



socialplatform

Report of the workshop on the
“ Right to health and of access to
healthcare in Europe”

Brussels, 21 October 2005

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AGENDA

Wednesday 12 October, 09.30 – 12.30,

- Chairman: Mr John Martin, Director WHO office to the European Union

09.30-10.00 ***What does the 'right to health' mean in Europe?***

- Presentation of the legal instruments (legal texts, differences between ECJ and ECHR, social charter, WHO declarations, UN instruments) by Ms Aleid Bos, LL.M, IFHHRO (International Federation of Health and Human Rights Organisations)
- Questions from the floor

10.00-11.00 ***Are these rights respected? Testimonies from the field***

- The challenges faced by homeless people in accessing health, Ms Dearbhal Murphy, FEANTSA
- Case study on access to healthcare for gays and lesbians in selected Eastern European countries, Mr Maxim Anmeghichean, ILGA
- The problems faced by undocumented migrants, Ms Nele Verbruggen, PICUM
- Roma people and the right to health, Mr Cristi Mihalache, Open Society Institute
- Health inequalities across Europe, Ms Ingrid Stegeman, EuroHealthNet
- Discussion

11.00-11.15 ***Coffee break***

11.15-12.00 ***Rising to the challenge: the response of health systems and institutions***

- Configuring health systems to meet the needs of disadvantaged groups, John O'Toole, Health Attache, Irish Permanent Representation to the EU
- Balancing the responsibility of population health with the health rights of migrants, Dr. Mia Honinckx, Belgian Federal Agency for the reception of Asylum Seekers (FEDASIL)
- A European perspective on the way that health services can address inequalities, Dr Petra Wilson, Deputy Director, European Health Management Association
- Q+A for the speakers

12.00-12.30 How can EU social policies contribute to fulfilling the right to health?

- Moderator, Georg Fischer, Head of Unit, Social Protection: pensions & health, DG Employment and Social Affairs
- Debate and conclusions for a poster to be displayed at the 'Ideas Cafe' lunch

Brief summary of the workshop

EPHA's workshop on 'The right to health and the right of access to health care' dealt with the complex issues related to a rights based approach to health. The workshop began with a review of the different international legal instruments on the right to health, included testimonies from different communities about the difficulties they experience in accessing health, and featured responses from health agencies about how health rights could be better respected.

The workshop stimulated a lively debate and a range of questions and recommendations were agreed upon by the participants and presented at the Ideas Cafe:

Questions Raised:

- The right to health and access to healthcare is not adequately respected, monitored or implemented. There is a big gap between theory and practice.
- Jurisprudence can be a useful tool to raise the profile of health rights, but limits to the ability of the ECJ to address health and social rights.
- Stigma-exclusion affect health rights. Are politicians ready to recognise their role in addressing and tackling health rights?
- OMC and EU tools run into problems of subsidiarity, health systems are a national responsibility.
- Reinforce access to health services and the key determinants of health.

Recommendations :

- Acknowledge the importance of the right to health at EU level and ensure that this commitment by governments to internationally recognised health rights is translated into EU policy instruments: e.g. OMC
- Participation of civil society to give voices to the needs of excluded peoples. Information and literacy are strongly linked to health status.
- Tackling stigma by identifying "champions" and ensuring that current trends towards patient empowerment does not lead to greater inequality.
- Action is needed at policy level, within the health system itself and support for excluded groups to access health.
- Research and evidence needs to reach the debate about the cost of healthcare is really the cost of ill-health. Prevention is rarely measured but costs less!

Full report of the workshop

The workshop was opened by the chair, **Dr John Martin, Director WHO office to the European Union** who set out the structure of the event, a legal overview of the instruments defining health rights highlighted by testimony from NGOs about the practical difficulties experienced by excluded groups in enjoying their health rights. This was followed by a response from health agencies on the way that the health system can assist communities to access health and a moderated debate which clarified questions and recommendations for the EU to improve the right to health and access to healthcare in Europe.

