EUROPEAN PARLIAMENT

DIRECTORATE-GENERAL FOR INTERNAL POLICIES

POLICY DEPARTMENT A
ECONOMIC AND SCIENTIFIC POLICY

Economic and Monetary Affairs

Employment and Social Affairs

Environment, Public Health and Food Safety

Industry, Research and Energy

Internal Market and Consumer Protection

Workshop on Discrimination in Healthcare

MEETING DOCUMENT

EN

2014

Workshop on Discrimination in Healthcare/Meeting Document

EUROPEAN PARLIAMENT

DIRECTORATE GENERAL FOR INTERNAL POLICIES
POLICY DEPARTMENT A: ECONOMIC AND SCIENTIFIC POLICY

WORKSHOP

Discrimination in Healthcare

Brussels, 22 January 2014

MEETING DOCUMENT

Organised by the Policy Department A-Economy & Science
for the Committee on the Environment, Public Health and Food Safety (ENVI)

Workshop on Discrimination in Healthcare

Wednesday, 22 January 2014 from 12.30 to 14.45
European Parliament, Room P7C050, Brussels

AGENDA

12.30 - 12.35
Welcome and opening by Co-chairs of the Health Working Group, Glenis WILLMOTT and Alojz PETERLE, MEPs

Part 1 How does discrimination affect people? Who is affected?

12.35 – 12.45
Discrimination in health care against people with mental illness
Prof. Graham THORNICROFT, Section of Community Psychiatry, Health Services and Population Research Department, Institute of Psychiatry, King's College London (UK)

12.45 – 12.55
Discrimination based on sexual orientation.
Mr Anthony BABAJEE, young LGBT activist (UK)

12.55 – 13.05
Racial and ethnic factors as a determinant of healthcare
Mr Marian MANDACHE, Executive Director, NGO Romani Criss (RO)

13.05 – 13.30
Q & A

Part 2 Developing policies

13.30 – 13.40
Multiple discrimination in healthcare
Mr Ioannis N. DIMITRAKOPOULOS, Head of Department Equality and Citizens' Rights. EU Agency for Fundamental Rights (AT)

13.40 – 13.50
Daily tracking and resolving discrimination in access to healthcare services
Mr Gianfranco COSTANZO, Head of Unit Relations with National and International Institutions, Project Cycle Management and Corporate Social Responsibility, National Institute for Health, Migration and Poverty (IT)

13.50 – 14.30
Q & A

14.30 - 14.40
Conclusions

14.40 Closing

SHORT BIOGRAPHIES OF EXPERTS

Prof. Graham Thornicroft

Graham Thornicroft is Professor of Community Psychiatry, and Head of the Health Service Research Department at the Institute of Psychiatry, King's College London. He is a Consultant Psychiatrist working in an Early Intervention community mental health team in South London, and is Director of King's Improvement Science.

His areas of expertise include: mental health needs assessment, the development of new outcome scales, cost-effectiveness evaluation of mental health treatments, stigma and discrimination, the development of community-based mental health services, and global mental health.

He has published 29 books and 333 peer-reviewed scientific papers (e.g. Discrimination against People with Mental Illness, Self-stigma, empowerment and perceived discrimination among people with bipolar disorder or depression in 13 European countries: The GAMIAN-Europe study, Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey, etc.).

Mr Anthony Babajee

Unashamedly positive, Ant Babajee has been living with HIV since 2007. He grew up in south-west England and currently lives in London. Ant came out as gay at the age of 19 during the first year of a German and history degree. Being mixed race (with a father from Mauritius), gay and HIV-positive, Ant jokes that on diversity monitoring forms he has to tick lots of boxes!

Ant currently works as a marketer and graphic designer, but his background is in broadcast journalism, including five years at the BBC. As he regained confidence after his HIV diagnosis, Ant has sought to use his media skills to talk about his experiences of living with the virus. Even though he is open to his wonderfully supportive friends and family, the biggest challenge Ant faces is disclosing his positive status to new people he meets, such is the stigma that still surrounds HIV 30 years after the first cases emerged.

Ant has talked about openly living with HIV as a gay man in numerous interviews on radio, television and the web. He has appeared in the national and local media in the UK – on ITV News, Gaydio and numerous BBC local radio stations. In early 2013, he was featured in FS magazine, published by sexual-health charity GMFA, as a gay community role model.

Ant has been volunteering with Terrence Higgins Trust, Europe's largest HIV and sexual-health charity, since 2010 and became a trustee at the end of 2013. He supports other people living with the virus around Britain as the volunteer moderator on the myHIV web forum. He also volunteers with THT's health improvement team on the London gay scene as well as with GMFA. Ant is also a member of UK-CAB, a network of HIV treatment advocates, and ReShape – a recently formed HIV and hepatitis C thinktank.

Ant is an avid tweeter as @t4rdis – he is a fan of British sci-fi series Doctor Who – and regularly discusses LGBT and HIV issues with his followers. He also posts to his Tumblr blog at t4rdis.me.

Mr Marian Mandache

Marian Mandache was born in an Ursari Roma family in Romania. He became a lawyer in the Bucharest Bar (2005) and got his LL.M. from Columbia University (2010) where he also served as a teaching assistant of Prof. Jack Greenberg. Marian works on Roma rights since 1999 and he is currently the Acting Executive Director of the NGO Romani CRISS. He acquired valuable field experience by conducting numerous fact-finding missions on various human rights violations. He has drafted complaints to the ECtHR on Roma issues. He has litigated landmark cases on hate-speech (against the President of Romania, the Prime-Minister, the Minister of Foreign Affairs), on school segregation (School 19 Craiova) or law enforcement misconduct. Marian was part of expert groups drafting law proposals (e.g. amendments to the Romanian anti-discrimination legislation) and developing international standards (CoE, EC, OSCE). Marian has delivered trainings for judges, police officers and civic activists. He has authored six books on the human rights situation of Roma.

Mr Ioannis Dimitrakopoulos

Ioannis Dimitrakopoulos is Head of the 'Equality and Citizens' Rights' department at the European Union Agency for Fundamental Rights (FRA). His areas of expertise include issues of equality and non-discrimination, as well as child rights. He studied sociology at Manchester and Essex University, UK. Since the mid-1980s he worked in academic institutions, where he lectured and conducted quantitative and qualitative social research. In parallel, during the 1990s he worked in local and regional government. Later he coordinated national and transnational research projects. Since 2003, when he started working for the Agency, he has been responsible for several of its major publications and contributed extensively to a number of policy documents.

Dr Gianfranco Costanzo

Dr Constanzo is the Head of Unit for International relations, relations with regions and project cycle management of the National Institute for Health, Migration and Poverty (NIHMP). Prior to joining the NIHMP, he was a senior medical officer at the Ministry of Health, in charge of overseeing the preparatory works conducted for the meetings of the Council of Health Ministers' Working Party of public health. Between 2002 and 2008, Dr Constanzo's main responsibility at the Ministry of Health was to coordinate health cooperation programmes. From 1999 to 2001, Dr Constanzo was supporting the work of the Ministry of Health from Brussels, where he was in charge of the health dossiers linked to the EU's enlargement process. Prior to this position, Dr Constanzo was a seconded expert at the European Commission's Directorate General for Health and Consumers. Dr Constanzo is a medical doctor by training and he has post-degree diploma in gynaecology and obstetrics.

