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

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Abstract

There has been a continuous decrease in the social and health conditions of the Hungarian Roma minority in recent years. This is primarily the result of the low socio-economic status of Roma people, and cannot be improved without both poverty reduction and social integration. The current government health sector legislation is aimed at improving the living and health standards of the Roma, through supporting equal access to quality healthcare services and preventive programs. Despite these goals however, there has been little measurable improvement in the health condition of the Roma people. This article assesses the reasons behind this policy failure and argues that while government programs targeting social mobility of the Roma should not be disregarded, they must take into consideration the complex cultural characteristics of this group. Extensive reform of health legislation and the medical education system is recommended in order to improve the health status of the Roma minority through proper access to quality healthcare services.

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The views contained inside remain solely those of the author who may be contacted at ibolya@policy.hu. For a fuller account of this policy research project, please visit <http://www.policy.hu/ibolya/>.

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1 Introduction

Health should not be seen as a condition of the absence of disease. 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, a stable job with a regular income and sufficient social protection”. Yet the Roma in Hungary and the whole of Central and Eastern Europe have the worst health conditions (Ringold, 2000).

As a result, it can be concluded that morbidity and mortality indicators of this minority are generally worse than those pertaining to the majority population in Hungary (Babusik, 2004). However, the Roma, as a significant social group within the entire population of Hungary, often have to face negative discrimination from (majority) members of society due to their unique culture as well as their economical, social and regional disadvantages. According to the 2005 survey of the World Health Organization, the average life expectancy for Hungarians is 68 for males, and 77 for females. This means a relatively poor health status on the European scene, considering the geopolitical conditions of Hungary. Yet behind this low average there are significant geographical and social differences, too. In villages with a population of less than 1000, the life expectancy of males is 50% lower than in big cities. As the vast majority of Roma live in such locations, we are able to say that such a 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 stood at 10.2 million. This is not always the case with the Roma population, though - where life expectancy is very low. Roma tend to live, on average, 10 years less than non-Roma (Doncsev, 2000b). Moreover, Roma populations are younger than other groups' owing to there being a notably higher birth rate here, and in spite of the fact that the infant mortality rate among Roma communities in Hungary is around double the national average's (European Commission, 2004). The 1991 census in Hungary registered 142.693 people as being Roma in the country. When this data is contrasted with that provided by other sources, it differs substantially. In 1993, 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 is: Hungarians (92.3%), Roma (1.9%) and other or unknown (5.8%). According to the 2001 census, 190.046 people reported themselves as being Roma, although some researchers estimate their number to be between 450.000 and 600.000. The discrepancy among different sources is partly due to the fact that some researchers consider people to be of Roma origin only if they declare themselves as 'Roma'; while, for others, people are considered Roma according to environmental and situational factors.

Evidence shows that one's social environment – e.g. income, type of work and social networks - are major determinants of health (Lavis and Sullivan, 1999; Wilkinson, 1996). Váczi (1989) also says that the health status of 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 Roma, though unemployment and poverty are definitely higher for this group compared to in 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 a market economy. After the break-down of the communist system, most of these unskilled Roma people became unemployed (i.e. who had previously worked as manual laborers). As a result, in post-transition years the unemployment rate was considerably higher among Roma (35.8%) than among the non-Roma (11.2%) (Speder, Habich, 1997). The rate of unemployed Roma people is presently estimated to be 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 over several years. Thus, the real danger concerning this minority is more a poverty issue than an ethnicity issue. The vicious circle of marginalized social status, being stigmatized for it, and insufficient self-advocacy skills will result in a lack of motivation as regards social mobility. Still, the gaps in health status between Roma and the majority population reflect official discrimination and a marginalization of this minority from the members of mainstream society. In other words, the problems affecting the health of the Roma population mostly have a social origin - though the cultural elements 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. So eliminating biases and discriminatory attitudes in mainstream society

with regard to the Roma is of primary importance when it is to do with their social integration.