Ms Aleid Bos – International Federation of Health and Human Rights Organisations (IFHHRO) outlined the international instruments which set out the right to health: European Social Charter, European Convention on Human Rights, various Regional Instruments, WHO declarations and other UN documents. She also highlighted the differences between Luxemburg-based European Court of Justice and European Court of Human Rights (ECHR) in Strasburg. She stressed the role of NGOs in raising awareness of health rights, engaging in dialogue, filing complaints about violations of the right to health and of access to healthcare.

Ms Dearbhal Murphy, European Federation of national organisations working with the homeless (FEANTSA) highlighted the complex and multiple health needs of homeless individuals. They are often stigmatised and discriminated against and rarely have access to the continuity of care needed for chronic illnesses and mental health problems. An integrated approach involving low-threshold services is needed.

Mr Maxim Anmeghichean, European Region of the International Lesbian and Gay Association (ILGA-Europe) reported the results of a project exploring the health rights of gay, lesbian, transsexual and transgendered people in several CEE countries. Discrimination, stigmatisation and a lack of trust in healthcare systems are a real problem. Many young people are socially isolated when coming to terms with their sexuality and their needs are rarely understood and many experience depression and feel suicidal.

Ms Nele Verbruggen, Platform for international cooperation on undocumented migrants (PICUM) explained that undocumented migrants face problems in accessing health care both on the level of the law and on a practical level. Some countries do not have any provision in their laws to safeguard access to health care for undocumented migrants. But in those countries that do have such a provision, undocumented migrants still face many barriers caused by complex procedures, the fear of being denounced, etcetera.

Mr Cristi Mihalache, [Open Society Institute initiative on Roma health](#) and **Mr Valeriu Nicolae** from the **European Roma Information Office (ERIO)** provided striking pictures of the poor living conditions and ill health suffered by Roma communities in Europe. For example, high risks of communicable diseases, addictions, lack of access to the most basic

healthcare services and up to 10 years shorter life-expectancy than other nationals.

Ms Ingrid Stegeman, [EuroHealthNet](#) outlined the positive correlation between social status and health outcomes across Europe. There is strong gradient which shows that the higher socio-economic category a person is the better health they experience. No European country has managed to make major progress in reducing health inequalities.

Discussion

Historically the right to health and healthcare is defined for nationals and then it is often extended to non-nationals.

For many migrants, they live in areas where there are restrictions or qualifications on the right to healthcare. In addition, a representative from the International Organisation for Migration noted that many migrants do not know their rights and how to contact the health services. At the level of healthcare clinics and hospitals the environment must meet the cultural diversity of the migrants.

Where individuals experience discrimination, NGOs can play a role in taking cases to court for failure to respect legislation on non-discrimination.

Ms Nele Verbruggen (PICUM) gave an example of two NGOs which complained to the Council of Europe last year about migrants' right to health. Ms Irene Donadio (IPPF) mentioned that their Irish member brought 4 cases before the European Court of Human Rights. Adding to the debate, Tamsin Rose (EPHA) suggested that the current debate about how to control spiralling healthcare costs could undermine efforts to put forward the human rights dimension of health and healthcare.

The first speaker to open the second half of the workshop, **Mr John O'Toole, Health Attache of the Irish Permanent Representation to the EU** spoke about national initiatives to improve the health of the traveller community that was the result of strong political support. He recommended that NGOs build personal contacts with ministers, present or future politicians, as a way to achieve changes over the long-term. In response to questions from the audience he underlined that contacts to senior officials are useful but politicians set the agenda and make the critical decisions.

Ms Mia Honinckx, Medical Services, Belgian Federal Agency for the reception of Asylum Seekers ([FEDASIL](#)) said that the asylum seekers at reception centres in Belgium are provided with medical services, bed, bath and bread. Even undocumented migrants have the right of access to healthcare but those whose applications are officially being processed can have their costs reimbursed. Individuals without documents are only eligible for emergency health treatment. TB is the only communicable disease that all asylum-seekers are screened for – this is because it is the most common illness.

