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Improvement of Medical Education in Hungary: a Key Issue in Roma Access to Quality Health Care

Research Paper

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Abstract

My research aims at exploring barriers in access of Roma people to health care and examining and analyzing medical school curricula for better cooperation of medical personnel with the Roma minority. Primarily, I will give an overview of the status of Roma people in Hungarian society, their political representation; moreover the present structure of health care policy and its special measures to improve the health situation of the Roma.

I will also give an account what elements are missing from 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 issues, such as poverty or ethnic minority existence.

The underlying attitudes behind the formation of these curricula are also of great importance for my topic, moreover the exploration of these attitudes being passed from old to new generations through education. The study also focuses on current practices of health care institutions considering Roma patients; moreover, the communication between healthcare providers and their patients of Roma origin. As a result I intend to reveal the possible barriers of satisfactory access to health care for this minority. Subsequently, I investigate how medical schools' curricula could be improved in the light of the conclusions of the Roma situation in health care. Additionally, after reviewing good examples for inter-ethnic medical education existing in Hungary and in other countries, I present best practices for possible adaptation.

1. Introduction

Health is a priority in its own right, which cannot be overstressed. In the words of Nobel Laureate Amartya Sen, health (like education) is among the basic capabilities that gives value to human life[1]. One definition of health 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 protection".[2]

However, it seems the misconception; health is a condition of absence of diseases is still widely accepted in Hungarian culture. By reviewing different indicators affecting the general health status, it seems obvious that health should be considered in its complexity. As a result, programs aimed at influencing the health status of a population must be far reaching and comprehensive enough to influence all factors mentioned above. In other words, they should not be limited to the area of institutional support system or health care.

According to sociological research, Roma people tend to live at least 10 years less than non-Roma in general (Doncsev, 2000). The health conditions, morbidity and mortality indicators of this minority are generally worse than members of mainstream society in Hungary (Babusik, 2004). Additionally, their relatively low social status and their cultural characteristics are supplemented by stereotypes from mainstream society, resulting in biases and discrimination, which Roma are forced to face on a regular basis. The socio-cultural factors contributing to their marginalization and disadvantages are extremely complex, which have not been successfully tackled by any government policy so far, despite of the wide-ranging political programs launched for the improvement of Roma life standards. These facts are alarming; especially, because the Roma are a significant minority in Hungary and their inclusion has not been satisfactorily realized up to date.

There are numerous factors contributing to the low health status of Hungarian Romas; comprising of unhealthy living conditions at segregated settlements, where a high

[1] See Sen, (1999). *Development as Freedom*, Chapter 1.
[2] *Toward a New Public Health,* Ottawa Conference, WHO, Geneva, 1986

number of Roma people live, and unequal access to quality health care services. Studies focusing on the communication and cooperation of healthcare providers and the Roma, reveal the ethnic background of patients affects medical personnel's attitude towards them, which might result in Romas receiving medical services of lower quality (Neményi, 2001 and Babusik, 2004). Separate wards maintained for Roma patients and pregnant Roma women at hospitals, forced sterilization[3] are reoccurring cases in different forms of discrimination applied against the Roma in health care.

The method employed in my research consists of an analytical overview of relevant research and expert studies, analysis of statistical data on the health situation of the Roma from different aspects, examination of relevant policy, completed by the completion of in-depth interviews with people involved in Roma health; Roma experts, policy makers, NGO representatives, lobbyists, teachers and students of medical schools, Roma patients and healthcare providers to generate relevant information on the given issue.

In my paper, after presenting the social and health status of Roma people in Hungary and current policy on their social inclusion, 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 do not reach their goals without sufficient 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 I draw general

[3] *Roma Rights, Health Care* (2004) European Roma Rights Center

conclusions, based on my research findings, to contribute to the promotion of more efficient legislation on access of Roma people to quality health care.

2. Social Inequalities Resulting in Poor Health Status

2. 1. Socio-Economic Changes and Unemployment Rate

The 1991 census in Hungary registered 142.693 people as Roma in residing 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. According to the 2001 census 190.046 people reported themselves as Roma; however, some researchers estimate 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]. 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 transition from the communist political system to market economy, economic regression and the enacted restrictive measures had a major impact on social and health conditions in Hungary as well as on our ability to tackle them. After the break-down of the communist system a huge proportion of unskilled Roma people became unemployed working previously as manual laborers in the manufacturing industry. With appropriate qualifications Roma people could not enter the work force again, therefore a social tendency took place resulting in Roma families' ending up on the margins of society in large numbers. These indicators have slightly changed during the past 15 years; however, research data shows

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[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 Roma, who identify themselves Roma.

that the representation of Roma students at secondary schools still does not exceed 20%[6], while their numbers in further education is even lower. Therefore, the Roma population still struggles with social disadvantages arising from low education.

During and after Hungary's transition from a socialist state model to market economy the country had to cope with the new situation brought about by the political changes. According to Ladányi and Szelényi (1997), the socialist system was an unsuccessful attempt for forced modernization. As a result, the state could successfully decrease the number of employees in agriculture living in agricultural areas while increasing the numbers of industrial workers concentrated in urban settlements. However, the system was not profit-oriented, and increasing the number of workplaces for eliminating unemployment and pretending economic stability, Hungary could not compete with economic trends of the global market. This lead to the collapse of the political regime in 1989.

After the transition by entering market economy, the number of workplaces drastically dropped during transition times. However, unemployment affected Roma people the most. Before the transition a high number of unskilled Roma were employed in the manufacturing industry becoming unemployed after closing down unproductive factories. Roma were fired first during reducing staff at workplaces and their chances for reintegration to the labor force have become worse since then.

According to Speder and Habich (1997) the rate of unemployment was considerably higher among Roma (35,8%) than among the non-Roma (11,2%)[7]. Havas and Kemény (1995) measured practically full employment rate among the Roma in a study conducted in 1971. However, according to the authors, in 1993-1994 Roma employment rate was half of the ratio measured among non-Roma workers, whose employment rate also decreased from 87% to 63%. The phenomenon affected Roma women the most, from whom only 17% was registered employee in the early 90's. The rate of unemployed Roma people is presently

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[6] Havas, G & Kemény, I & Liskó, I (2001) *Cigány gyerekek az általános iskolában* (Roma Children in the Primary School), Oktatáskutató Intézet, Budapest

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

estimated 10 times higher than the national average[8]. It happened parallel with the unemployment rate rising to 7,2% again, after a general decrease as a result of economic development following the recession of transition years[9]. As a conclusion, economic trends of political transition forced Roma people under the poverty line resulting in very low social status, from which they have been unable to break out until now.

2.2 Geographic Isolation

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 sociological estimation 29% of Roma population live in completely segregated environment, 23% live at communities, where the proportion of Roma is very high, and a relatively small number of them (14%) moved to integrated communities (Havas, Kemény, Liskó, 2001).

Another representative survey shows that 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 (Babusik, 2004). Further results of the survey show that settlements with multiple disadvantages do not offer local GP services directly. 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 such communities suffer multiple disadvantages with the lack of local and assessable health care.

The size and other characteristics of the settlement indicates the access of its members to health care services. A significant amount of Roma people try to integrate into mainstream society by leaving these Roma settlements and try move to neighboring villages

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[8] *World Report: Hungary* (2002). Human Rights Watch
[9] *Country Report.* (2005). World Bank

with better infrastructure. However, without educational qualifications eligible for well-paying jobs, it is almost impossible to move to a non-segregated neighborhood in order to escape from the stigma of living at a segregated Roma settlement. Therefore, the vast majority of these people end up in the vicious circle of poverty and social deprivation as a result of being unable to break out the segregation these settlements symbolize.