Oral reports conducted so as to analyze the underlying factors behind improper access to quality health care for Roma reveal discriminations: separate wards kept for Roma patients and pregnant Roma women at hospitals, or forced sterilization (ERRC Report, 2004) are reoccurring issues within widespread forms of discrimination against this minority in Hungarian healthcare institutions. In my view, these issues can be addressed most efficiently from the perspective of medical education. More specifically, the sensitivity of future healthcare providers is of crucial importance with regard to the characteristics of poverty and cultural differences related to ethnicity in inter-ethnic contents built into 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 look at possible modifications for medical schools in their curricula in the interests of successfully achieving policy goals. The method applied includes an overview of current legislation on this issue, and analysis of statistical data related to the health status and social conditions of Roma. I have also analyzed research conducted in the field and made interviews with government representatives, the staff of medical schools and healthcare institutions, medical students, Roma themselves, and with representatives of the civil sector and experts on Roma health.

In this paper, after examining the present changes in legislation and current policy on Roma integration, I will examine the implementation of such tools in order to reveal to what extent they are able to promote the access of Roma people to quality health care and deal with their health status; also, to reduce discriminatory practices resorted to at healthcare institutions against them. I will also give an account of what elements are missing from present legislation concerning Roma health - and analyze underlying reasons regarding why government initiatives are doomed to failure if they lack wide-ranging public acceptance. I also wish to look at the curricula of medical schools in the interests of identifying content specifically included to sensitize future healthcare providers as regards social and cultural issues (such as poverty or a minority existence). Additionally, after reviewing such initiatives in other countries, I will give successful examples to educators dealing with medical issues in the interests of teaching professionals to deal sensitively with ethnic minorities generally. Finally, in the last

chapter, based on my research findings I will make policy recommendations to promote more efficient legislation to deal with giving Roma access 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, i.e. after the fall of the former socialist regime. Before the change, a substantial improvement in public health status had taken place between World War II and the 1960s, mainly because of increasing living standards due to the positive changes in the social and economic conditions of the country.

From the 60's onwards, though, a serious decline occurred 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 - so, until the 1980s, mostly quantitative goals were satisfied via giving extensions to recovery periods and increasing the number of hospital beds (Füzesi, Ivády, Kovácsy, Orbán, 2005).

The present organization of the public health system took place during the transition period. Hungary has already passed the most difficult phases of political transition, and has accumulated experience while preparing to fulfil European Community obligations and requirements. The right to a healthy environment, to maintenance of income via social security, and to an optimal level of psychical and mental health is set in the Hungarian Constitution, alongside making the government responsible for social welfare and healthcare provision.

As already mentioned, the current social security system existing in Hungary is a result of historical development and the most recent responses to the challenges of economic and social transition. Things have become more pluralistic, with divided responsibilities instead of placing all responsibilities onto the state. Hierarchical relationships among different stakeholders have moved towards being contractual ones. Yet according to Gyukics (1999), in a market-based healthcare system formed as a result of transition, disadvantaged Roma have, in the main, access to medical services of a lower quality due to their social disadvantages.

The National Public Health Program was accepted by Parliament in 2001, and it contained specific elements for improving the access of disadvantaged people to a quality healthcare service. It regulates the improvement of the living conditions of Roma,

and aims to support the equal access of disadvantaged social groups to quality healthcare services and preventive programs; also, to alter the discriminatory attitudes of healthcare providers towards Roma patients. What is more, modifications in graduate and post-graduate education for medical personnel in relation to socio-economic background, health status and the cultural characteristics of a Roma minority are also important elements of the program. Yet such curricula content in medical institutions are still relatively rare; also, it is difficult to see any measurable improvements in the health status of Roma people since this policy was launched.

The Decade of Health Government program aims to improve the health status of the whole of the Hungarian population. The main priorities of the initiative are based on the most important problems related to the health conditions of society. A specifically targeted area is improvement in the health conditions of the most disadvantaged social groups, including Roma. While developing the program, experiences from both national and international health areas were taken into account, and 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 reforms. According to government plans, the most important objectives are improving the health conditions of the population generally, an increase in life expectancy, and facilitating life quality as determined by one's health. The program was adopted by an entire consensus of Parliament, and its implementation began in April 2003.

A Medium Term Package on the Improvement of Life Circumstances and the Social Status of the Roma Minority appeared in 2001. The wide-ranging program contains measures to provide equal rights for the Roma, improve their quality of life and living conditions, and to develop their physical and mental health, besides providing chances for equal education and marketable job opportunities so as to promote their social integration. However, a lack of systemic data on the effects of specific health policies on the Roma points to a general problem for realization of such programs.