PRESENTATIONS AND FACTSHEET

Presentation by Prof. Graham Thornicroft

Evidence to decrease mental health related stigma and discrimination

Professor Graham Thornicroft

graham.thornicroft@kcl.ac.uk

Institute of Psychiatry

at The Maudsley

World Health Organisation Collaborating Centre

KING'S College LONDON Founded 1829

University of London

"The issue of stigma against mental illness sometimes feels like the worst part about it." Tom

Plan

1. mental health gap
2. premature mortality
3. what must we do?

Plan

1. mental health gap
2. premature mortality
3. what must we do?

Challenge 1: the 'treatment gap'

- 20-30% of global population has mental illness each year
- > 66% of people with mental illness receive no treatment
- treatment gap occurs in all countries:
  - in Europe 74% and in Nigeria up to 98% untreated

- R. Kohn, et al (2004) Bull. of World Health Org. 82: 858-866
- Wang, P. S., et al (2007) Lancet, 370, 841-850
- Thornicroft, G. (2007) Lancet, 370, 807-808

Treatment gap: percent treated in high, medium & low resource settings

	High income % treated	Low & middle income % treated
Physical disorders		
Diabetes	94%	77%
Heart disease	78%	51%
Asthma	65%	44%
Mental disorders		
Depression	29%	8%
Bipolar disorder	29%	13%
Panic disorder	33%	9%

Ormel J. et al (2008) British Journal of Psychiatry, 192, 368-375.

Plan

1. mental health gap
2. premature mortality
3. what must we do?

Challenge 2: premature mortality

BJPsych The British Journal of Psychiatry (2011) 199, 453–458. doi: 10.1192/bjp.bp.110.085100

Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders†

Kristian Wahlbeck, Jeanette Westman, Merete Nordentoft, Mika Gissler and Thomas Munk Laursen

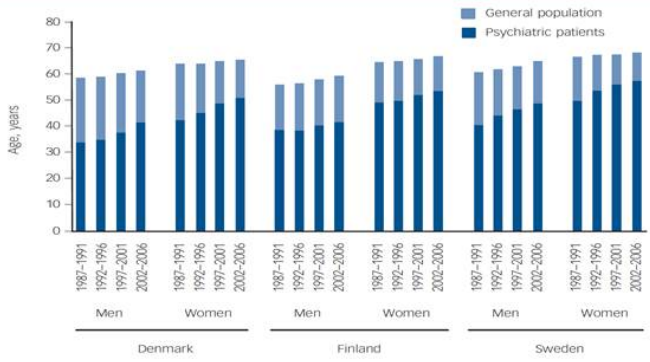


Fig. 2 Total life expectancy among psychiatric patients and general population in Denmark, Finland and Sweden 1987–2006 at 15 years of age.

BJPsych The British Journal of Psychiatry (2011)
199, 441–442. doi: 10.1192/bjp.bp.111.092718

Editorial

Physical health disparities and mental illness: the scandal of premature mortality†

Graham Thornicroft

Summary
A 20-year mortality gap for men, and 15 years for women, is still experienced by people with mental illness in high-income countries. The combination of lifestyle risk factors, higher rates of unnatural deaths and poorer physical healthcare contribute to this scandal of premature mortality that contravenes international conventions for the 'right to health.'

Declaration of interest
None.

BMJ
BMJ 2013;346:f2539 doi: 10.1136/bmj.f2539 (Published 22 May 2013) Page 1 of 14

RESEARCH

The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers

OPEN ACCESS

David Lawrence *research professor*[1], Kirsten J Hancock *senior analyst*[1], Stephen Kisely *professor*[2,3]

[1]Telethon Institute for Child Health Research, Centre for Child Health Research, The University of Western Australia, PO Box 855 West Perth WA 6872 Australia; [2]School of Medicine, The University of Queensland, Brisbane, Australia; [3]Griffith Institute for Health and Medical Research, Griffith University, Brisbane, Australia

BMJ
BMJ 2013;346:f2969 doi: 10.1136/bmj.f2969 (Published 14 May 2013) Page 1 of 2

EDITORIALS

Premature death among people with mental illness

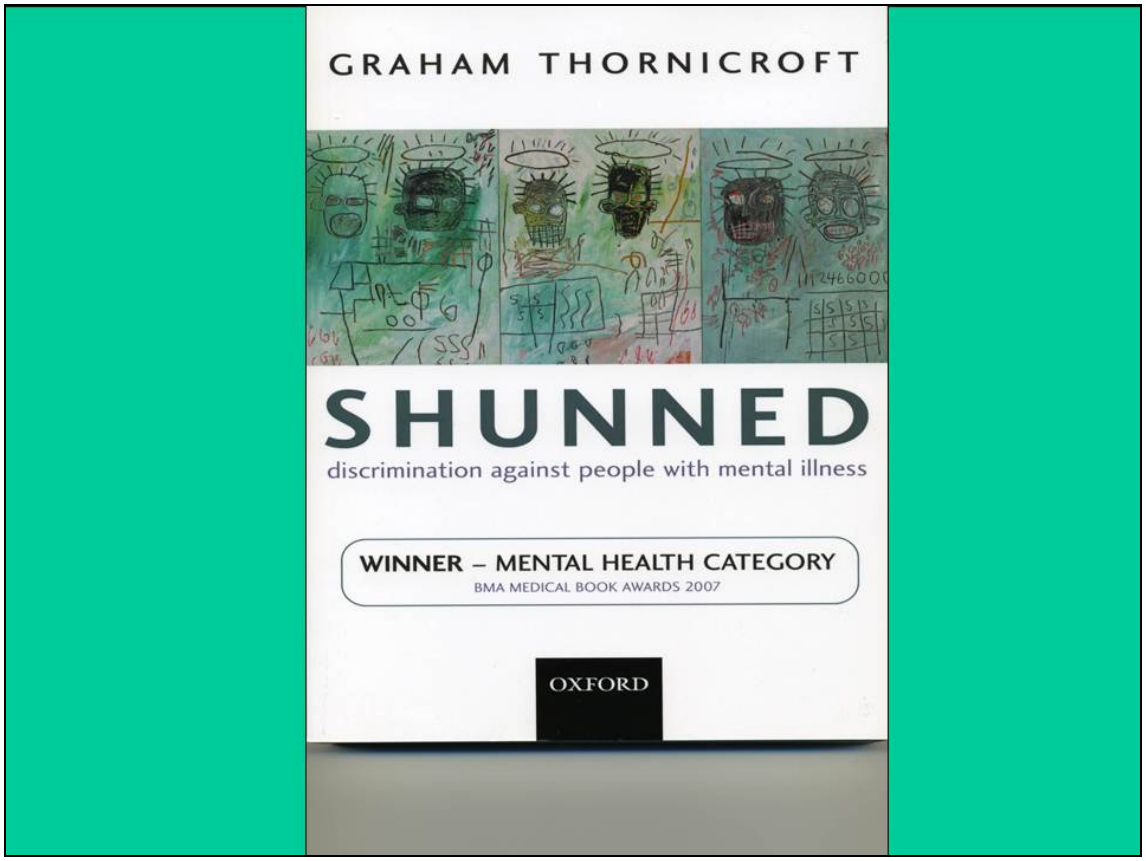
At best a failure to act on evidence; at worst a form of lethal discrimination

Graham Thornicroft *professor of community psychiatry*

Health Service and Population Research Department, King's College London, Institute of Psychiatry, London SE5 8AF, UK

Plan

1. mental health gap
2. premature mortality
3. what must we do?