Dr Petra Wilson, Deputy Director of the [European Health Management Association](#) (EHMA) gave an European perspective on the way that health services can address inequalities. She presented the results of a project “Tackling health inequalities and social exclusion in Europe” run together with Eurohealthnet, which concludes that inequalities could be addressed by improving the general access to public services, cultural sensitivity in the delivery of services, highly trained staff, effective monitoring and auditing of services for the targeted groups.

The final section of the workshop was a discussion moderated by **Mr Georg Fischer, European Commission - Head of Unit, Social protection, pensions & health, DG Employment and Social Affairs**. The debate focussed on questions and recommendations to be taken forward for the EU institutions.



EPHA Briefing on human rights

Subject	EPHA Briefing on Human Rights and Fundamental Rights
Author	Sidsela Nyebak
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➤ **What is meant by human rights?**

Human rights are rights that are recognised and guaranteed by a number of international legal instruments. Unlike other rights - like for example consumer rights, where you have to be a consumer to enjoy them - human rights are granted to everyone regardless of status, sex, age, race or any other factor. Hence, human rights are often considered to be universal, meaning they are the same for every human being wherever they are in the world. This issue is controversial, however, because some commentators hold that different cultures and tradition make it impossible to have the same rights all over the globe.

➤ **Rights and duties**

Enjoying rights also means having duties. You cannot exercise your rights without due regard to other people's rights. The right to life, for example, means that an individual has the right to life but also a duty to respect other people's right to life.

➤ **The scope of human rights**

Human rights create minimum standards but not comprehensive guidelines for life. Most



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human rights, as guaranteed by treaties, require strict legal interpretations as to what they do and do not cover. Hence Committees and Courts have provided general comments and rulings on a number of different rights, setting out what they actually mean¹.

A common misconception is that human rights are much wider than they actually are. The right to an adequate standard of living², for example, includes 'adequate food, clothing and housing', but this does not mean you have the right to gourmet food, designer labels and exclusive homes. Human rights provide minimum basic protection rather than the standards that people might want. In addition, sometimes different rights may be in conflict.

➤ **Respect, protect and fulfil**

Human rights are granted on paper but none of us can enjoy them if they are not implemented, monitored and protected. The various human rights instruments set out that state parties undertake to respect, protect and fulfil the rights of the treaty in question. Failure to do so may have legal as well as political repercussions (see 'enforcement of human rights' below).

It is important, however, to be aware that most human rights instruments provide so-called 'claw-back clauses', outlining conditions under which it may be acceptable to limit certain rights. Such restrictions are usually subject to being in the interest of national security, public safety, order, health, or morals, or the protection of the rights and freedoms of other people. In addition, derogations in times of public emergencies threatening the nation, may be permitted³. Treaties establishing rights indicate which rights are 'non-derogable' (cannot be limited) and which rights may be 'derogated' from and under what conditions.

➤ **The enforcement of human rights**

The enforcement mechanisms for human rights vary and have often been criticised for being weak and ineffective. Depending on the provisions of the treaty in question, courts and committees deal with breaches of human rights. In the case of treaties under the UN system, committees⁴ deliver opinions on alleged breaches.

¹ See for example case-law from the ECHR <http://www.echr.coe.int/ECHR/EN/Header/Case-Law/HUDOC/HUDOC+database/> or general comments from the Human Rights Committee <http://www.ohchr.org/english/bodies/hrc/comments.htm>

² Article 11(1), ICESCR

³ See for example Article 4 of the ICCPR: <http://www.ohchr.org/english/bodies/hrc/index.htm>

⁴ ICCPR: <http://www.ohchr.org/english/bodies/hrc/index.htm>, ICESCR: <http://www.ohchr.org/english/bodies/cescr/index.htm>



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The *European Convention on Human Rights (ECHR)*, on the other hand, has a court to adjudicate on human rights violations. The European Court of Human Rights in Strasbourg has produced an impressive body of case law⁵. The judgements are legally binding and therefore often seen as more effective than the opinions of UN style committees.