The degree of government monitoring of the situation is insufficient, while studies conducted by non-governmental organizations on implementation do not reveal any general, systemic picture of the situation. With existing resources, the process of policy implementation does not seem to function effectively when looking at the real needs of this minority. Most of the problems affecting the health circumstances of Roma remain unsolved in practice, so a large proportion of Roma people often do not have proper

access to quality health services, and their social status does not seem to be improving either.

The 2002-2006 Government Program (accepted by the new cabinet) was created in the name of democratic, European values, celebrating diversity and recognizing the equal rights of people residing in Hungary. There is a special section dealing with the improvement of living conditions of the Roma; it says that the social status of this minority is the result of a dramatically evolving process in society, instead of being merely an ethnical issue. The document places special emphasis on social protection of the Roma, an improvement of their educational standards and living conditions, preservation of their culture and identity, and development of communications between the majority and Roma members of the population, while also seeking to combat 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 reducing major differences in access to quality health care by noting some of the regional differences and difficulties in GPs work. Elements that would have an affect on Roma are increases in salary in connection with GP positions in the most disadvantaged regions of Hungary, i.e. where GP posts have remained unfilled for a large period of time. In addition to this nominative financing, GPs will be 'eligible' according to the number of registered patients in their local community.

There is a budget available for grants to GPs taking on a (normally) unfilled GP position. However, some experts handling medical issues do question the efficiency of such incentive programs and doubt that there would be notable increases in the number of filled GP positions in such locations. The reason for such 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 remains the same. Thus, there is a greater need for programs aiming at sensitizing medical personnel with regard to disadvantaged social groups at both the gradual and post-gradual level.

The strategic aims of the Hungarian government noted above are in tune with the health promotion approach of the European Union; there is also 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 2005 to 2015 time period. Priority areas for improvement in relation to the general life conditions of Roma are education, housing and employment – i.e. alongside health. The general program goal is

to raise the inclusive nature of health systems in participating countries. There is a major focus on expansion of access to health care via a breaking down of barriers between Roma communities and healthcare providers. Hungary's priority in the initiative is to increase the number of Roma nurses, district nurses, doctors, and social workers, all through scholarships.

There are still no noteworthy 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 whether the Hungarian Decade Action Plan or the country's EU accession process has been made any major contribution to the promotion of Roma health up until now. According to a study conducted by the Open Society Institute, the Hungarian government is being criticized at an international level for the inconsistencies involved in monitoring Roma programs that are launched. Additionally, it reveals several weaknesses in the Decade Action Plan idea, including the fact that there has been little Roma participation in its creation, and a lack of specificity in descriptions of activities and monitoring; also, there is insufficient mainstreaming of the Decade's cross cutting themes of discrimination, gender and poverty.

3 Social Conditions Affecting Roma Health

From among factors affecting health education, economical status, economic activity and living conditions play a dominant role. These determinants can influence the appearance of both physical and mental illnesses. Risk factors affecting health appear in a joint manner, thereby strengthening each other, which leads to difficulties in upholding one's health status.

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

Government efforts to promote Roma health often fail to confront the social structures which shape a person's health in the first place: inequality and discrimination in education, employment, and housing; poor access to clean water and sanitation; a 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 say that the health indicators referred to above come from the low socio-economic status of Roma people in society - and they cannot improve without poverty reduction and the social integration of this minority. In addition, government programs aimed at the 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 for the Roma population, not only because of cultural insensitivity or a perhaps discriminatory attitude of medical personnel towards them - but due to regional inequalities as well. Roma communities usually dwell within segregated settlements, while most Roma live in the most deprived and socially disadvantaged regions of Hungary. A representative survey conducted in 2003 explained that Roma often lack proper medical treatment for geographical reasons, for they live in segregated settlements that are far from not only local hospitals but often from the surgery of the closest GP in their area. Further results of the survey show that settlements with multiple disadvantages do not offer local practitioner services directly; while they also tend to lack other basic institutional services. In settlements where there is no GP, the number of Roma among the general population tends to be significantly higher; therefore, the inhabitants of these communities have multiple disadvantages via this lack of local and accessible health care.