What is stigma?

- Problem of knowledge = Ignorance
- Problem of attitudes = Prejudice
- Problem of behaviour = Discrimination

Eg help seeking
Eg treatment provision

Local level interventions

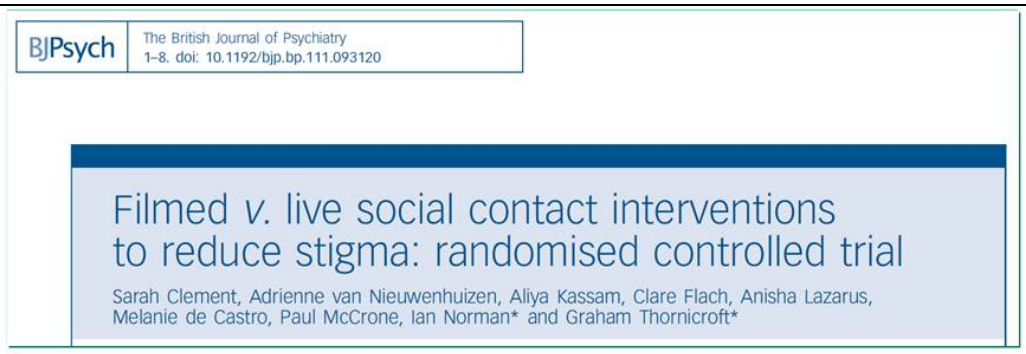
Social contact theory

- theory from Bogardus 1924
- direct, personal social contact with individual(s) of stigmatised group is effective to reduce stigma

Target Groups

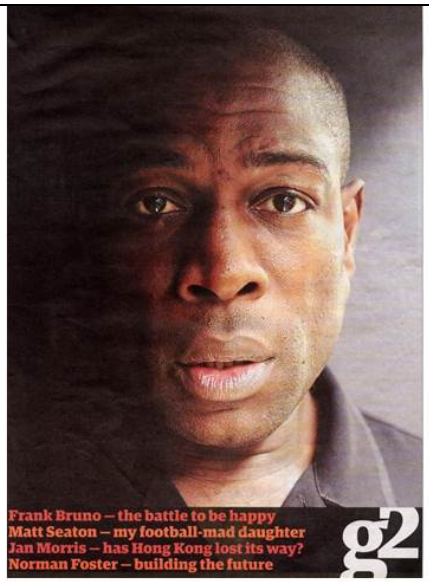
- Police officers √
- Young people √
- Medical students √
- Nurse students √

1. Pinfold V. et al (2003). Reducing psychiatric stigma and discrimination: Evaluating an educational intervention with the police force in England. Social Psychiatry & Psychiatric Epidemiology, 38, 337-344.
2. Pinfold V. et al (2003). Reducing psychiatric stigma and discrimination: Evaluation of educational interventions in UK secondary schools. British Journal of Psychiatry, 182, 342-346.
3. Kassam A, Thornicroft G et al (2011) Mental illness: clinicians' attitudes scale. Acta Psyc. Scand.
4. Clement S et al (2012) Filmed v. live social contact interventions to reduce stigma: randomised controlled trial BJP

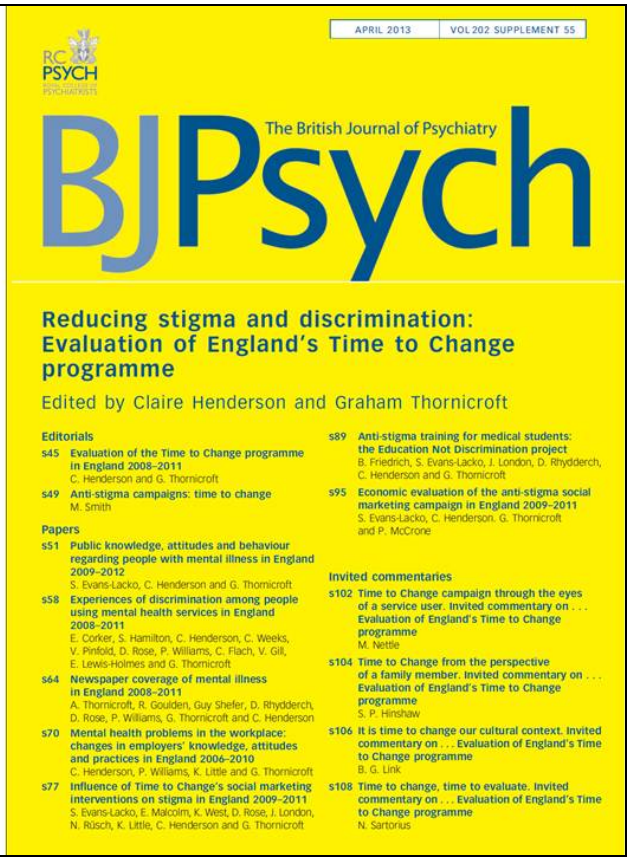


- compared live consumer talks, DVD consumer talks, and boring lecture for nursing students
- attitudes, compassion and behaviour improved for live consumer and dvd groups
- both better than lecture - still better 4 months later
- recorded sessions most cost-effective