A research 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).

Neményi (2000) conducted a representative research among Roma and non-Roma families in order to reveal contributing factors to and amount of their influence on low health status of Roma people. Some of the subjects involved identify themselves as Roma, while some were considered to be Roma by the district nurses visiting Roma homes also questioned in the research. The third group consisted of non-Roma participants. The families' housing conditions were of utmost importance for the research team as an important element affecting health. It is obvious from the table below that the given Roma families lived among much poorer housing conditions than the non-Roma subjects.

Table 1: The housing conditions of Roma, assumed Roma and non-Roma families in a given community

In the studied flat it is given	**Roma (%)**	**Assumed Roma (%)**	**Non-Roma (%)**	**Total number**
Cold water	78	80	97	88
Hot water	44	50	85	67
Electricity	90	94	99	96
Type of heating				
Stove, mixed	54	53	29	
Gas	21	26	44	34
Electricity	13	10	4	8
Central heating	2	3	17	10
Other	4	8	6	6
Sewage system	46	46	70	59

Source: Neményi (2000)

The differences in the proportion of premature birth and abortion in the group revealed by the study are also striking. From the 1259 mothers considered non-Roma by the district nurses 92% had never had premature birth, while 21% of those mothers, who the nurses thought to be of Roma origin had already had at least one. The difference is also significant in the proportion of spontaneous or planned abortions the mothers, involved in the study, had. 21% of the Roma mothers had already had at least one spontaneous abortion, while this rate was only 12% in the case of the non-Roma mothers. The number of planned abortions was also higher among the Roma women: 35%, which ratio was 22% among the non-Roma mothers. The given numbers reveal serious problems in access to information on birth prevention concerning both groups, but especially in the case of the Roma women. It is alarming that half of the Roma mothers involved had already had more than one abortion, but 3-4 or even more cases were not rare either.

Table 2: The existence of conditions contributing to the development of the child by the perception of district nurses working with Roma and non-Roma families

Conditions contributing to child development	**The child is considered Roma by the district nurse (%)**				**The child is considered non-Roma by the district nurse (%)**			
Type of settlement	Capital city	City, town	Village	Total	Capital city	City, town	Village	Total
Given	61	42	47	52	90	89	86	89
Not given	39	58	53	48	10	11	14	11
Total number	248	166	140	554	681	329	195	1205

Source: Neményi (2000)

According to the numbers, the nurses did not find satisfactory the conditions contributing to the proper development of the child in the case of almost half of the Roma families. This negative prejudice mostly affects families living in the countryside. However, the most shocking result is the perception of the district nurses on the given phenomenon. According to their answers, the most significant difference in the existence of the necessary conditions for child care does not rely on the housing conditions of the family, but their ethnic background. As the real economic and social conditions of the families were not well-known for the researchers, they had to rely on the presumably biased perception of the nurses cooperating with members of the given community.

Although they explained the lack of proper child-developmental conditions mostly by Roma ethnic background probably partly influenced by misconceptions on the Roma, the existence of the measured factors were still significantly lower in the case of Roma families. This should be rather explained by disadvantaged socio-economic conditions and lack of information on proper health concept.

2.3 Segregation in Education

The Roma's incapability to break out of low socio-economic status can be partly explained by their generally low education. According to Radó (1997) while 62% of Hungarian students continued from primary to secondary school in 1997, only 9% of Roma students did so. Havas, Kemény and Liskó (2001) identified 126 Roma-dominated segregated primary schools in Hungary, where 40% of all Roma students go. This ratio is only 6,3% among non-Roma students. While in 1991 7,1% of Roma students studied at segregated primary schools, this rate increased to 18,1% by 2001. These schools usually offer lower quality of education with a stigmatizing effect on the child, whose chances to be accepted to a quality secondary school are extremely low after completing such type of primary education. Therefore, the most frequent step after finishing a segregated primary school is dropping out of the educational system or attending a vocational school. Consequently, the attendance rate of Roma students in higher education is still extremely low.

Table 3: Education of Roma and non-Roma population, 1994 (%)

Highest school level	**Roma**	**Non-Roma**
Preschool	0.3	9.1
0-7 grades	11.2	32.6
8th grade	35.8	45.8
Vocational training school	19.4	10.7
High school diploma	23.8	1.6
Further education	0.2	9.5
Total	100	100

Source: Havas-Kemény-Liskó (2001)

Prerequisites to caring for one's mental and physical well-being include some knowledge of what the concept of health entails, moreover access to the means of achieving it. Schools provide essential information on nutrition, hygiene, access to the health care system and

disease prevention – which might happen through education, access to school nurses, vaccinations, etc. When Roma children have difficulties in accessing education, they are less likely to acquire the tools with which to take control over their own health and other life choices. Therefore, it is important that policy-makers are sensitive towards such issues. In education, attendance has to be emphasized at all levels with special focus on kindergarten programs, in order to provide a sufficient basis for Roma children in the education process.

2.4 Low Health Status as a Result of Social Inequalities

Education, economic status, economical activity and living conditions have a dominant role on the state of health. The above mentioned determinants influence the appearance of both 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.

The National Institute for Health Development reveals drastic facts on the health status of Roma in Hungary in a 2001 report. According to the survey, among other psychosomatic illnesses some level of depression affect 75% of the Hungarian Roma population. Moreover, from social and psychosocial factors level of education, economic background, living environment, housing conditions, and the ability to tackle problems have a dominant role. These elements mutually affect the appearance and consistency of both physical and mental illnesses. From the risk factors smoking, insufficient nourishment, the lack of preventive activities proved strongly affecting Roma health status. Such factors often appear in a joint manner strengthening each other's effects resulting in a permanently low health status difficult to change.

The study also reveals that 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.[10] According to nurses involved in the research, Roma patients

[10] *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 Care Services) Report (2001). National Institute for Health Development

more often need medical treatment due to chronic illnesses and much more rarely than the average with screening or preventive purposes. As a result the time of staying in hospital is usually longer in the case of Roma patients. Half of the Roma families asked in the study found it problematic to cover the cost of medicine prescribed by the GP; moreover, access to pharmacies is also difficult due to their geographical isolation. Additinally, there is still an 18.3 percent probability at birth of not surviving to age 60. This survival rate is lower than in other countries in the region with Slovenia (11.8%), Czech Republic (12.1%), Slovakia (14.9%) and Poland (15.1%) (UNDP 2005 Human Development Report).

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 their social integration. Moreover, government programs targeting social mobility of the Roma should not disregard, but has to take into consideration the complex cultural characteristics of this social group. Moreover, comprehensive programs are needed to offer complex solutions in social services, housing conditions, education and access to quality health care.

2.5 Stereotypes on the Roma in Hungarian Society

2.5.1 The Nature of Social Stereotypes

Stereotypes are present in many forms on different layers of society. Stereotypical attitude means associating the same type of behavior or characteristics with each person belonging to one group, regardless of the differences among group members. Stereotypes are not always negative; however, in most cases are insulting for members of the given group. They serve as a basis for the formation of prejudices, which are in all cases negative, more complex and stronger phenomena than stereotypes. According to Aronson's (1999)

definition, prejudice is a hostile or negative attitude against a certain group, an attitude based on generalization arising from wrong or incomplete information. From a dominant, majority perspective it might be difficult to understand the victim's position as target of prejudice often linked together with minority or ethnic existence.