4 Stereotypes of Healthcare Providers regarding the Roma

Roma people in Hungary have traditionally been targets of ethnic prejudice. The, at times, stereotypical social characteristics existing with regard to the Roma population are 'unfavorable' when compared to those of mainstream society. Such prejudices are deeply rooted and are transmitted across generations – so they are also difficult to identify and change. When assessing public opinion about the Roma, not only cultural differences but the great socio-economic barrier between Roma and non-Roma serves to determine the origins of anti-Roma feelings. According to a representative survey taken

among Hungarian citizens in 1992 and 1993, 60% of respondents would mind if Roma people moved into their neighborhood - and 64% of them would not like it if their child married a Roma (Kostma, 1999). These numbers reveal a very strong hostility against this minority in Hungarians, one that is present in different segments and layers of society.

Social inequalities, which Roma need to face up to, are quite often supplemented by the negative, biased attitudes of medical personnel in different healthcare institutions. These notions originate from different stereotypes being had as regards Roma people - due to insufficient information and a lack of objective data on cultural differences, poverty and related issues (including ethnicity). A clear distinction thus arises, for there are two types of discrimination in healthcare: when a person, due to their Roma origin, does not have access to a certain health service; and when a Roma person experiences overt discrimination when using the health service. There are specific occasions on which such discrimination might occur here.

- when there is insufficient access to a GP or medical specialist,
- healthcare providers assuming that a Roma patient cannot afford to pay gratuity money for the medical service,
- negative discrimination in antenatal care
- improper access to preventive treatments.

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 is well demonstrated in 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 most widespread forms of discrimination in health care affecting the Roma.

Another survey done by the European Roma Rights Center (ERRC), in 2004, pointed to the same type of discrimination in another hospital, where pregnant women were also located in separate rooms from non-Roma, and they 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 Defense 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), which related to an illegal sterilization of a young Hungarian woman of Roma origin. The patient was asked to sign forms giving her consent to such an operation – yet there was no explanation about the process or its outcome.

A survey already cited, one measuring Roma people's perceptions of the attitudes of medical personnel towards them, reveals that 44.5 % of Roma patients experience some level of hostility from their GP, which rate is a lot higher than with medical staff at hospitals. One reason for the difference might be the fact that GPs give more frequent medical services to patients, in general, than do doctors at hospitals. When Roma were asked about their experiences as regards gaining access to medical services, 20.7% had had experience of a local GP's not wishing to make a house call to attend to an ill adult patient at night or when on weekend duty. Additionally, 11.3% of persons had experienced the same thing when their children were ill; while the situation is worst of all in ghetto-like, segregated, geographically isolated Roma settlement, for, in such locations, 40% of patients claim to have experienced such a thing. And 18.6% of the total Roma population of the country live in a settlement without a GP.

Another survey reflects the satisfaction of Hungarian society in general, regardless of ethnic affiliation, with the attitudes of healthcare providers. In this study, only 10% of subjects had experienced negative attitudes from medical personnel or had had problems of communication. Conversely, 74% of respondents did think there were inequalities present in the quality of services in the healthcare system that severely affected poor people. In these respondents' views, such a phenomenon most notably affects Roma people - alongside the homeless, the elderly and those not willing to offer gratuity money to medical personnel. As a conclusion here, therefore, Roma more frequently experience problems as regards 'cooperation' and communication with healthcare professionals than do mainstream members of society.

Although there are numerous reports known dealing with discriminatory acts of healthcare providers towards Roma, a remedy is, in general, available neither in the courts nor via any other mechanism. Thus, besides improvements being needed in the institutional background of the healthcare system, specific steps are required to sensitize medical personnel towards cultural and ethnic differences - and so that they guarantee equal rights to health care to improve Roma people's health status.

5 The Curricula of Medical Schools

The present state of medical education requires extensive reform. There are no efficient selective mechanisms built into 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. In connection with practicing healthcare providers, I have gathered data from suitably 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; while full respect for a patient's rights should also be a criterion for selection of the most suitable future professionals for the profession. However, medical universities and colleges, like other higher-educational institutions, receive normative support according to the number of students they enroll. Thus, implementation of selective systems in medical education is doomed to failure until normative government support of universities is made dependent on the number of students enrolled (Jákó, 2003).

