SNAPSHOT: SITUATION OF ROMA IN EUROPE

HEALTHCARE, INCLUSION OF PEOPLE WITH DISABILITIES, LONG-TERM CARE

1-in-4 Roma does not have **health insurance.**

22% of Roma have a **longstanding illness** or health problem.

10% of Roma aged 16-24, 13% of Roma aged 65+, 16% of Roma aged 25-64 reported discrimination experiences when **accessing health services.**

10 YEARS The Roma have a **10-year shorter life expectancy** than that of majority population.

Roma women live, on average, 11 years less, and Roma men live 9.1 years less.

10x higher vulnerability of Roma to **tuberculosis** compared to majority population.

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Roma communities across Europe face persistent and severe health inequalities compared to the majority population. This health gap is evident across nearly all health indicators, including life expectancy, infant mortality, suicide rates, and the prevalence of both chronic and preventable diseases. Life expectancy for Roma is 10+ years shorter than that of the majority population, and Roma children and adults suffer disproportionately from poor health outcomes.

These disparities are due to a wide range of structural and social determinants, such as absolute and relative poverty, material deprivation, substandard and overcrowded housing, lack of sanitation and clean water, poor nutrition, exposure to physically demanding and unsafe labour, and institutional racism and discrimination, especially in healthcare systems.

These health inequalities are life-long and intergenerational. Roma with disabilities, whether physical or mental, face multiple barriers in accessing employment, care services, and income support. Older Roma also often bear the heaviest burden of unmet medical needs and exclusion from health systems, despite complex needs accumulated in a lifetime of disadvantage.

High levels of stress, anxiety, and depression are prevalent among Roma, linked to lifelong exposure to poverty, antigypsyism, social exclusion, and trauma. Yet mental health services are virtually inaccessible for most of them, due to a combination of stigma, lack of culturally sensitive providers, and systemic underinvestment in public mental health infrastructure.

Access to sexual and reproductive health and rights, including information, education, and contraception, remains difficult in many Roma communities, compounded by a longstanding tradition of discrimination by healthcare providers, culminating in historical atrocities such as forced sterilisation and obstetric violence.

Health insurance remains inaccessible for many Roma, especially those without formal employment or legal documentation. They also encounter barriers such as lack of ID documents or permanent residence, language and literacy challenges, and bureaucratic complexity, which hinder their ability to access even subsidised healthcare. In many countries, public healthcare infrastructure does not serve Roma communities adequately, with clinics and hospitals located far from segregated or rural areas, and private healthcare remaining unaffordable.

Antigypsyism in healthcare settings remains widespread, with instances of segregation in maternity wards, racial profiling, refusal of care, and verbal abuse by medical professionals well documented in many countries. Moreover, Roma patients often receive substandard care or are denied the dignity of informed consent and respectful treatment. The lack of sufficient health mediators and Roma health professionals further deepens the divide and mistrust between communities and healthcare providers.

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The umbrella term "Roma" encompasses diverse groups, including Roma, Sinti, Kale, Romanichels, Boyash/Rudari, Ashkali, Egyptians, Yenish, Dom, Lom, Rom and Abdal, as well as Traveller populations (gens du voyage, Gypsies, Camminanti, etc.), in accordance with terminology used by the European Commission.

Recommendations:

- **Tackle the social determinants of health and address the root causes of poor Roma health outcomes** by improving housing, sanitation, nutrition, environmental safety, and working conditions. Mainstream a social determinants of health approach across all relevant policies.

- **Guarantee universal health insurance and access to affordable care**, by ensuring that all Roma are covered by health insurance and that healthcare, including specialist and long-term care, is free or affordable at the point of use. Remove administrative, financial, and documentation barriers that prevent Roma from accessing care.

- **Expand healthcare and long-term care infrastructure in underserved areas**, by investing in accessible, well-staffed healthcare and long-term care facilities where Roma people live, in rural and remote communities, particularly segregated and informal ones.

- **Strengthen and institutionalise Roma health mediation,** by scaling up Roma health mediator programmes, ensuring that the mediators are Roma themselves, and that they are formally employed by national health systems, receive fair compensation, and have access to continuous training and institutional recognition.

- **Ensure non-discriminatory, inclusive, and accountable health services**, by combating antigypsyism and systemic discrimination in healthcare and enforcing anti-discrimination legislation, implementing mandatory anti-bias training for all medical and care staff, and ending segregation and exclusion in service provision. Establish robust monitoring and accountability mechanisms, including internal controls, regular racism audits of institutions, accessible complaint procedures, and active oversight.

- **Provide for effective access to sexual and reproductive health and rights for all Roma, particularly Roma women and girls,** including contraception, family planning, safe abortions, prenatal and postnatal care. Acknowledge and provide reparations for past abuses such as forced sterilisation.

- **Address communicable and chronic health conditions with a harm reduction lens and invest in the prevention and compassionate**, supportive treatment for conditions such as HIV, hepatitis, tuberculosis, cardiovascular disease, premature births, and substance abuse, which disproportionately affect Roma communities.

- **Promote independent living and adequately resourced family-based care models,** by advancing deinstitutionalisation strategies and supporting family and community-based care, with financial, material, and professional assistance to provide much-needed respite and to ensure that care does not become an undue burden on relatives.

- **Engage Roma communities and their civil society organisations in health policy and practice**, in a bid to foster trust and improve service uptake through actively involving Roma communities and their civil society organisations in the design, implementation, and monitoring of health and care policies and programmes.

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