Lerner (1980) claims that in a given situation people tend to blame someone, who can be made responsible for an outcome they find unfair or difficult to explain. This can be explained by our common motivation to regard the world as a complex phenomenon functioning by fair principles. This is the reason humans tend to search for and blame a victim, in order to be able to explain a certain situation for ourselves for better orientation in the world. Certain minorities in a given society might be special targets of such phenomena, given their cultural and social characteristics different from the social norms majority members of the society represent.

Ramsi (1987) dealt with the cognitive processes as basis for the development of children's understanding of ethnicity. Children create different categories based on racial and cultural characteristics to classify data on differences between people. In the beginning these categories are simple and children find it hard to understand that the groups are defined through a large number of common characteristics and that what they experience as a criteria for defining does not have to be correct. The second process is search for clarity and stability. Children tend to fit the information they receive into their already existing system of belief, often resisting and neglecting information that are not in accordance with it. If the child's belief system contains mostly negative attitudes towards others it becomes a prejudice. However, according to Ramsi, child's natural need for order, stability and rules, makes belief systems resistant to change. The reason for this is the following: when children learn the rules of their world, they experience everything that is different as negative. Those children who have more developed ability to classify information on the basis of more criteria, change their belief system easier and get rid of the prejudices and stereotypes easier.

As a conclusion, complete deconstruction of prejudices is impossible; however, it is possible to develop abilities to re-examine stereotype and negative information that provide

the basis of prejudice. In this process creating awareness towards socio-cultural differences and their acceptance through education at all age groups is of vital importance.

2.5.2 Discrimination against the Roma in Health Care

Discrimination is a spectrum-like social form of behavior based on differentiation. It is implied on purpose or unconsciously on disadvantaged social groups or people belonging to them. This type of differentiation is not based on the subject's real qualities relevant to the given situation in a discriminatory act, but on the stereotypes and biases the person has on the social group the subject belongs to. The purpose of a discriminatory act is the subject belonging to a certain social group usually identified by race, ethnicity, nationality, religion, citizenship, sex, gender or special needs.

Roma people in Hungary have traditionally been targets of ethnic prejudice. The sometimes stereotypical social characteristics[11] 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 layers of society.

Social inequalities, the Roma need to face, are relatively often supplemented with negative, biased attitude of medical personnel at different health care 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.

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

Neményi (1999) examined the relationship of Roma mothers and nurses in health care in a qualitative study.[12] The research results show that interactions and communications lead to misinterpretations on both sides, which result in deepening mistrust, and as a result, the effectiveness of curative support is weakened. The main difference in the perception of healthcare providers and Roma mothers was in the field of procreativity. Most of the medical doctors, nurses, and midwives questioned by the researchers assumed that the fertility of Roma women is due to their lack of family planning, poor education and ignorance. According to the perception of these healthcare providers, these mothers only live their biological life surrendering to their unconscious and natural destiny. They keep them 'wild-women', 'natural human beings', a population half way between a semi-civilized life to 'normal' culture. In medical personnel's opinion, the reason for being unable to give them information and advice originates from a real communication gap, their different language, or sometimes because of their under-education. On the other hand, they admitted not having enough information on Roma culture and way of life and some of them also observed that some healthcare providers are biased against representatives of social groups different from mainstream norms, especially the Roma. As a fact they never learned to handle such difficulties by obtaining communication or conflict-solving techniques. Consequently, inadequate communication can result in further consequences in health care: segregation and marginalization without having access to quality health care.

According to the interviews made with the Roma mothers, ignorance, spontaneity assumed by healthcare providers seem to be true only partially. In the majority of cases when fertility habits differed from the majority, it was due to the traditional values. On the other hand, among families without strict traditional customs, a low number of children is a sign that these families followed the majority norms. The researchers also observed that the Roma women participating suffer by the simultaneous claim of the broader and the narrower community to follow their norms, and these two sometimes contradictory effects can result in

[12] 80 Roma mothers were interviewed from the 3 sub-groups of Roma residing in Hungary: Vlach, Boyash and Romungro (Hungarian Romas or musicians), additionally, a fourth, so-called control group, the Roma of Budapest were selected.

a conflicting perception of their procreativity. It also became obvious that the myth of "wild-women" in the perception of healthcare providers on Roma mothers influenced their self-perception in a negative way. The interviews with the Roma mothers also show that, according to their everyday experiences, they feel perceived through the prism of prejudice instead of normal human beings with their own characteristics and problems by healthcare providers. Additionally, advice and instructions of healthcare representatives can only be effective if the person giving them is trustworthy and genuine for the Roma.

According to one type of classification, 2 types of discrimination can be identified in health care concerning the Roma: 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 health care providers that a Roma patient cannot afford to pay gratuity money[13] for the medical service,

-negative discrimination in antenatal care

-improper access to preventive treatments.[14]

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.

A 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

[13] 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.

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 study 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[15]. 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 research reflects the satisfaction of Hungarian society in general, regardless of ethnic affiliation, with the attitude of healthcare providers[16]. According to this study, only 10% of subjects had 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 health care system severely affecting poor people. In the respondents' views this phenomenon the most significantly affects Roma

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[14] *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 Care Services) Report (2001). National Institute for Health Development

people besides the homeless, the elderly and those, who are not willing to offer gratuity 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.

Despite of the numerous reports revealing 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 health care 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.

3. Health Care Policy and Existing Inequalities

3.1 Changes in Health Care Legislation in the Past Decades

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

The current social protection system in Hungary is a result of the historical development and most recent responses to the challenges of the economic and social transition. The system became more pluralistic with divided responsibilities instead of placing

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

all responsibilities in the responsibility of the state. The hierarchical relationships among different stakeholders moved towards contractual ones. 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 health care provisions.

The "Decade of Health" Government program aims at improving the health status of the whole Hungarian population. To enhance this process, the Government is committed not only to consolidate and modernize the current health care system but to implement its financing reform. According to the Government, a health-centered governmental strategy is being implemented, which mobilizes all economic means and entire mental capacity of society in the interest of each individual.

The most important objective is to improve the health status of the population, to increase life expectancy at birth and to facilitate the quality of life determined by health. The health system is being reorganized to provide accountable, effective services with controlled quality can be financed as a result of modernized and consolidated organization and its effective functioning provides decent livelihood for those providing the care. The program was adopted by the entire consensus of Parliament and its implementation started in April 2003. However, there are still unsolved areas, requiring urgent treatment: a large proportion of Roma do not have proper access to quality health care services.

3.2 Roma Health Care Policy

As already mentioned, in the 1990's the social security system 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 health care system formed as a result of transition, disadvantaged Roma people mostly have access to medical services of lower quality due to their social drawbacks.

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[16] *Opinions on Health Care Reform in the Hungarian Public* (2004). Szonda Ipsos

The National Public Health Program was accepted by the Parliament in 2001 containing specific elements to improve the access of disadvantaged people to quality health care 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 health care services and preventive programs. Changing the discriminatory attitude of healthcare representatives 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 improvement of the health status of the whole Hungarian population is the aim of the Decade of Health Government Program. According to Government plans the main focus of the initiative are the most important health problems of society, more specifically 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. Specifically targeted area is the improvement in the 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 health care system but to carry on its financing reform. 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 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.