Looking at higher education in the international dimension, due to globalization and the free movement of capital universities have become greatly dependent on the labor market and on economic factors behind it (Appadurai, 2000). Such a phenomenon became significant after Hungary joined the European Union, following the requirements of the Bologna process. In the intense competition among universities, these institutions are forced to follow the conditions set by global economic trends. Therefore, any selective mechanisms built into the system reduce the opportunities of universities in the global competition - so it is not in their interest to make use of any systems to select the most suitable students for the profession.

As a result of the process described above, a growing number of medical personnel educated in Hungary migrate to more developed countries in the interests 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 will end up in foreign medical institutions. According to a 2005 survey of the Hungarian Hospital Association, there is a dramatic lack of doctors nationwide, the ratio being 15-20%; yet, 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 that would relate to social disadvantages, poverty and ethnicity to thus sensitize future healthcare providers as regards such issues. According to my research findings, topics linked to social disadvantage, 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 backgrounds, which could otherwise prepare them for the challenges of the profession. 66.6% of the students I collected data from via interviews and focus group discussions (from 4 Hungarian universities and 3 colleges) found medical education to be too much theory and as outcome-based, and it had a strong focus on technical concerns. So, in their view, medical curricula often do not focus enough on the humanistic side of the medical profession, which might result in disappointment and confusion on the side of the students by the time they actually start their medical practice. Nevertheless, an understanding of different value systems, being able to communicate and cooperate with people regardless of their social and ethnical origins, noting the characteristics of poverty and its endless, often hopeless circle are features that future medical personnel will need to acquire in order to understand and fulfill the real needs of each individual patient.

Neményi (1998) stresses the need for integration of ethnical content into medical schools' curricula - and sees the importance of initiatives for improvements in 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 Roma. As a result, the curricula of medical schools need to be filled with both theoretical-factual and practical, life-like features, having both cultural and social contents.

Some initiatives already implemented in Hungary can be mentioned as good examples in the given field, as they are targeting the social sensitization of future medical personnel. In 1999, the Hungarian Soros Foundation launched a medical program called Interethnic Training for Doctors. From 13 applications, submitted by different faculties of medical universities and colleges, 7 proposals were granted. Via this, graduate and postgraduate elective courses as well as educational materials were developed at these institutions, being aimed 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 continual basis, and there has been growing interest from students over the years. While at most faculties it is an elective course, at one university it is a *mandatory* subject. According to teachers who developed and have been teaching these courses, the reason for their adaptation and long-term existence lies in the positive attitude involved in guiding faculty members towards dealing with such 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, acceptance of the programs varied from student to student, whose interest was rather low in the primary phase. One reason for this could have been the high number of mandatory courses students have to complete during their studies, i.e. so they might lack motivation to select an elective course with such content. However, he did see the program as being successful in general because the programs developed were rich in information on the culture of Roma and on the phenomena contributing to poverty and social disadvantage; and, as such, the school representatives were motivated to adapt them into a local curriculum.

As for medical education generally, according to most university teachers active in the field of cross-cultural medical training I interviewed in higher educational institutions, there is tense competition among different faculties to gain credits for their *own* courses. Often, therefore, courses related to human behavior e.g. medical ethics or with an inter-ethnic content 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 will mostly depend on the social sensitivity and underlying attitudes of the teacher(s) dealing with them.

Another positive example with regard to initiatives in inter-ethnic medical education is the so-called Summer Camp on Empathy program of the Semmelweis University of Budapest. Within the framework of this initiative (taking place on a yearly basis), undergraduate medical students have an 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 - as emphasized by situational and role-play activities. Camp participants also have the chance to visit and talk to Roma people, thereby getting first-hand experience of their living conditions, and on the complexity of socio-cultural factors leading to their poor health status. The program was initiated by the students' body at the university, as a

common need had emerged for them to include such content into their studies. All participants whom I interviewed saw the program as being extremely beneficial to their personal and human development. All of them thought that their social and communicational skills had improved due to the program, and that they had become more sensitive to social disadvantages and cultural differences by understanding the underlying phenomena contributing to such social characteristics.