National level interventions

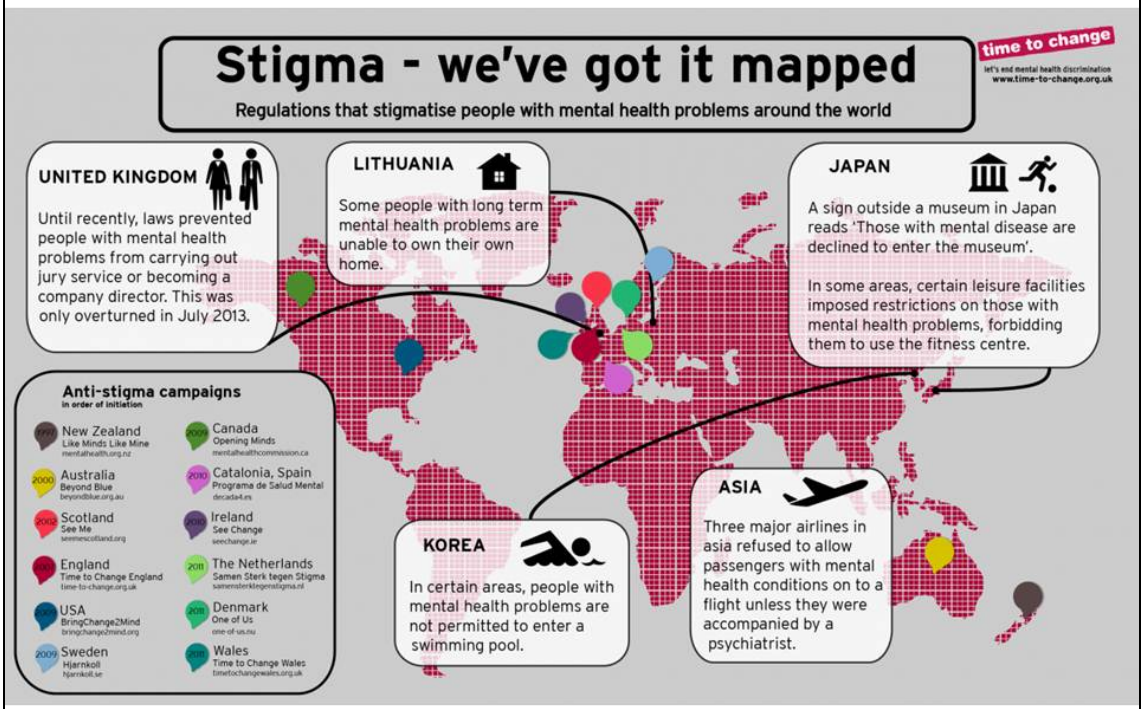


Former World Heavyweight Boxing Champion Frank Bruno supports Time to Change in England by disclosing bipolar disorder



Time to Change: 4 year outcomes

- 8 papers published in British Journal of Psychiatry 2013
- Clear positive changes across England
- Small to moderate sized improvements
- Most positive change in service users reports of experienced discrimination (<11%)



metronews.ca
Tuesday, June 5, 2012

NEWS 03

Mental illness 'nothing to be ashamed of,' Close says

Health. Oscar nominee in town for conference on combatting stigma

JOE LOFARO
joe.lofaro@metronews.ca

Talking about mental illness is scary, but Oscar-nominated actress Glenn Close told a conference in Ottawa Monday it's the best way to confront the stigma surrounding the topic and get people the help they need.

Close brought her sister and nephew to share their personal struggles with mental illness at the Together Against Stigma Conference — a gathering touted by the Mental Health Commission of Canada as the world's largest international conference on eliminating mental-health stigma. Nearly 600 researchers, mental-health professionals and policy makers are attending the three-day conference.

Close's sister Jessie was suicidal while suffering from bipolar disorder, and her nephew Calen Pick suffers from schizoaffective disorder.

Actress Glenn Close, centre, her nephew Calen Pick and sister Jessie Close pose for a photo in Ottawa on Monday. Glenn Close was in the city to address a major conference about confronting stigma in mental health, drawing from her experience with her family to explain why people with mental illness need to reach out for help.

FRED CHARTRAND/THE CANADIAN PRESS

Close said coming out about her family's problems was intimidating and she even wondered what impact it might have on her acting career. Then, she considered what might happen if she did nothing.

"That's not an option," she said. "If anything, it makes me more determined."

Jessie Close and Pick went public with their illnesses when they joined the actress to help launch Bring Change 2 Mind, a non-profit organization dedicated to eradicating the stigma and discrimination around mental illness.

Glenn Close said one of the best things families can do when confronted with a mental illness is to start small by talking about it with a family member, and then reach out to a community organization for help.

"It's tremendously important that we come out," said Close. "There's nothing to be ashamed of. You're not alone."

More information about the conference, which wraps up Wednesday at the Delta Ottawa City Centre, is available at togetheragainststigma2012.ca.

Follow Joe Lofaro on Twitter @giuseppelo

U.N. Convention on the Rights of Persons with Disabilities (CRPD)

- adopted in 2006 by the UN General Assembly
- first comprehensive human rights treaty of the 21st century
- developed by Committee of General Assembly 2002-8
- human rights instrument with clear social development dimension
- affirms that all persons with all types of disabilities are holders of all human rights and fundamental freedoms

Epidemiology and Psychiatric Sciences, page 1 of 14. © Cambridge University Press 2012
doi:10.1017/S2045796012000467

ORIGINAL ARTICLE

Development of the ITHACA Toolkit for monitoring human rights and general health care in psychiatric and social care institutions

J. Randall[1†], G. Thornicroft[1†*], L. Burti[2], H. Katschnig[3], O. Lewis[4], J. Russo[4], T. Shaw[1], K. Wahlbeck[5] and D. Rose, for the ITHACA Project Group[1‡]

www.ithacastudy.eu

Further information

Contact: graham.thornicroft@kcl.ac.uk

Resources: dropbox for > 50 stigma documents

Presentation by Mr Anthony Babajee

It Starts with Me campaign

FS magazine


FS TURNS 10

FS celebrates its 10th birthday this month! The first issue of the magazine to be distributed on the gay scene in London hit the bars and clubs back in 2002 – so it feels like a good opportunity for us to take a look back at some of the things that have happened in that time. Words by Anthony Babajee (@t4rdis) and Gavin Smith

2002

2003

2004


"Break the stigma, talk about it, educate yourself and take responsibility for protecting yourself." – Ant Babajee

Ant Babajee

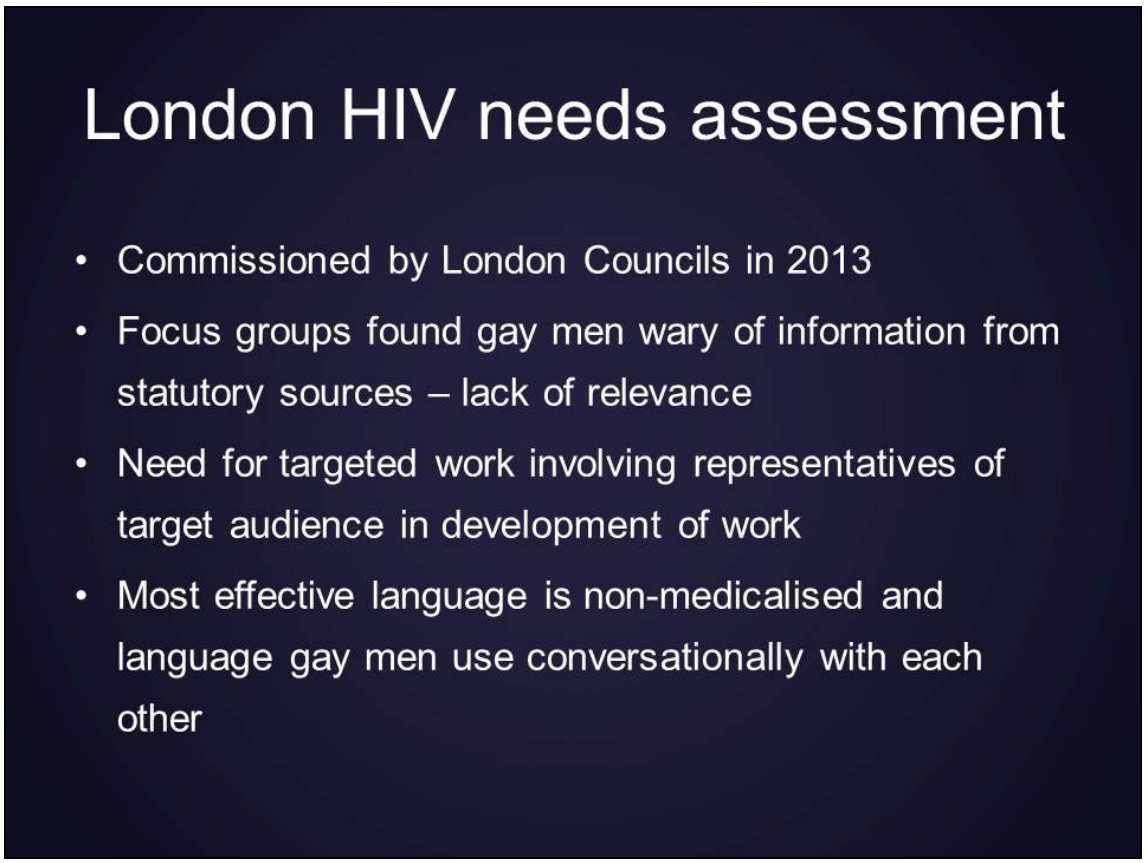
Ant has been living with HIV for six years and by being honest about his status, he has helped himself and others too.