The supervision of these programs 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 research resources the process of policy implementation does not seem to function effectively taking into account the real needs of the Roma minority. Most of the problems affecting their health circumstances 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 was created in the name of democratic, European values celebrating diversity recognizing the equal rights of people residing in Hungary. 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. 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 100 Steps Government Program of the present cabinet launched in 2005 sets out 21 areas for change in 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[17] 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.

As a significant change, the health security system will become the primary stakeholder of the system. At the same time local municipalities will not be responsible for maintaining health care institutions, except for GPs offices. Patients will be required to provide co-payment at visits to the doctor, which would substitute and hopefully decrease the phenomenon of gratuity money in health care. Those who oppose co-payment argue for its relatively high financial burden on disadvantaged people, who might not be able to cover it. However, according to the views of supporters of the reform, in today's corrupt practice they are also expected to offer some gratuity money to the medical personnel, which is illegal and often creates a basis for shameful situations.

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 care systems in participating countries. There is strong focus on the

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

expansion of access to health care by breaking down barriers between Roma communities and health care 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[18] the Hungarian Government is being critiqued on international level for the inconsistency in the monitoring of 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.

According to the survey of the Brussels-based European Consumer Powerhouse[19], Hungary is ranked the 10th on a scale of measuring the quality of health care services in 12 countries. From 60 points, Hungary was given 35, while the best countries achieved as much as 46-48. In the survey the most scores were given to countries, which operate multiple financial mechanisms independently from the fact that the services are private or state-owned. The best countries, the Netherlands, Switzerland and Germany, proved to imply a client-centered perspective in the health care system functioning with efficient transparency. Hungary is below the average in communicating with patients, which is a result of bureaucratic functioning and information management; moreover the generally negative attitude of medical personnel.

Services can be obtained by anyone today as a basic right in the health care system; however, according to the Minister of Health, it is impossible to control in today's system who pays the compulsory social security contribution. The most crucial problem in health care is

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

[19] European Health Consumer Index, See more: *Népszabadság*, Aug. 8th, 2005

the very underdeveloped infrastructure and the incoherent service-providing system. The money allocated to health care is not used transparently; therefore, spending is too high contrasted with the quality of the services provided to patients. If there were positive examples, e.g. financially profitable hospitals with open communication and positive attitude towards the clients from the side of motivated healthcare representatives, it would be easier for health care institutions to conduct positive changes in their operation.

3.3 Roma Self-Representation

The right for legal protection concerning Hungarian minorities is included in the Hungarian Constitution (Article 68). It declares that national and ethnic minorities residing in Hungary are entitled for active participation in public life and the protection of their own culture. Hungary accepted the Convention of Rome by Act XXXI passed in 1993 on Convention for the Protection of Human Rights and Fundamental Freedoms. Article 14 declares 'the enjoyment of rights and freedoms set in this convention shall be secured without discrimination on any ground such as sex, race, color, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or any other status.'

As a result of the economic and political transition having taken place in the early 1990s, Roma representation became a possibility in Hungary. The 1993 Act on the Rights of National and Ethnic Minorities gave Roma the right to form self-governments. Several Roma NGOs and local Roma self-governments started their operation. In the Hungarian political system local Roma self-overnments function as local political self-advocacy forums, besides local governments; however, without budget allocated to their operation. Lack of permanent financial support, and proper advocacy skills often make the operation of these organizations and minority self-governments very difficult. Therefore, they are extremely dependent on local political stakeholders.

Ladányi (2003) strongly opposes the existence of minority self-governments; as, according to him, they are 'the political manifestation of institutionalized discrimination'. As

not only the Roma, but the whole community is represented at the Roma self-government elections taking place parallel with the local municipal elections, the representation of majority members of the community is higher when the decision is made on the most potential candidate to represent Roma issues on local level. Thus, practically no one can be elected to represent the political will of the Roma without the agreement and support of local government members. Ladányi also claims the election process of the Budapest Roma Self-Government and the National Roma Self-Government, being an umbrella organization of local Roma self-governments, is usually surrounded by a high amount of political manipulation and corruption. Moreover, as these self-governments are financially completely dependent on local governments, they mostly have a formal role in local politics. The reform of the present system has been a topic of long and widespread political discussion, with no efficient results so far; as the homogenous, ethnic-based representation of such stratified social group as the Roma does not guarantee a pluralist, democratic political participation.

As a state response to the obstacles the newly founded and inexperienced civil and political institutions had to face in the 1990's, in 1995 the Public Foundation for Hungarian National and Ethnic Minorities[20] was founded to support minority culture and different initiatives related to them. In the same year another organization was established, the Public Foundation for Hungarian Roma[21], specifically for the consistent support of this minority. In 2002 a Roma politician László Teleki was nominated as Political State Secretary for Roma Affairs to become member of the cabinet and represent the voice of the Roma on government level.

The Roma Affairs Coordination Council[22] was founded in 1999 as a political forum to coordinate Roma-related programs among different ministries. Due to the 2002 modification of the act for its operation, the president of the Council became the Minister leading the Prime Minister's Office and the already mentioned Political State Secretary for Roma Affairs was appointed as deputy president. The founding meeting of the political body was held in

[20] Magyarországi Nemzeti és Etnikai Kisebbségi Közalapítvány
[21] Magyarországi Cigányokért Közalapítvány

2002 with the topic of planned modification concerning the Medium Term Package on the Improvement of the Life Circumstances and Social Status of the Roma Minority passed in 1999. The wide-ranging program contains measures to provide equal rights for the Roma, improve their quality of life and their living conditions; moreover, 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 such programs.

According to international law, states are obliged to combat all forms of discrimination and to provide effective remedy where such discrimination exists. Under the European Union's "Race Equality Directive"[23]– which entered into force in July 2003 and with which EU candidate states must also comply – states are required to *act* to combat direct or indirect discrimination, related to racial or ethnic origin, in both the public and private sectors, and including in public health care bodies. Additionally, they are also required to abolish laws, regulations and administrative provisions contrary to the principle of equal treatment, ensure the implementation of effective proportionate and dissuasive sanctions, and imply relevant laws specifically to implement the Directive.

As a result, in April 2003 the Committee for Equal Opportunities[24] was established to handle discriminatory cases concerning minorities in Hungary. In the same year the Government decided to nominate a minister, Katalin Lévai without allocated budget to be responsible for the same issue. The reason for setting up the post was the goal of coordinating the work among different ministries with special focus on the aspects of equal opportunities before entering the European Union. Consequently, the CXXV Act was passed in 2003 on Equal Treatment and the Promotion of Equal Opportunities. This initiative was meant to open a new chapter in the social integration of disadvantaged social groups and the

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[22] The Roma Affairs Coordination Council (Cigányügyi Koordinációs Tanács) was established due to the 1048/1999 Government Order

[23] Council Directive 2000/43 of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin, Official Journal. L 180, 19/07/2000

[24] Esélyegyenlőségi Bizottság

European integration of Hungary. According to Lévai (2003) the victims of most discriminatory acts in today's Hungary are the Roma, women and people with special needs. Therefore, there was a tremendous need for passing the Act, which is mainly the result of active lobbying from Roma organizations and politicians successfully bringing public and EU attention to the issue.