In 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 a course found it useful; however, those who did not think the teacher had effective communication skills, enough empathy, sensitivity or an openness towards the group were *not* content with it. 80% of the students did not find it practical enough, for it had very little or no focus when it came to gaining information on ethnic differences or Roma people. Thus, a significant barrier to the successful implementation of inter-ethnic programs could well be underlying attitudes of faculty members and students.

Such programs are usually adapted and supported by teachers who are already open to the issue of cross-cultural education and who see it as important to promote in medical training. However, according to 66.6% of the 15 medical school teachers I interviewed, the reason for there *not* being introduced at an institution might be due to the fact that leading medical faculty members do not place it among priority areas in the educational process. While adaptation of such educational content materials is only being *advised* to medical schools by the central government, no one can be held responsible for its not being included in local curricula therefore. This is true for the students as well: if the course given is not made compulsory as regards selection by university staff, only those students who already have some sensitivity towards the issue will choose it; while those who do not find it important will usually not include it in their studies, even though they could be the primary target group for such training.

Attitudes towards different social and cultural groupings in society are inherited, being passed on to the next generation at medical schools; for this 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 (where interviews focus group discussions occurred) had at least one parent with a university or college degree, we can conclude that most of them come from middle or upper-class

families – and these 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 will also be limited. This would be an underlying reason for the relatively low degree of interest being shown by students' towards issues related to poverty and social disadvantage.

6 Foreign 'Lessons'

Research data shows that socio-cultural differences between patient and healthcare providers 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 since the 1960's, i.e. with the emergence of the Civil Rights Movement (Chin, 2000, as cited in Smedley, Stith, and Nelson, 2003). There are several ways cross-cultural contents might be integrated into the curricula of medical schools on undergraduate and graduate levels and in a continuing medical education. Their aim is to develop certain competencies, including specific knowledge, skills and attitudes. While there is no one existing way via which to include such issues in medical curricula, they should always be adapted to the cultural environment of a given setting.

Access by minority groups to the same standard of health care is a matter of growing concern in the United States too. From the 1960's and 70's, U.S. government legislation began to focus on 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 the 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 grouping. Byrd and Clayton also argue that African-American health professionals had an important policy agenda in the wake of the Civil Rights Era. As a result of government attempts to correct minority under-representation in health care, the number of students from different minority groups at medical schools rapidly grew between 1965 and 1970, with the peak being 75% of African-Americans accepted when applying to medical school in 1969.

Medical schools in the U.S. already have good practices as regards cross-cultural education to sensitize healthcare providers towards different minorities and cultural

groups. These models are also applicable for the Hungarian setting, with some adaptation, for when dealing with Roma. The Department of Social Medicine at the Harvard Medical School in Boston offered 15 courses on socially-related issues for 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, and also health ethics on a national and international dimension. So undergraduate students here have an opportunity to face up to the realities of social segregation, ethnic discrimination and inequalities in health care coming from socio-cultural differences.

Strategic priorities of the American Medical Student Association, consisting of 60 000 physicians-in-training as members country-wide, are the fight 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 raising awareness of the importance of focusing medical care on the needs of each individual patient. Additionally, the organization is pushing for the acceptance of under-represented communities; and it empowers medical students to give a voice to such individuals within a health care setting. Throughout their programs they are dedicated to fighting inequality, promoting diversity, and facilitating change for marginalized populations having representatives at medical schools countrywide. The Association can also educate the medical community as regards biases and the discriminations such persons face within the healthcare system. Having been exposed to such content by the time of entering the medical profession, medical students who have taken part in such programs will presumably understand cultural differences and social inequalities related to ethnicity more than those who had not become involved in such initiatives in their studies.

7 Shortcomings in Present Legislation dealing with Health Care

National health policies relevant to minority inclusion include increasing tolerance levels 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 such schools. Therefore, according

to the program it is of utmost importance to emphasize the complexity of social disadvantages in any medical education. Also, future health service providers need to see the *realities* of poverty and social problems via direct, first-hand experience as a part of their education in order to be sensitive to the social and ethnic background of patients.

Yet the Central Government has not hinted at any measures in its legislation for 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 - though their adaptation is not compulsory. There is thus an urgent need for reform in this area, too.