In order for a human rights violation case to be heard by either a committee or the European Court of Human Rights, the case has to comply with a set of strict admissibility criteria⁶. These usually include the exhaustion of local remedies and that the matter has not been ruled on in principle in another, similar case. Hence, the process of bringing cases of breaches of human rights before the international enforcement mechanisms is both time consuming and challenging.

➤ A brief overview of the major human rights instruments

The human rights discourse is fairly new. The *UN Charter* states that '*promoting and encouraging respect for human rights and fundamental freedoms*' is one of the purposes of the United Nations.⁷ The first international document on human rights is the 1948 *UN Universal Declaration of Human Rights (UDHR)*⁸, which sets out key human rights such as the right to life, freedom of expression and a fair trial. Although not a legally binding document at the time, many of the rights contained in the UDHR are now considered part of customary international law.

The onset of the Cold War and the diverging world views of the East and the West influenced the next key step in the development of international human rights documents. Although originally planned to result in one legal covenant, the process of developing a major new treaty separated civil and political rights from economic, social and cultural rights. Hence, in 1966 the *International Covenant on Civil and Political Rights (ICCPR)*⁹ and the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*¹⁰ were signed. These two Covenants entered into force in 1976. (It should be noted that the the ICESCR specifically covers the right to health).

In addition there are a range of more specialised treaties, including for example the

⁵ European Court case law can be found at <http://www.echr.coe.int/ECHR/EN/Header/Case-Law/HUDOC/HUDOC+database/>

⁶ For an overview of the ICCPR and ICESCR complaints procedures see <http://www.ohchr.org/english/bodies/petitions/index.htm>. For the European Court see <http://www.echr.coe.int/ECHR/EN/Header/Applicants/Information+for+applicants/Notes+for+the+guidance+of+persons+wishing+to+apply+to+the+ECHR/>

⁷ <http://www.unhchr.ch/html/menu3/b/ch-chp1.htm>

⁸ <http://www.unhchr.ch/udhr/lang/eng.htm>

⁹ http://www.unhchr.ch/html/menu3/b/a_ccpr.htm

¹⁰ http://www.unhchr.ch/html/menu3/b/a_cescr.htm



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*Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*¹¹ and the *Convention on the Rights of the Child (CRC)*¹². For a full list of international human rights instruments please see <http://www.ohchr.org/english/law/index.htm>.

There are also regional human rights instruments. The most well known one is the *European Convention on Human Rights and Fundamental Freedoms (ECHR)*¹³, drawn up under the auspices of the Council of Europe in 1950. In addition, there is an *American Convention on Human Rights*¹⁴ and an *African Charter of Human and People's Rights*¹⁵.

➤ **Human rights in the EU**

All EU Member States are parties to the *European Convention on Human Rights and Fundamental Freedoms*. Candidate countries have to sign and ratify the *Convention* to be legible for accession to the Union. Most Member States are also parties to the *European Social Charter*¹⁶. In addition, human rights are guaranteed by national legislation and international obligations. Member States are parties to a range of other international human rights treaties.

➤ **The Charter of Fundamental Rights of the European Union**

The next question is why, in light of the international treaties that they had already signed up to, did the EU Member States create the *Charter of Fundamental Rights of the European Union*?

The answer lies in an opinion delivered by the European Court of Justice (ECJ) in 1996, that the European Communities as an entity could not accede to the European Convention on Human Rights, despite the fact that all Member States are parties to this treaty¹⁷. Therefore it was felt that the EU needed some kind of document to demonstrate its commitment to the fundamental values shared by all of its Member States. These are listed in the preamble of the *Charter* as '*human dignity, freedom, equality and solidarity*'.