FS magazine

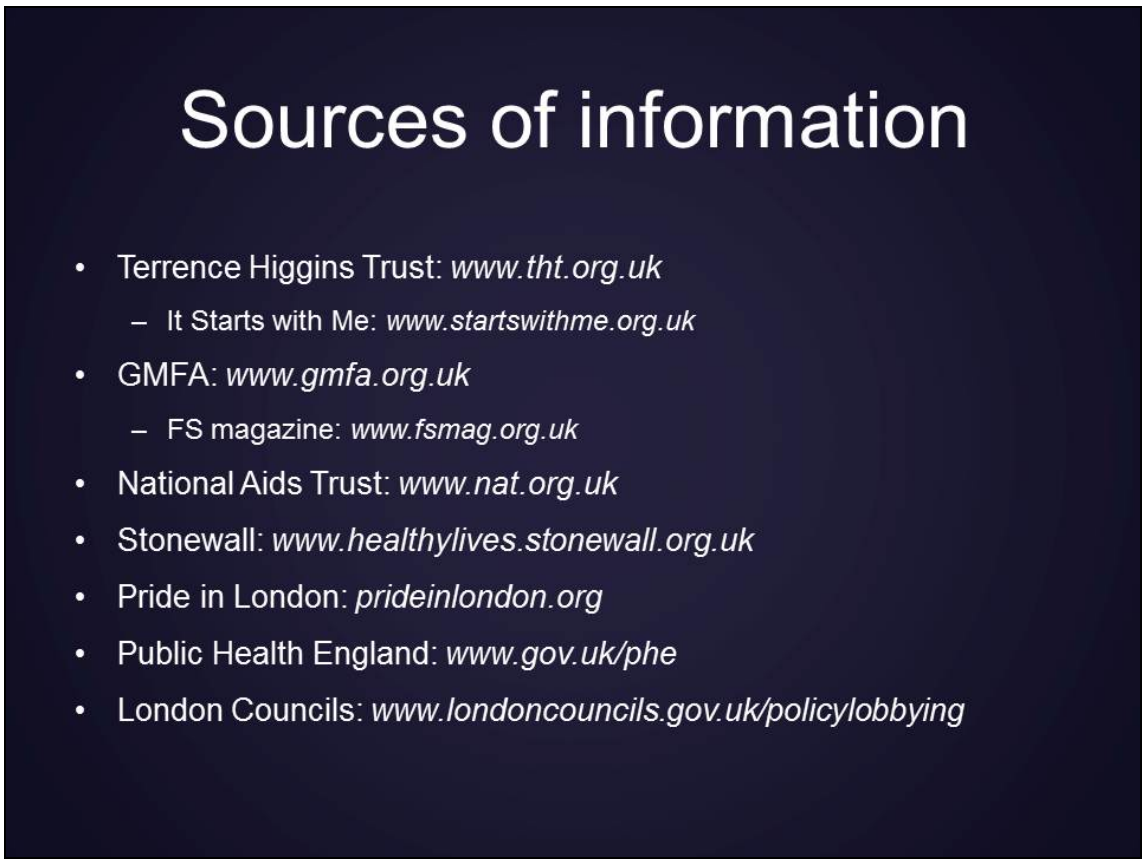
- **Non-judgmental** – meet gay men where they are in their lives rather than telling them where they should be
- **Real and relevant** – talk honestly about sex and sexual health in appropriate language
- **Challenging** – tackles hot topics – such as unprotected ('bareback') sex, sexualised drug-taking ('chem sex') and sexual racism – that may make some feel uncomfortable but that demand discussion
- **Thought-provoking and informative** – gay men encouraged to consider their own actions

HIV in the UK

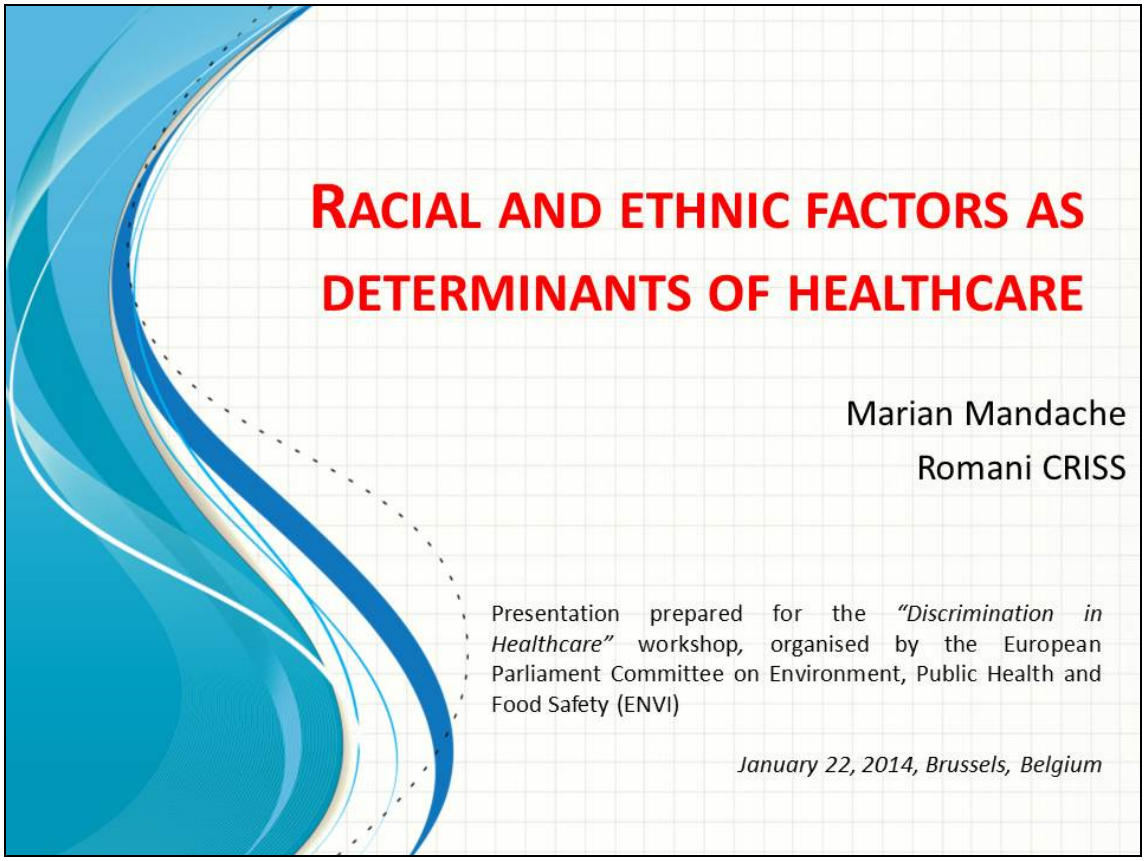
- In 2012, an estimated 98,400 people were living with HIV in the UK
- Of these, 22% were unaware of their HIV infection
- From 1 April 2013, local authorities in England responsible for commissioning of HIV prevention services