While in the Hungarian healthcare system operational costs are covered by social security and investments by local communities, a notable amount 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 also illegal (via the avoidance of tax-paying), though is tolerated by the authorities. According to a survey conducted in 1998 by the Social Research Informatics Center (TÁRKI) 5-6 patients from 10 directly give money to their GP. It can be estimated that only in the year 1998, given a 95% confidence interval of 24 billion, 42 billion forints (112 billion-196 million USD at the 1998 average rate) was given to medical personnel as 'gratitude money'. From this sum, doctors received 29 billion forints, while the rest of the money went to other staff. It can be assumed that such donations raise a doctor's salary by 150%.

Gratitude money is very widespread in the Hungarian healthcare system – and it is very difficult to detect; thus, 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, i.e. less than the average salary of a full-time employee in 2005, which is 186.000 forints. The practice of offering such rewards to healthcare personnel has become a part of Hungarian medical culture, so persons *not* able to provide such compensation are in danger of receiving medical care of lower quality. So this is another factor presumably having a significant effect on Roma people, i.e. who represent a layer of society severely struck down by poverty.

Another shortcoming of the present healthcare legislation is a lack of proper monitoring on the implementation of reform programs. Similarly to other government departments, the health sector is greatly influenced by politics in Hungary. In the past 4

years 3 ministers were chosen to make clear and rapid advances in the healthcare system - though strong political influences, resulting in frequent changes of personnel in decision-making positions, function as obstacles to the implementation of wide-ranging, effective and systemic programs to find real solutions to existing problems. Additionally, there is no consistent evaluation being handled by independent bodies that can offer objective feedback as regards such initiatives. And this points to a barrier when it comes to measuring the efficiency of the government's Roma-related programs in general.

8 Conclusion

Roma people in Hungary are regularly subjected to discrimination in healthcare institutions. The existence of this phenomenon is partly due to there being a lack of preparation at medical schools for the realities of the profession, where there would be the acquiring of skills necessary for proper communication and cooperation with patients from different ethnic and cultural groups. The education at medical schools is mainly theoretical and technically-based, and there is minor emphasis on practice. Thus, medical students have not been 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. So there is a great responsibility for medical school teachers here: they should include inter-ethnic contents in studies, and form attitudes via developing skills in students necessary for successful communication and cooperation with disadvantaged social groups.

A lack of centralized legislation on cross-cultural courses in medical school curricula leads to the infrequent occurrence of such programs at educational institutions. Moreover, such content often lack the attention of curriculum designers. While the government makes only *recommendations* to medical schools on the issue, no systemic changes can be expected for medical education - and only those institutions will employ them where faculty members are *already open* to 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 being resorted to for a comprehensive improvement of financial conditions and the quality of service on offer at medical schools and healthcare institutions.

Besides legislation reform, the perceptions of healthcare providers need to be changed with regard to people from different ethnic and cultural backgrounds (at a postgraduate level too). Also, it is of the utmost importance that representatives of disadvantaged social and cultural groups, such as the Roma, enter medical schools and become healthcare providers, or, indeed, medical school *instructors*. This way, while gaining the social prestige had by this profession, they would also have the opportunity to change the perceptions of society on the Roma – and also the attitudes of medical students, as future healthcare providers, towards social disadvantage and cultural differences.

9 Policy Recommendations to Promote Roma Access to Quality Health Care

- Changing current legislation, and making the application of cross-cultural courses *compulsory* at medical schools at all levels
- Creating post-graduate, regularly applied, practice-oriented, cross-cultural training programs to get sensitization of medical staff working in healthcare
- Strengthening the cooperation of medical universities within 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 so that they can 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 programs learned from other countries to thus sensitize medical students towards minority groupings and socially disadvantaged people
- Closely and consistently monitoring the implementation of government policy concerning Roma by independent bodies, and without dependence on the government
- Launching community development programs to motivate stakeholders involved in social services for the Roma at local and regional levels (local and regional government, local GP and hospital, family support centers, Roma and non-Roma NGOs, Roma self-government) to cooperate for efficient access of the Roma to healthcare services
- Allocating resources to hospitals to employ social workers for better cooperation with patients with different cultural backgrounds
- Building up effective measures via which to combat the existence of gratitude money in health care
- Creating proper conditions to motivate medical personnel to remain in the country as part of the labor force in order to eliminate the 'brain drain' process

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