Despite of the reforms in legislation, lack of proper monitoring on the implementation of Roma programs means a general problem on all political levels. The monitoring body set up in 2003 to measure the efficiency of the Government's Roma programs belongs to the Roma Integration Directorate[25]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. As a result, it is very difficult to provide objective feedback on the implementation of Roma-related programs. Consequently, the monitoring body's operation has not been without difficulties due to its strong dependence on the politics, which means a general problem in the health system among other sectors. The ministries whose programs are evaluated by the existing monitoring body have the right to veto the yearly monitoring reports submitted to the government on their work in implementing Roma programs; therefore, there is no constant, reliable evaluation implied in the present system, which endangers the efficiency of political programs targeting Roma inclusion. This means a common barrier to measuring the efficiency of the Government's Roma-related programs on all levels in general. In the past 4 years 3 ministers were nominated to reach visible rapid achievements in the health care 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.

As a result, the development and effective implementation and monitoring of programs at all levels is required, particularly where the implementation of national strategies relies on local authorities. This is especially important in the context of the primary health

care system, which is primarily a locally handled issue. Therefore, transparency in public administration is of crucial importance and strong emphasis should be placed on eliminating the initiation or tolerance of discriminatory practices by local authorities.

3.4 Current Reform of the Medical Insurance System

The reform process of the present medical insurance system became a vital issue of the 2006 political elections. As a result, political parties had different programs on the modification of the present system to be realized after being elected, unfortunately often influenced by populist political propaganda. The main difference in the reform ideas concerning the system was between the programs of the 2 main parties on the left and the right side. The social-liberal coalition consisting of the socialist party MSZP[26] dominant on the left with its coalition partner SZDSZ[27], which is a liberal party with significantly smaller representation in parliament, supported the idea of privatization in the public welfare system. However, the opponent main right-wing, Christian-conservative party FIDESZ[28] strongly refused any efforts towards privatization in the system.

The social-liberal coalition residing in parliament during 2002-2006 developed a widespread reform program for privatizing the public welfare system as its present form is the heritage of the old socialist regime. Thus, after 16 years of the change of the previous political regime, the transition in the health care system cannot be postponed any longer. The present system is too centralized and, as a result, too expensive, while a growing dissatisfaction both on the side of the patients and health care providers is a well-known phenomenon for long years. The Government seems to admit the fact that, in the Hungarian health care system the needs of the middle and upper-classes are served more, while poor populations have unequal access to health care services. They find the functioning of the present system extremely wasteful and non-transparent, in which hospitals have too much

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[25] Romaügyi Főosztály
[26] Hungarian Socialist Party (Magyar Szocialista Párt)
[27] Union of Free Democrats (Szabad Demokraták Szövetsége)
[28] Union of Young Democrats (Fiatal Demokraták Szövetsége)

responsibility compared to GPs. Therefore, in the future GPs offices shall have higher financial sources allocated in order to increase their activities in preventing illnesses.

The political agenda of the ruling coalition included the reform of the present welfare system as the most important step in public health care to be realized after the 2006 political elections. The model proposes a divided and privatized medical insurance system with 3 basic types of packages. The most basic type includes emergency treatment, epidemic and public health, moreover some elements of mother and child protection. For the second level only those citizens would be eligible, who regularly social security contribution. This package includes the whole range of basic health care services. While the third level means those extra services in health care, which are self-financed. According to its promoters, the whole concept reflects the concept of solidarity, as the third level would mean faster or more comfortable services, but no one would be eligible for any services on this level, where those who choose the second level were excluded from.

According to the reform proposal, developed by health experts of the Hungarian liberal party (SZDSZ), state involvement in public health care should be reduced as much as possible, which includes the privatization of certain hospitals as well. Reducing the role of the state is especially important in the management of health care institutions and in the supply of services, while an increase is needed in its involvement in regulation and supervision. The cabinet argues that this means a guarantee that only those institutions would be able to stay alive on the market, which provide sufficient and quality medical services regardless if they are in private hands or state owned. Thus the new system would be more fair and the role of state bureaucracy would be decreased in it.

A forum, Health Care Council[29] would also be established operating under the Hungarian Parliament in order to advocate for the rights and responsibilities of all stakeholders involved. One of its main tasks would be to set the tariffs of different health care services in advance; while, in today's system, this process is done by the Ministry of Health

[29] Egészségügyi Tanács

without any visibility; therefore, its difficult to control. The proposal also includes the set up and operation of a strict quality assurance system. The results of the regular control on quality would be made public, in order to inform clients about the conditions of the market.

The government expects an increase in the quality of health care services due to the future competition among different private companies involved in medical insurance by the introduction of a market-based system. Being independent from political influences private service providers will be able to make finance-driven decisions flexibly adapting to the current trends of the market, which is also an expectation from the program. According to the plans of the Ministry of Health, the reform would be financed from the 700-800 billion forints, which Hungary is eligible for to be spent on health care from European resources for regional development. Privatization in health care would open the opportunity for private companies as well to use some part of this fund.

The largest right-wing party strongly opposes the reform initiatives for privatization in health care protesting against reducing state participation in public health care and placing hospitals on private grounds. Their main argument is the public poll held in 2004 about the privatization of hospitals, when the majority of Hungarian citizens voted against private ownership concerning state-financed hospitals. In many cases, when local authorities decided to close down a hospital operating at the given community due to financially unproductive operation, local residents vigorously protested against having to go to another town or city for medical services due to the planned elimination of their local hospital. The other main argument of those people, who voted against the privatization of hospitals was the uncertainty of future operation, cost and quality of services, of the health care institutions run by private stakeholders without state supervision.

As for those, who oppose the privatization of the medical insurance system, the paradigm promoted by the social-liberal cabinet, that private insurance companies will “compete for the patients’ goodwill” cannot be guaranteed by the reform concept in question. They argue that the gigantic health care market must only be given to private stakeholders, if the operational efficiency of the system will improve as a result. Their main concern is the

assumption that private investors prefer clients, who mean the possible lowest financial risk for them. The perfect client comes from a relatively well-off socio-economical background and has a relatively stable health status. However, the elderly, or disadvantaged, poor people, including the Roma having poor health indicators do not belong to this “preferred” circle of clients. They do not have a regular, or have a very low monthly income, which correlates with their state of health. Therefore, if no effective measures will be built into the new health security system to protect the rights and promote the access of these high risk groups to quality health care, it will not only reproduce, but even increase inequalities already existing in health care.

Another risk factor is the relatively expensive operational costs of private insurance companies compared to state financed ones. Due to the market driven existence of private investors, the costs of competition for clients increases their operational costs[30]. As a result, these private stakeholders tend to work with over 10% of operational costs, while state-financed ones usually have these costs at 5%[31]. Thus, according to those, who oppose the reform on privatization, the expensive operational costs of private companies might be easily charged on the clients.

One cannot expect a complete solution from the competition of medical insurance companies for solving all the existing problems in the health care system. However, the well-controlled operation of private stakeholders in medical security system might result in improvement in the quality and efficiency of services. Thorough state supervision would be the only guarantee for disadvantaged social groups like the Roma to have an increase in access to quality health care.

3.5 The U.S. Medical Insurance System

The U.S. medical insurance system is a good example for the limitation of market tendencies. There is no compulsory medical insurance, only private companies function in

[30] These operational costs might include PR, marketing, manipulation of clients, extra administration etc.
[31] The National Medical Insurance Center (Országos Egészségbiztosítási Pénztár) needs to function with only 1,5% of operational costs; however, this heavily underfinanced management threatens the normal operation of the company.

health care and 14% is devoted to the financial costs of the health care system, while this number is only 8% in Europe as an average.

