



European Network Against Racism
Réseau européen contre le racisme
Europäisches Netz gegen Rassismus

Solidarity & Health

Comments of the European Network Against Racism (ENAR) on
the European Commission's consultation on EU action to reduce
health inequalities

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The European Network against Racism (ENAR) is a network of some 600 NGOs working to combat racism in all EU Member States. ENAR is determined to fight racism, xenophobia, anti-Semitism and Islamophobia, to promote equality of treatment between EU citizens and third country nationals, and to link local/regional/national and European initiatives.

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“The Health status of ethnic minorities is generally poorer than that of the majority populations. Access to healthcare is a key concern. Health is an area that intersects with other areas¹”

1. Introduction

Racism is a reality in the lives of many ethnic and religious minorities² in the EU. The real extent of this reality however is often unknown and undocumented. In the area of health, access to healthcare is a question of grave concern for ethnic minorities and NGOs working in this area. The right and capacity to access available healthcare is clearly affected by legal status but also by other indirectly discriminatory factors such as where one lives, access to employment, capacity to make social insurance contributions, and poverty.

ENAR therefore hopes that the **EU would seize the opportunity for action to reduce health inequalities by putting non-discrimination, anti-racism and social inclusion at the heart of health policy, social policy and employment policy; and ensuring equality mainstreaming and policy coherence at all stages and levels.**

In order to contribute to the efforts of developing a diagnosis on the need for EU action to reduce health inequalities in Europe the “ENAR Shadow Report on Racism in Europe 2007” is attached to this submission. The ENAR Shadow Report for Europe provides a unique mechanism to collect and present views of civil society on the state of racism in EU member states and across Europe. The report draws on 25 national shadow reports prepared by ENAR members across the European Union. It identifies communities vulnerable to racism and presents an overview of manifestations of racism in a range of areas, including health, as well as an assessment of the legal and political context and responses by governments.

ENAR is a member of the Social Platform³ and has participated in the development of the Platform’s response to this consultation. This paper is intended to build on that analysis and its recognition of the importance of reducing health inequalities in the EU. Consequently this submission will not address the range of concerns and issues highlighted in the Social Platform’s response but rather concentrate on providing a brief response from the perspective of race equality and non-discrimination.

2. Health inequalities - increasing trends within the EU

Racism and discrimination are phenomena that are contrary to the values of the European Union and undermine social cohesion and the realisation of human rights. The ENAR Shadow Reports

¹ Racism in Europe, ENAR Shadow Report 2007

² The submission refers to “ethnic and religious minorities”. There is no universally accepted and binding definition of a minority in international law, however one definition has been within the framework of Article 27 of the United Nations International Covenant on Civil and Political Rights: “A group of citizens of a State, constituting a numerical minority in a non-dominant position in that State, endowed with ethnic, religious or linguistic characteristics which differ from those of the majority of the population, having a sense of solidarity with one other, motivated, if only implicitly, by a collective will to survive and whose aim is to achieve equality with the majority in fact and in law”.

³ www.socialplatform.org

demonstrate that racism is a persistent and pervasive issue across Europe, and highlight the need for a renewed focus in this area, in particular when looking at the obstacles to access to healthcare and the general health status of ethnic and religious minorities within the EU.

In this section a brief outline⁴ is provided on the main **impediments that Europe's many ethnic and religious minorities face regarding access to healthcare, including language problems and the lack of culturally appropriate health services.**

The trends regarding health inequalities

The health status of ethnic minorities is generally poorer than that of majority populations. This is demonstrated by indicators such as longevity and the infant mortality rate. For example, the Netherlands, Ireland and Slovakia are a few amongst many countries where ethnic minorities experience lower life expectancy. Infant mortality rates are also found to be higher. The report from the Netherlands explains that immigrants have a higher mortality rate than "native" Dutch people for almost all age groups and that the gap is highest in infants.

Access to healthcare is a key concern and is an area that intersects with many other areas. For example, ethnic minorities are employees within the healthcare sector and may experience discrimination in employment. Poverty, employment and legal status are also factors that impact on the health and mental health of ethnic minorities as well as their right to access quality healthcare.

The right and capacity to access available healthcare however is affected clearly by legal status but also by other indirectly discriminatory factors such as where one lives, access to employment and capacity to make social insurance contributions and poverty. Research shows that in general ethnic minorities earn less than their counterparts and also experience discrimination in accessing employment.

We see increasingly across Europe that access to healthcare - other than the most basic of services such as emergency services - are becoming tied to legal status and employment. Poverty and its impact on healthcare are highlighted by e.g. Bulgaria where Roma are at particular risk and Greece where access is highly dependent on social insurance contributions. Factors such as where one lives also have an impact. For example, Roma in Poland are more likely to be living in rural settlements where access to healthcare is already an issue. Employment impacts on health in ways other than income and for example, in Italy employment is recognised as a health risk where migrants are at a particular risk of accidents at work.

Language as a barrier to accessing healthcare has also been highlighted in Cyprus, Denmark, Estonia, Ireland and Malta. In Estonia for example, it is highlighted that Russian speakers, who represent a large minority in Estonia, are deprived proper access to healthcare as doctors are not required to speak Russian. This impacts particularly on older Russian patients.