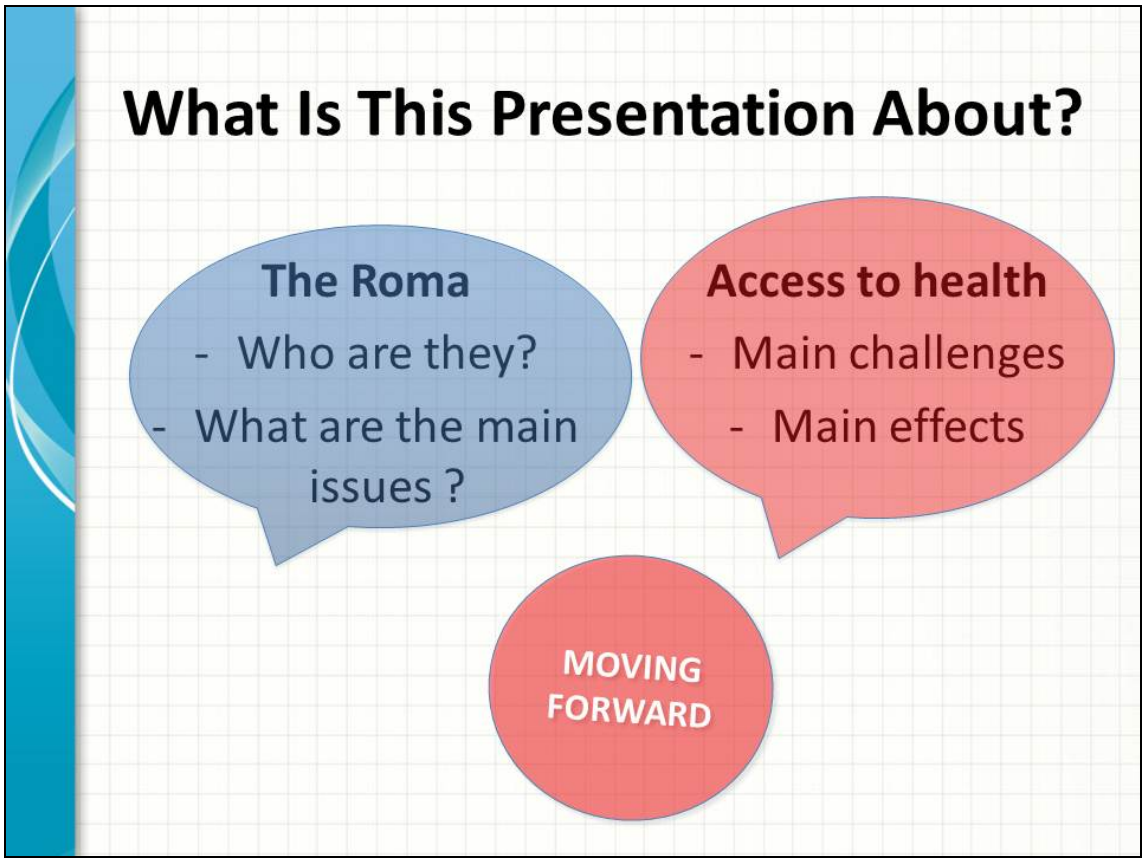

London HIV needs assessment
• Commissioned by London Councils in 2013
• Focus groups found gay men wary of information from statutory sources – lack of relevance
• Need for targeted work involving representatives of target audience in development of work
• Most effective language is non-medicalised and language gay men use conversationally with each other


Some thoughts
• Ignorance – just talk and ask questions
• LGBT people are, first and foremost, people too
• Don't assume what was true five years ago is still the case – cf: rise in popularity of smartphone dating apps
• Seek to understand and please don't patronise
• "I've been positive for 10 years and you'll be OK" – disclosure, peer support and mentoring
• Can the healthcare or support worker relate to me? Can I trust them?
• The 'right' services – eg: care services for older LGBT people
• Getting politics out of the bedroom, but the political will to improve and shape services


Sources of information
• Terrence Higgins Trust: www.tht.org.uk
– It Starts with Me: www.startswithme.org.uk
• GMFA: www.gmfa.org.uk
– FS magazine: www.fsmag.org.uk
• National Aids Trust: www.nat.org.uk
• Stonewall: www.healthylives.stonewall.org.uk
• Pride in London: prideinlondon.org
• Public Health England: www.gov.uk/phe
• London Councils: www.londoncouncils.gov.uk/policylobbying

Presentation by Mr Marian Mandache





The Roma in One Slide

- The Roma are a population that migrated out of NW India around year 1000-1050 and spread all over Europe and most of the world;
- Nomadism, Slavery, Holocaust, Free Movement
- The Roma are culturally, economically and socially heterogeneous;
- However, Roma are, probably, the most impoverished and most discriminated against population in Europe (see e.g. ECHR decision in DH v. the Czech Rep.).

Some of the Main Challenges

- the impact of the environment and standard of living upon peoples' health;
- the causes and consequences of the lack of a social insurance;
- formal and informal costs associated to healthcare provision;
- overt and hidden ethnic discrimination.

