti-Gypsy attitudes in Hungary' In Enyedi, Zs., & Erős, F. (eds.) *Authoritarianism and Prejudice: Central European Perspectives.* Budapest: Osiris Kiadó.

Füzesi, Zs., & Ivády, V., & Kovácsy, Zs., & Orbán K. (2005). 'Hungarian healthcare reforms in the 1990s' In Shakarishvili, G. (ed) *Decentralization in Healthcare, Analyses and Experiences in Central and Eastern Europe in the 1990s*: OSI/LGI.

Gyukits, Gy. (1999). *A romák egészségügyi ellátásának szociális háttere,* (The Social Background of Roma Access to Healthcare), Budapest

Human Rights Watch (2002). *World Report: Hungary*

Hungarian Central Statistical Office (2005/1). *Report on Economy and Society*

Hungarian Hospital Association (2005) *Report on Human Resources of Healthcare Institutions*

Jaynes, G. D. & Williams, R. M. (eds.) (1989) *A Common Destiny: Blacks and American Society*. Washigton, DC: National Academy Press.

Jákó, J (2003). 'Az orvosképzés, szakképzés és a továbbképzés dilemmája'. (The Dilemma of Doctor Training, Specialization and Further Medical Training) *Magyar Tudomány*, 2003/12

Kemény, I., & Janki, B., & Lengyel, G. *A magyarországi cigányság 1971-2003.* (The Roma in Hungary1971-2003). Available online at http://www.mtaki.hu/kiadvanyok/kemeny_janky_lengyel_moi_ciganysag_main.html

Lavis, J., & Sullivan, T. (1999). 'Governing Health' In Drache D., & Sullivan S. (eds.) *Health Reform: Public Success and Private Failure*. London: Routledge.

Marmot, M., & Wilkinson, R.G. (eds.) (1999) *Social Determinants of Health*. Oxford: Oxford University Press.

Mediating Romany Health, Policy and Program Opportunities (2005) Open Society Institute Network Public Health Program

National Institute for Health Development (2001) *Roma felnőtt népesség egészségállapota, egészség magatartása és a romák valamint az egészségügyi szolgálatok közötti kapcsolat vizsgálata* (The Health Status of the Adult Roma Population, Health Behavior and the Analysis of the Relationship between the Roma and Health Services) Report

Neményi, M (1998). *Az egészségre ható tényezők deprivált családok gyermekeinél. (*Factors Affecting Health at Children of Deprived Families) Budapest: MTA Szociológiai Kutatóintézet.

Neményi, M (2001). *Egy határszerep anatómiája – védőnők a nemi, szakmai és etnikai identitás metszéspontjában* (The Anatomy of a Boarder Role –Nurses in the Focus of Sexual, Professional and Ethnic Identity) Budapest: MTA Szociológiai Kutatóintézet.

Postma, K. (1999). 'Social Determinants of Anti-Gypsy and Antisemitic Atitudes in Hungary.' In Enyedi, Zs., & Erős, F. (eds.) *Authoritarianism and Prejudice: Central European Perspectives.* Budapest: Osiris Kiadó.

Puporka, L., & Zádori, Zs. (1999). 'A magyarországi romák egészségügyi állapota' (The Health Status of Hungarian Roma) World Bank-Hungarian Regional Office, NGO Studies: Volume 2, Roma Press Center.

Ringold, D. (2000). *Roma and the Transition in Central and Eastern Europe: Trends and Challenges*. Washington, DC: The World Bank.

Smedley B. D. & Stith A. Y., and Nelson, A. R., (eds.) (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Healthcare

Speder, Zs., & Habich, R. (1997). *Nyertesek és vesztesek* (Winners and Losers. Transformational Outcomes in a Comparative Context.) Hungarian Household Intestigation, Budapest

Szirtesi, Z. (1998) *A cigányság egészségügyi helyzete.* (The Health Situation of the Roma Population) Budapest: Agroinform Kiadóház.

Szonda Ipsos (2005) *Vélemények az egészségügy reformjáról a magyar lakosság körében.* (Opinions on Health Care Reform in the Hungarian Public) 2005

Váczi, M. (1991). 'A cigányság egészségi állapota és az ebből adódó egészségmegőrzési feladatok' (The Health Status of the Roma Population and Related Tasks for Preserving Health) In *Egészségnevelés*, 1991/2., 62–67.

Wilkinson, R. (1996). *Unhealthy Societies: The Affliction of Inequality*. London: Routledge.

World Health Organization (2005). World Health Report 2005. Geneva:WHO.