Specific health problems can affect ethnic and religious minorities disproportionately or arise out of specific experiences such as migration. Concern with regard to the mental health of ethnic minorities and specifically, with regard to mental health services is highlighted in national reports. Discrimination within mental health services or **lack of culturally appropriate mental health services** is highlighted in reports including reports from Czech Republic, Denmark, Germany, Ireland and the Netherlands. A lack of other specialised services for e.g. asylum seekers is noted in reports from Hungary, Ireland and Malta.

⁴ Abstracts are taken from the attached "ENAR Shadow Report on Racism in Europe 2007".

Drug use within ethnic minority communities and migrant communities was named as an emerging concern in the 2006 report. 2007 national reports continue to highlight this issue with reports from the Czech Republic and Italy pointing specifically to drug abuse within the Roma community.

Women experience specific problems in the area of health where not only do they not enjoy a right to healthcare but within the healthcare services, other rights have been abused. The issue of the sterilisation of Roma women in the Czech Republic, it is reported, has not yet been resolved. In Italy a study found that 60% of ethnic minority women received caesareans compared with 30% of their Italian counterparts. Furthermore, the report from Italy highlights that migrant women are more likely to undergo voluntary termination of pregnancy, in a context where the figures for other women are actually decreasing. NGOs also highlight the experience of children in accessing healthcare, where their legal status is of key factor.

3. The role of the EU in making a difference in addressing health inequalities - possible actions and impacts

The influence of the European Union on policies for health and health services has increased significantly in recent years. Although EU member states have the prime responsibility for protecting and improving the health of their citizens and their medical care, the EU can contribute in supporting/coordinating member states' actions in this area and in raising awareness about the dimensions and implications of health inequalities within the EU. **The EU can bring added value by strengthening the Open Method of Coordination and by developing common targets and disaggregated indicators by different vulnerable groups including migrant and ethnic minority groups in order to better monitor the extent of health inequalities in the EU.** Improved data collection on health inequalities as part of an OMC is essential. The lack of adequate data collection and of clear and targeted objectives from the side of the member states is a serious issue and needs to be addressed. The EU can promote the reduction of health inequalities as a policy priority both at EU and national level.

Health inequalities are a problem shared by all member states and several EU policies impact on these inequalities such as employment, housing, transport, enterprise, finance and education. The EU can contribute by putting non-discrimination, anti-racism and social inclusion at the heart of health policy, social policy and employment policy; and ensuring equality mainstreaming and policy coherence at all stages and levels.

Barriers to accessing health services are not only a violation of fundamental rights and a threat to the health of victims, but are also **a serious threat to the vast majority of the population.** There is a serious risk that contagious diseases, such as tuberculosis, are not identified on time and spread among the population. Therefore creating or maintaining barriers to access health services is not only discriminatory and criminal; it is also self-damaging and the EU should make use of all its policy tools to underline the importance of such implications and tackle these problems.

4. Examples of good practices⁵

In **Finland** in recent years, genital mutilation has received a lot of international attention. In 2002, the Finnish League for Human Rights (Ihmisoikeusliitto) launched the KoKonainen-projekti (Full Woman Project), which was intended to prevent genital mutilation on immigrant girls in Finland. The project

⁵ Examples taken from the attached "ENAR Shadow Report on Racism in Europe 2007".

also aimed at providing support and assistance to circumcised girls and women. Apart from that, there have also been research projects, as well as training for immigrant and health workers to recognise and prevent female circumcision. The project also produced training and publicity materials. The international seminar was held in Helsinki, Finland, in September 2007.

In **Italy**, the project “Foreign seasonal workers in the agricultural sector in Italy”, carried out by *Medici Senza Frontiere*, was addressed to the migrant seasonal workers in the Southern regions of Italy. Through a mobile clinic, MSF doctors and nurses provided migrants and refugees with medical assistance and legal advice. This experience is described in the research report “*I frutti dell’ipocrisia*” (The fruits of hypocrisy), which analyses, through hundreds of interviews, the working conditions and the state of health of these workers.

In the **Netherlands**, in 2007 a new professional code was drawn up for psychologists, in which a specific article on discrimination has been included. The article states that unjustified discrimination is prohibited and that psychologists should take into account individual characteristics and circumstances of each client, as well as cultural differences that exist between clients. Despite these differences, psychologists should make an effort to ensure that people in the same situation are treated the same. A number of experts argue that the anti-discrimination article is not complete as no attention has been paid to the consequences of how cultural diversity influences professional standards.

Conclusion

ENAR strongly hopes that the European Commission’s Communication on “Solidarity in Health” will take into account the experiences and social realities of the many ethnic and religious minorities who live in Europe. Based on a sound human rights basis, the framework proposed by this submission analyses these obstacles and the increasing trends of health inequalities in the EU. In this context ENAR hopes that there will be increasing political will to address these issues at European level to help bridge the gap in health and in life expectancy of minority groups between and within the EU member states.