THE IMPACT OF THE ENVIRONMENT AND STANDARD OF LIVING UPON PEOPLES' HEALTH

- The diseases faced by the communities serviced by health mediators are not diseases specific to the Roma. They are consequences of the reactions of the human body to the conditions of living a poor life in polluted environments;
- These diseases remind us that the communities in question are placed close to garbage pits or treatment plants (environmental racism). And this continues to happen systematically in Europe (e.g. 100 Roma people still leave next to the water-waste plant for 10 years after being "relocated there by the Miercurea Ciuc Mayoralty in Romania");
- Financial problems lead to not being able to eat healthy food and maintain a minimum level of hygiene, which, even if accepted cannot be respected;
- The affiliation to "less fortunate" groups often generates negligent treatment from the part of doctors towards the people belonging to these groups, which may have dramatic consequences;
- The idea is that the Roma are "used to it" and immune to precarious conditions, proves out to be just a myth, being a sort of evading the responsibilities of the institutions and of the medical staff, but not only.

THE CAUSES AND CONSEQUENCES OF THE LACK OF A SOCIAL INSURANCE

- In 2014, in many European countries, many Roma individuals have no birth certificates, no IDs and no property papers, after tens of generations. This does hamper efforts to getting insurance and access to health care;
- The health insurance systems may vary in different EU states. Great concern across Europe for cutting state costs due to the "financial crisis";
- In Romania, the main ways to get insured are to have a legal work contract or to register for social welfare. The social welfare may be cut off as a result of changes in the granting criteria (or as a result of the people choosing welfare meals and then being ineligible for social welfare), but also due to the temporary migration abroad;
- New health law is being proposed; it aims at reducing costs.

FORMAL AND INFORMAL COSTS ASSOCIATED TO HEALTHCARE PROVISION

Direct costs

- Medical insurance, copayments, medication;
- Most vulnerable ones are the large families with low income.

Indirect costs

- Transportation to the medical office (particularly, in remote rural areas)

OVERT AND HIDDEN ETHNIC DISCRIMINATION

- Forced sterilisation of Roma, most notably in Slovakia;
- Segregation of Roma women and children in hospitals;
- Discrimination by medical staff;
- Systemic state-sponsored racism.

FORCED STERILIZATION OF ROMA

- Between 1971 and 1991 in Czechoslovakia, the "reduction of the Roma population" through surgical sterilisation, performed without the knowledge of the women themselves, was a widespread governmental practice.
- The sterilisation would be performed on Romani women without their knowledge during Caesarean sections or abortions.
- Some victims claim that they were made to sign documents without understanding their content. By signing these documents, they involuntarily authorised the hospital to sterilise them.
- In exchange, they sometimes were offered financial compensation or material benefits like furniture from Social Services – though it was not explicitly stated what this compensation was for.
- The justification for sterilisation practices according to the stakeholders was "high, unhealthy" reproduction (ROMEDIA).

SEGREGATION OF ROMA WOMEN AND CHILDREN IN HOSPITALS

- Cases reported in Romania, Hungary, Bulgaria and other countries;
- In 2011, Romani CRISS and ECPI reported the case of segregation of Roma children in the Marie Curie Hospital in Bucharest;
- Roma children patients were being placed in different rooms than the Romanian children patients;
- The trial is still pending at national level.

DISCRIMINATION BY MEDICAL STAFF

Practices that may lead to discriminatory behavior within the health public system include:

- examining Roma patients after the examination of all non-Roma patients, regardless of the time of arrival of the former;
- using of derogatory language;
- redirecting the patients towards suppliers of medical services from the proximity;
- Improper or lack of informing towards the risks associated with some intervention forms.

DISCRIMINATION BY MEDICAL STAFF

"As I stepped outside to wait for my husband, a tall, thin man aged around 40 came to me. "Excuse me, excuse me", he said. I wonder if he observed my dark skin colour and that I am a black- haired woman in order to think that I am a gypsy. Excuse me; did you deliver a baby here? Yes. Please, could you tell my wife to come out? Sure, of course! I noticed he was a gypsy, and whatever he was, he was still human. Of course! Nevertheless, where is she? I do not remember but it is with A or 16A... something with A and B. When I went there, I did not see anything, where could this annex be. I ask a nurse: excuse me, do you know where this annex is? What are you looking for there, who are you looking for? Well, a man asked me to call his wife. All right but there are only gypsies there. All right, I had gotten angry but I did not say anything, I went inside. It was cold, it was winter. January. Winter, not summer. Our children and this is true exactly as I say it, my baby girl and the children in the annex had their head wrapped in a scarf, as they did it there, some sort of bonnet. I entered in that annex, it was bigger than this one, divided in two by a folding screen, like in the gynaecology room, there was only Iris there [neighbourhood populated with Roma persons]. None of the children there, (...), did not have that type of wrapped bonnet, nor any regular bonnet, maybe the mothers could not bring any bonnets from home, the children weren't even wrapped, nothing... and the nurse was inside. I went to the woman I was looking for, I told her that her husband was waiting for her outside and she left. I ask the nurse: "aren't the children cold?" (...) Do not worry Madame, it is not cold she said, these are gypsy people. I felt so bad then, that honestly I tell you, I went out crying... now really, what did that child do wrong because he was born a gypsy and not a Romanian? This is a real and true case..."

(testimony presented in ROMANI CRISS - Roma Health. Perspective Of The Actors Involved In The Health System – Doctors, Health Mediators And Patients report)

SYSTEMIC STATE –SPONSORED RACISM

- Many European Governments, such as France, continuously and overtly hunt down Roma, on the base of their ethnic origin, destroying their homes. These practices impact directly their state of health, as well as their access to healthcare;
- Many European Governments, such as Romania, turn a blind eye to the numerous and grave forced evictions of Roma by local authorities, followed by demolition of their homes and placement in toxic areas (e.g. former chemical laboratory in Baia Mare or garbage pit in Cluj-Napoca). This Mayoralties continue to receive funding from the EU;
- Two decades of democracy in Eastern European countries brought to little in terms of "Roma integration". It did not bring about even the "regularisation" of a population which lives in the respective countries for hundreds of years. The massive lack of property documents is interconnected with the lack of IDs and sometimes birth-certificates. Inaction/poor progress made by Governments in this regards is an indicator on their commitment to address the Roma situation;
- When Mayoralties such as Bucharest spend indecent amounts of money for floral arrangements and only hire one health mediator (for about 150 euros/month) in the entire 2 million inhabitants city, the level of commitment is obvious and so are the results as to increasing access of Roma to healthcare.

Main Effects

The FRA – Fundamental Rights Agency:

"The results are shocking in many respects: of those surveyed in this report, one in three is unemployed, 20 % are not covered by health insurance, and 90 % are living below national poverty lines. Although governments and societies have been aware of Roma exclusion and deprivation, the magnitude and the similarity of exclusion patterns across EU Member States is striking and leaves no excuse for delaying swift, effective action to improve the situation".

The Fundamental Rights Agency,
The situation of Roma in 11 EU Member States. Survey results at glance

Ways Forward ?

Time has come to head towards a **common sense** approach:

•Training for medical students and staff on diversity and anti-discrimination;

•Pilot and scale-up available experiences. In Romania, since 2002, when the health mediator programme created by Romani CRISS was taken over by the Ministry of Health, the Government has failed to try doing anything similar. So did most other Governments;

•Less money into researching the problems Roma face (there seems to be general consensus the situation is bad), more money into actually dealing with problems, such as community health programs for vulnerable groups;

•EU to make funding available for litigating against discrimination;

•EU to start using the infringement procedure to fight discrimination against Roma. If millions of Roma face massive, unacceptable discrimination across the members states, and no Government is brought before the EU Court of Justice, then something is wrong;

•EU to implement mechanisms for suspending European funding for local and national authorities which engage in systemic discrimination or fail to register progress in implementing national strategies for Roma.