There are 3 basic categories in the system, which makes it similar to the currently debated privatization reform program in the Hungarian health care. The first group consist of those, who do not have any medical insurance; those, who belong to the second are relatively underinsured, while the third category means a "well-insured" status. For the most deprived layers, there is free medical insurance (Medicaid) covering only the basic types of medical services. However, only the most disadvantaged are eligible for the state-financed medical insurance. As a result, in today's United States 40-45 million people do not have medical insurance due to the relatively high costs. In other words, if these people have a medical problem with hospital treatment they might end up in serious financial debt. Therefore, the number of those, who urge comprehensive reform on the current status of the medical insurance system, in order to eliminate the existing inequalities in access, has been growing.

According to the results of the 2003 National Health Interview Survey[32] conducted on 93.000 subjects, nearly half (46%) of non-elderly black and more than one-third (35%) non-elderly Hispanic adults, who do not have health insurance reported to have one or more chronic health conditions. Moreover, 28% of uninsured African-American and 27% of uninsured Hispanic adults with chronic conditions reported no visits to health professionals in the 12 months prior to the survey. 50% of uninsured African-American and 42% of uninsured Hispanic adults who have a chronic condition had reported to have an unmet need for either medical care or prescription of drugs. Such conditions result in consistently low health status at the given social groups with extremely high out-of-pocket spending burdens on health care services.

[32] It is a survey of the health status, access to care, use of health care services, and economic and social characteristics of the U.S. population.

The results of the National Survey of America's Families (NSAF)[33] indicate that African-American adults were 13.4% less likely than white adults to have to have Employer Sponsored Insurance (ESI) coverage in 1997. Moreover, African-American adults' uninsurance rate was 8.7% higher than whites in the same year. The numbers do not show statistically significant changes by 2002 contrasted with the original year:

Table 4: Health Insurance Coverage Differences between Black and White Adults, 1997 and 2002

Insurance Status	**1997**		**2002**	
	African-American adults (%)	**White adults (%)**	**African-American adults (%)**	**White adults (%)**
All Incomes				
ESI	62.5	75.9	62.6	75.4
Public	10.6	3.7	12.5	4.3
Uninsured	21.7	13.0	20.0	12.4
Low-Income				
ESI	34.5	43.4	33.4	43.2
Public	23.9	13.3	27.9	16.5
Uninsured	34.3	31.2	32.3	29.2

Source: 1997 and 2002 National Survey of America's Families (NSAF) data reported by Wherry and Finegold (2004).
Note: Insurance rate estimates do not sum up to 100 percent because estimates for "other" insurance (non-group private insurance, Medicare, and other unspecified insurance) are not included.

As Table 5 shows, according to 1999 data, African-American adults were less likely to have a USOC[34] and more likely to have an ER[35]visit in the past 12 months. In some categories the 2002 data show decrease in their access to health care. In 2002 African-Americans were more likely to have a USOC, less likely to have a breast exam doctor or a visit in the past 12 months. Compared to white patients, they claimed less frequently their health care providers listening to them and explaining information well, moreover they were more likely to have an ER visit in the past 12 months.

[33] A nationally representative household survey of the non-institutionalized civilian U.S. population under age 65 that oversampled low-income families with children.
[34] Usual source of care
[35] Emergency room

Table 5: Health Care Access and Use Differences between Low-Income Black and White Adults, 1999 and 2002

Outcome Measure	**1999**		**2002**	
	African-American adults (%)	**White adults (%)**	**African-American adults (%)**	**White adults (%)**
No usual source of care	26.1	18.9	26.2	18.4
Physician visit (past 12 months)	66.0	67.2	65.7	69.8
Any breast exam (past 12 months, women)	47.8	48.4	47.0	52.4
Any inpatient hospitalization (12 months)	17.0	13.2	15.2	13.4
Any emergency room visit (12 months)	37.1	28.1	35.3	28.2
Health care providers listen and explain well	68.5	72.9	74.1	79.0
Postpone care for any reason	17.6	18.3	8.8	12.3
Postpone care for cost	12.7	13.9	5.2	8.3

Sources: For usual source of care, breast exams, and emergency room visits, Garrett's and Yemane's (2006) estimates based on 1999 and 2002 NSAF data. For all others, 1999 estimates from Ku and Waidmann (2003); 2002 estimates based on Garrett's and Yemane's (2006) analysis of NSAF data.

Satcher (2000) claims that in the twentieth century unprecedented improvement took place in the health status and longevity of people in the United States. Despite of this progress and significant achievements in human rights movements, health statistics demonstrate the disproportionately higher burden of disease, disability and death experienced by racial and ethnic minorities. The author mentions the following statistics to demonstrate the alarming differences in the health status of different ethnic groups:

-African-American women are four times as likely to die in labor and delivery as their majority counterparts;

-Asian-Americans have a higher incidence of liver cancer;

-African-American males over 65 years are twice as likely to have prostate cancer;

-American Indians have the highest risk of Type 2 diabetes;

-Hispanics are twice as likely to suffer diabetes as the majority population. Consequently the federal government has committed itself to the elimination of such disparities by 2010.

4. Medical Education as a Key Issue for Roma Access to Quality Health Care

4.1 Hungarian Medical Education

Due to globalization and the free movement of capital, universities are dependent on the labor market, which is lead by the actual economic trends (Appadurai, 2000). This phenomenon became intensely significant after the Hungary's joining the European Union. 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 this process, 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 lack of doctors nationwide.[36] This ratio is 15-20%; however, as the report states, 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 in health care.

The present state of medical education requires widespread 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).

4.2 The Attitude of Medical Teachers and Students

The underlying attitude of teachers on ethnical issues is of crucial importance at the implementation of inter-ethnic contents into medical school curricula. Attitudes towards different social groups in society are inherited, passed on to the next generation through education, which is a basic determinant of medical culture in our case. This value system is a complex code of values and norms of behavior, which is very difficult to detect. The negative or biased attitude of university teachers can be one of the reasons preventing the inclusion of Roma-related contents into medical curricula resulting in the lack of students' attitudes being formulated in a positive way towards social disadvantages. It is also of utmost importance that representatives of disadvantaged social groups, such as the Roma enter medical schools and become health care providers and teachers of medical schools receiving the social prestige of this profession in order to change the perception of society on the Roma; moreover, the attitude of medical students.