(Re)Sources

- **Romani CRISS - Roma Health. Perspective Of The Actors Involved In The Health System – Doctors, Health Mediators And Patients**

http://www.romanicriss.org/PDF/raport%20final%20osi%20health%20_engleza.pdf

- **ROMEDIA - Forced Sterilization Of Romani Women – A Persisting Human Rights Violation**

http://romediafoundation.wordpress.com/2013/02/07/forced-sterilization-of-romani-women-a-persisting-human-rights-violation/

- **The Fundamental Rights Agency - The situation of Roma in 11 EU Member States - Survey results at a glance** http://fra.europa.eu/en/publication/2012/situation-roma-11-eu-member-states-survey-results-glance


Thank you
for your
attention !

Factsheet by Mr Ioannis Dimitrakopoulos

FRA

HELPING TO MAKE FUNDAMENTAL RIGHTS A REALITY FOR EVERYONE IN THE EUROPEAN UNION

EQUALITY

Inequalities and multiple discrimination in access to and quality of healthcare

Article 21 of the Charter of Fundamental Rights of the European Union recognises the right to be free from discrimination, including on the grounds of sex, racial or ethnic origin, and religion or belief. Article 35 guarantees the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices.

Policy context

The European Union has laws prohibiting discrimination on six grounds, namely: sex, age, disability, religion or belief, race or ethnic origin, and sexual orientation. All too often, however, people are discriminated against on more than one ground; this is called 'multiple' discrimination. An elderly woman belonging to a minority ethnic group, for example, may be treated unequally because she is old, a woman and belongs to an ethnic minority. A younger male member of that ethnic minority or an elderly woman of a different ethnic group may not face similar treatment.

From a legal perspective, two difficulties exist in addressing multiple discrimination when accessing healthcare:

- EU law protects against discrimination only on grounds of sex and racial or ethnic origin when accessing healthcare.
- EU law and the law of most EU Member States do not specifically recognise or make provisions for dealing with multiple discrimination.

As a result, victims of multiple discrimination may have difficulties in bringing successful claims before a court or any other complaints body. Furthermore, policy makers are not obliged to take multiple discrimination into account when formulating policies to improve equal access to healthcare.

FRA research

The FRA report *Inequalities and multiple discrimination in access to and quality of healthcare* examines experiences of unequal treatment on more than one ground in healthcare, providing evidence of discrimination or unfair treatment. The report supplements a 2011 FRA report, *EU-MIDIS Data in Focus 5: Multiple Discrimination*, which focuses on multiple discrimination experiences by respondents of ethnic or immigrant origin, compared with the general population.

This latest FRA report analyses barriers and individual experiences of multiple discrimination in healthcare and how they can prevent access to healthcare services. It aims to contribute to discussions on the adoption of the proposed EU Horizontal Directive legislation which would extend equal protection against discrimination on age, disability, religion or belief and sexual orientation to all fields, including healthcare. The work also aims to improve understanding of how policy makers and complaints procedures deal with multiple discrimination.

Methodology

This report is based on legal desk research and social fieldwork conducted in: Austria, the Czech Republic, Italy, Sweden and the United Kingdom. In the fieldwork, more than 170 health users at risk of multiple discrimination due to the interplay of their age, sex, ethnicity and disability as well as 140 health professionals, representatives of equality bodies, health complaint bodies and non-governmental organisations (NGOs) were interviewed. The evidence collected though the fieldwork is analysed against existing legal instruments addressing multiple discrimination in healthcare at the national, European and international levels. The report looks at three particular groups at risk of multiple discrimination in access to healthcare:

- women with a migrant/ethnic minority background, including women with disabilities, trying to access reproductive healthcare;
- older people with a migrant/ethnic minority background, including those with disabilities;
- migrant/ethnic minority young people aged 18 to 25 years, with intellectual disabilities.

Key issues

The FRA research findings show that healthcare systems may create barriers in access to healthcare or provide healthcare of a different quality to people who share more than one protected trait, such as sex, disability and ethnicity. Communication and language barriers, for example, affect many groups specifically protected by anti-discrimination law, but individuals who share more than one protected characteristic face additional complex challenges. The report's findings also show that such health users might experience a lack of dignity and respect when meeting, communicating and interacting with healthcare staff.

Evidence-based advice

Given the evidence gathered by the FRA, the EU and its Member States could take several steps to improve the situation as regards multiple discrimination.

European Union law

The EU could:

- provide equal protection against discrimination on all grounds protected by EU law in areas beyond employment – as envisaged in the European Commission's proposed 'Horizontal Directive';
- introduce stronger measures to prevent, and combat multiple discrimination, ensuring that sex discrimination is also protected.

Institutionalising multi-dimensional equality in the healthcare system

EU Member States could:

- consider more dissuasive and proportionate compensation for discrimination cases in healthcare;
- increase free language assistance in healthcare settings and when providing health information – including translation and mediation services for those who do not speak or understand the language. This includes 'sign' language and other forms of support for people with sensory or intellectual impairments;
- encourage more positive actions for those facing a risk of intersectional discrimination: for example, by accommodating the needs of women belonging to ethnic minorities who want to be treated by female healthcare professionals; by funding community-based mobile outreach programmes targeting different ethnic communities and equality groups among them; by allocating more time for medical consultations for people belonging to these groups;
- consider providing training for healthcare professionals on discrimination and multiple discrimination, cultural competence and understanding disabilities;
- collect systematically health statistics that can provide a full picture of the intersection of different grounds, including data on ethnicity (recording both migrant status and ethnicity, where legal) and disability (taking into account the human rights framing of disability enshrined in the United Nations Convention on the Rights of Persons with Disability (CRPD), the so-called social model of disability).

Access to justice

The EU and its Member States could:

- increase healthcare users' awareness of the existence and functioning of available complaint mechanisms, both for healthcare and discrimination issues;
- consider creating one equality body that covers a number of discrimination grounds so that 'multiple' discrimination can be tackled more effectively. Furthermore, referral mechanisms between equality bodies and health complaint bodies, and awareness of anti-discrimination legislation among health complaint bodies, should be enhanced.

Further information:

The FRA report on *Inequalities and multiple discrimination in access to and quality of healthcare* is available at: *http://fra.europa.eu/en/publication/2013/inequalities-discrimination-healthcare*

For an overview of FRA's work on multiple discrimination, see: *http://fra.europa.eu/en/project/2011/multiple-discrimination-healthcare*

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NOTES

EUROPEAN PARLIAMENT

DIRECTORATE-GENERAL FOR INTERNAL POLICIES

POLICY DEPARTMENT A
ECONOMIC AND SCIENTIFIC POLICY

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