In the 2nd semester of the 2004/2005 school year a course, called 'Romology and Minority Mental Hygiene', was implemented at the Health Care College of Semmelweis University in Budapest. The 30-hour-elective course was designed to enrich the information students possessed on the Roma in Hungary, while preparing the participants for successful future cooperation with them. 80 students signed up for the course and 63 participants finished it. Prior to attending the course the students were asked about their motivation for entering it. The primary motivation of 16 students (29%) was their interest in Roma culture, 21 of them (38%) intended to understand them more besides being interested in Roma

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

culture, while 8 students (14%) were interested in their culture, had the intention to understand them more, moreover wished to contribute to their social mobility somehow. 11 participants (21%) signed up for the course for other reasons (e.g. credit score). According to the results, the most dominant motivating force was learning more about Roma culture and the desire to understand people of Roma origin more. 82% of the course participants had mixed experiences with the Roma; they know some Roma families, 'who live a very acceptable life'; however, these students also had very negative experiences with them as well. The rate of those students, who only had negative experiences with the Roma preceding the course, was relatively lower but still significant; 18%. The course was 10 weeks long with 3 lessons on a weekly basis. When it ended, the biases of the students towards the Roma were measured by the Bogardus Social distance scale. The subjects were asked to rate their attitude towards different social groups on a 1-7 scale[37]. The results are listed in the following table:

Table 6: The attitude of medical students towards different social groups on the Bogardus-scale

Social group	**Attitude rate (1-7)**
Arabic people	3,8
Croatian people	3,0
People with hearing problems	2,5
Roma people	**3,9**
People with eyesight problems	2,5
Jewish people	3,0
Chinese people	3,9
People with physical disabilities	2,2
Italian people	2,4
People with mental disabilities	3,2
English people	2,3
Homosexual people	4,0
Prostitutes	5,0
Average rate of prejudices	**3,2**

Source: Mészáros-Kármán-Várkonyi (2005)

The results clearly show biases towards Roma people are highly above the average. This rate is only higher in the case of homosexuals and prostitutes. As a positive outcome, 95% of the students thought after the course their knowledge on Roma people had improved and

[37] The 2 extremes of the scale mean the following: 7= I would like if members of this group lived outside of the country. 1=I would even get married with a person from this group.

their attitude more positive towards them. From the 63 students 57 would like to participate in similar courses in the future as well, the majority of participants (71%) did not miss anything from the course, however 25% would have liked to meet representatives of the Roma and wanted more discussion and exchange of views on the issue.

4.3 Implementation of Inter-ethnic Contents in Curricula Focusing on Roma

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 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, it is of utmost importance to clearly emphasize the complexity of social disadvantages in medical education. Moreover, future health service providers have 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, and understand problems with social origin in their work.

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 45 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.

4.4 Models for Possible Adaptation

4.4.1 Interethnic Training for Doctors

As for medical education in general, according to most of the 15 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.

Some programs; however, implemented in Hungary can be cited as good models in the field of 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, 6 proposals were granted. The successful projects were submitted by 3 faculties of the Semmelweis University in Budapest and the Health Care College of the Universities of Pécs, Debrecen and Győr. Important goal was in the program to provide detailed, relevant

information on the Roma for future medical personnel; first-hand, practical experiences on their culture and socio-economic background; moreover, provide the students with techniques for possible conflict resolution while working with the Roma.

As a result graduate and postgraduate elective courses, moreover educational materials were developed at these institutions aiming at improving the cooperation of medical personnel with patients of Roma origin. According to the teachers I interviewed, 3 of these courses have been included in the curricula of the schools on a continuous basis with a growing interest from the students' part 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 holding 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 courses 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. He thinks a wider perspective is needed on health care and medical ethics in general both from the students' and the teachers' side. Moreover, there is too much focus on professional courses at medical schools, while subjects related to the humanistic side of health care is mostly of secondary importance. As a result, according to the presently existing medical culture in Hungary today, healthcare providers 'tend to heal illnesses instead of people'.

It was among the donors' intentions to support the sustainability of the programs created, therefore 3 2-day-long seminars were held for representatives of the given universities and colleges including presentations on the socio-economic situation of the Roma, focus-group discussions and exchange of experiences. 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 a direct result of the project model programs with inter-ethnic contents were developed for future adaptation at medical schools and a book[38] was edited with the manuscripts of lectures and seminars held by Roma and medical experts for the representatives of medical schools participating in the program.

The Health Care College of the Debrecen University, having implemented a post-graduate course for nurses and district nurses from the 6 projects approved, conducted a study on the effect the program had on the participants. They used 2 questionnaires prior to and after the course to gain feedback from the students. The first questionnaire included questions on their motivation for attending the course[39]. The primary factors of motivation were the importance of providing quality healthcare services to disadvantaged social groups and the increasing need for support. 97% of the applicants were very motivated to learn more about Roma and disadvantaged people after finishing the program. The closing questionnaire focused on the participants' perception on the success of the course; moreover, whether they found it necessary to adapt such courses in the curricula of medical schools. 77,7% of the respondents thought the course had a positive effect on their professional work, 40% gained new information on the Roma, 22% became better informed and 25% of the participants' already existing knowledge was reassured due to the program. 88% of the students would like to participate in similar courses and 94,5% would recommend the program to their colleagues. 90% of the participants found the training method implied satisfactory to fulfill their expectations from the course, which improved their conflict management and communication skills and offered unique solution for each question or problem arising during the course through different role-play activities. As a contradiction, only 50% of the respondents found the close cooperation with Roma leaders and Roma Self-governments important in health care, which means a relatively strong social distance from

[38] Ambrus, P. & Csépe, P. & Forrai, J. (2002) *Egészségügy, Kommunikáció, Cigányság* (Health Care, Communication, the Roma). Budapest: Új Aranyhíd Kft.
[39] That time the participants still did not know the course was accredited, they were only told about it later.

the target group; however, it cannot be expected from one such course to eliminate all existing stereotypes, possible negative feelings and biases participants possess on the Roma.

I interviewed all teachers, who coordinated the projects granted at the 6 medical schools. According to one of them people are afraid of conflicts in general and if possible they try to avoid them. It is especially true for conflicts arising from cultural or ethnic differences. However, if conflicts and problems are not faced directly, they have a more striking effect with outcomes very difficult to control.

Consequently, such courses have to be designed bringing the message that problems and conflicts are not something to be afraid of, but normal elements of human communication and cooperation. This is especially important in a profession such as health care, where human interactions take place very frequently and have a dominant role as prerequisite of the successful healing process. There are no absolute solutions for certain problems, but different techniques have to be thought future medical personnel as early as possible to be applied in real-life situations.

4.4.2 Empathy Activity Camp

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. Additionally, they are directly faced with the realities of what it means like to be e.g. homeless, a drug-addict or a person with HIV.

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 of the 10 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. Some students are grateful for attending the course as it made them face the realities the Roma have to cope with in their everyday life by visiting their homes, discussing their socio-economic situation directly with them. Until they had not had the opportunity to enter a Roma community in person, they could not grasp the essence of the problems they have to struggle with.

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. Unfortunately, it seems a relatively frequent phenomenon that teachers, who hold such courses do not possess the appropriate communication and social skills to make these courses effective and appealing enough for the students. Moreover, 36 (80%) students did not find it practical enough with very little or no focus on information on ethnic differences or Roma people. 16 (35,5%) of them thought it is included too early in the curriculum, prior to the compulsory medical practice they have to accomplish, therefore they cannot link the information they receive on these communication courses to practical phenomena, consequently it mostly remains on a theoretical level. In general 32 (71,1%) of the students, I collected data from, think the present system of medical education does not prepare them for the future realities of the profession.

Roma-related programs at medical schools 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 10 (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.

The inclusion of inter-ethnic contents in medical school curricula is a relatively new phenomenon in Hungary. The first such programs were developed and launched with the support of the Soros Foundation in Budapest in 1999, which has remained the most significant initiative with the most dominant and thorough effect in the field of Hungarian medical education since then. It seems obvious that further improvement is needed in courses focusing on the realities of medical profession in terms of communicating and cooperating with patients with varied socio-economic background. Therefore, models,

already successfully implemented in other countries can serve as good source for future implication.

4.4.3. 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. 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 of 75% of African-Americans accepted applying to medical school in 1969.

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. According to Prof. Robert Crone teaching at Harvard Medical School, who I interviewed for his views on the possible inclusion of inter-ethnic contents in medical studies, there is a continuously growing awareness on the issue at U.S. medical schools. Their intention at Harvard Medical School is to design and implement as many courses to expose students to disadvantaged communities as possible to prepare them for the future challenges of the profession. The required course he currently teaches at Harvard Medical School; *Seminar in Global Health Equity* engages students in conversation and analysis with experts from social medicine and related social science disciplines, health policy and public health. Therefore, participants have the opportunity to listen to lectures and exchange their views on global inequalities in health care and possible methods for their reduction.

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.

I interviewed 5 U.S. medical university students, who have experiences in both the American and Hungarian medical education completing some part of their studies in Hungary. According to their views, inter-ethnic contents are much more frequent in U.S. medical school curricula than in Hungary. They are usually elective courses and a large part of such inter-ethnic contents included in the curricula comes from the students' part. They perceive student organizations more powerful and effective in the U.S. in general, which might be a key issue in formulating their needs in their studies contributing to the quality improvement of curricula. These organizations are much better in advocating for students'

needs than in Hungary; therefore, students-teacher relationships are more based on democratic values. They find Hungarian medical education a more rigid and hierarchic system according to geopolitical, cultural and historical characteristics of the country and the Central Eastern European region; while they consider U.S. universities more open, dynamic and democratic institutions with more sensitivity towards the students' needs.

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 health care 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.

In U.S. medical education there are also some affirmative action programs available for minority students to enroll in the health professions. Government agencies play an active role in promoting equity in medical training programs. The Arthur Ashe Institute of Urban Health founded a Health Science Academy. Since 1997 the academy has been working with high school minority students (Latino, African-American, Caribbean) after-school and on weekends. The program offers the following services:

-Academic Support and Enrichment

-Psychological support

-Mentoring

-Exposure to health care professionals (role-models)

-Opportunities for critical thinking and problem solving

-Professional opportunities.

According to the students' and the teachers' views, these programs have proved very effective. From the 117 graduates of the program 90% entered four-year colleges and 97% of the Academy graduates remained in college[40]. The long-term goal of the initiative is to continually collect data on its graduates in order to gain insight into which program variables hinder success. As soon as these variables become unrevealed, model programs can be developed and implemented throughout the country to facilitate larger numbers of minority students in higher education programs in medicine, sciences, biomedical and health-related professions.

5. Conclusion

Hungarian Romas have been a target of widespread ethnic-based discrimination arising from prejudices of mainstream society. The phenomenon exists in health care as well preventing Roma access to quality health care services. This can partly be explained by the insufficient preparation of future healthcare providers to the realities and the challenges of the medical profession. Objective information on the cultural and socio-economic background of the Roma, moreover contents emphasizing skills and techniques, necessary for effective communication and cooperation with them are often missing elements from Hungarian medical school curricula. As a result, medical students are prepared for the realities of the profession to face and manage conflicts connected to cultural differences and social disadvantages in their everyday work. Consequently, inter-ethnic contents have to be included in medical studies on all levels in order to shape attitudes of medical students for

[40] Rosalind V. Wilson, Program Director, Arthur Ashe Institute of Urban Health; speech given at the conference: Increasing the Representation of Minorities in Medicine and the Health Professions: Policies, Partnerships and Outcomes, October 31, 2000, New York

understanding phenomena resulting in social disadvantages and accepting cultural differences.

There is a need for central legislation on including cross-cultural courses in medical school curricula as the operation of such programs is still unfrequented at such educational institutions. This is partly due to the fact that similar contents often lack enough attention from curriculum designers and still do not account for a significant part in the culture of Hungarian medical education. Thus, the government should imply restrictive measures on the given issue in order to reach systemic changes in the cross-cultural education of future healthcare providers. In Hungary medical schools, health care institutions and medical personnel are heavily under-supported, therefore inter-ethnic initiatives in medical education and quality health care services are doomed to failure until no comprehensive improvement takes place in the financial conditions of medical schools and health care institutions.

Moreover, affirmative action programs are needed in medical education in order to provide opportunities for socially disadvantaged and Roma students to enter medical schools and become healthcare providers. Therefore, having qualified medical personnel of Roma origin in the health care system would help changing the perception of society on Roma people and guarantee improved access for the Roma to quality health care services.

Literature

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

Aronson, E. (1999). *The Social Animal*, Worth Publishes, Inc. New York

Babusik, I (2004). '*A szegénység csapdájában, Cigányok Magyarországon – szociálisgazdasági 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 Health Care 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 Health Care 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 Country Report. 2005,* World Bank

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

Dr. Mészáros, J. & Kármán, J. & Várkonyi, Á. (2005) "Romológiai ismeretek – kisebbségi mentálhigiéné" című tantárgy bevezetésének tapasztalatai a Semmelweis Egyetem Egészségügyi Főiskolai Karán a 2004/2005-ös tanévben (The Experiences of the Course 'Romology and Minority Mentalhygiene' Implemented at the Health Care College of Semmelweis University in the 2004/2005 School Year), In *Védőnő* 2005/6.

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.

Garrett, B. & Yemane, A. (2006*) Racial and Ethnic Differences in Insurance Coverage and Health Care Access and Use – A Synthesis of Findings from the Assessing the New Federalism Project,* the Urban Institute, New York

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

Havas, G & Kemény, I (1995). A magyarországi romákról (About the Roma in Hungary). In *Szociológiai Szemle,* 1995. 3.

Havas, G & Kemény, I & Liskó, I (2001). *Cigány gyerekek az általános iskolában* (Roma Children in the Primary School), Oktatáskutató Intézet, Budapest

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) In *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

Ladányi, J & Szelényi, I (1997). 'Szuburbanizáció és gettósodás'. (Suburbanization and gettoization) In *Kritika* 1997/7

Ladányi, J. (2003). Romaügyek pedig nincsenek! (There are no Roma Issues!) In *Egyenlítő* 2003/1. 21-26.

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

Lerner, M (1980) *The Justice Motive*. Plenum Press, New York.

Lévai, K., (2003). *Pillangóhatás.* (Butterfly Effect) Budapest: Osiris Kiadó.

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.

Neményi, M (1999). *Gipsy Mothers and the Hungarian Health Care System*, Patrin Web Journal

Neményi, M (2000). *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 Etnical Identity), MTA Szociológiai Kutatóintézet

Neményi, M (2000). *Az egészségre ható tényezők "deprivált családok" gyermekeinél – cigány-magyar összehasonlítás* (Factors Affecting Health of Children in 'Deprived

Families' – a Roma non-Roma comparison) Available online at: http://www.romaweb.hu

.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.

Radó, P. (1997). *Report on the Education of Roma Students in Hungary. NEKH*

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

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

Report (2004). Amnesty International Hungary, Budapest

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

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 Care Services) Report, (2001). National Institute for Health Development

Roma Rights, Health Care (2004). European Roma Rights Center

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 Health Care

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

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

Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey, (2005) the Urban Institute and the University of Maryland

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.

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

Wherry, L. & Finegold, K. (2004). Changes in Health Insurance Coverage and Health Status by Race and Ethnicity, 1997-2002. In *Journal of the National Medical Association* 96 (12): 1577-82.

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

World Report: Hungary (2002). Human Rights Watch

World Health Report 2005. World Health Organization, Geneva: WHO.