➤ **What is the status of the Charter of Fundamental Rights of the EU?**

The *Charter of Fundamental Rights of the European Union* is a 'solemn proclamation' made by the Presidents of the Commission, Council and European Parliament at the Nice Summit in 2000. It is not a legally binding document, at least not yet. The full

¹¹ <http://www.unhchr.ch/html/menu3/b/e1cedaw.htm>

¹² <http://www.unhchr.ch/html/menu2/6/crc/treaties/crc.htm>

¹³ <http://conventions.coe.int/treaty/en/Treaties/Html/005.htm>

¹⁴ http://www.achpr.org/english/info/charter_en.html

¹⁵ http://www.achpr.org/english/info/charter_en.html

¹⁶ <http://conventions.coe.int/treaty/en/treaties/html/035.htm>

¹⁷ [Opinion 2/94 ECJ](#)

http://europa.eu.int/smartapi/cgi/sga_doc?smartapi!celexplus!prod!CELEXnumdoc&numdoc=61994V0002&lg=EN



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Charter was integrated as Part II of the proposed new Constitutional Treaty and it will thus become law if the Constitution is eventually ratified.

➤ **What are fundamental rights and how are they different from human rights?**

Fundamental rights, as presented in the *European Charter*, are more than just human rights. The document draws on several different legal sources. It is seen as reaffirming:

- constitutional traditions and international obligations common to Member States
- the *Treaty of the European Union* (TEU)
- the *Community Treaties*
- the *European Convention for the Protection of Human Rights and Fundamental Freedoms*
- the *Social Charters* adopted by the Community and the Council of Europe
- case-law of the European Court of Justice and the European Court of Human Rights

Hence, what distinguishes fundamental rights from human rights is that they are derived from several different sources, of which human rights is only one. The document compiles for the first time a Charter of Rights based on a combination of national and international legal obligations, EU treaties and European case-law. Therefore, all of these rights exist already in a variety of legal documents and in jurisprudence, but the *Charter* is the first time that they are all brought together in one document.

➤ **The normative value of the *Charter of Fundamental Rights***

Having established that the *Charter* is not yet legally binding does not mean that it is an irrelevant piece of paper. The term 'soft law' is often used to describe documents which are not legally binding but nevertheless are generally expected to be respected or followed. It is often politically easier for states to agree to documents which will not be legally binding but at the same time make a statement about their own norms or expected behaviour. In the case of the *Charter* the fact that the EU saw the necessity for compiling all these rights into one document, using the terms 'rights' and 'charter', gives it a certain normative significance. Its rights may not be legally binding but policy makers and EU institutions may be held accountable by reference to their public commitment to the rights in the *Charter*. It may be politically embarrassing for governments to be perceived as disregarding the rights contained in the Charter because of their proclamation of the values of these rights.

The right to health at global and EU level will be dealt with in a separate EPHA briefing.

The WHO Publication entitled “25 Questions and Answers on health and human rights” provides useful additional reading.



EPHA Briefing on human rights

<http://www.who.int/entity/hhr/NEW37871OMSOK.pdf>

From testimonies from the field...

A collection of case studies featuring the stories of:

➤ **Homeless people**

Submitted by FEANTSA

<http://www.feantsa.org>

➤ **Lesbian, gay and transgender communities**

Submitted by ILGA Europe

<http://www.ilga-europe.org>

➤ **Undocumented migrants**

Submitted by PICUM

<http://www.picum.org>

➤ **Roma communities**

Submitted by ERIO

<http://www.erionet.org>

➤ **Socio-economic inequalities in health**

...to a call for action!

Testimonies from the field

Case study of the homeless by FEANTSA

The key issues for this target group when exercising their right to health

Homeless people, particularly those who have lived in the street, generally suffer from extremely poor health. What is more, their health needs are generally multiple and complex, with possible mental, physical and substance abuse issues adding up to a high aggregate of vulnerability.

In terms of availability and accessibility of care, the main problems encountered by homeless people are stigma and discrimination when attempting to access services. There may be a great reluctance on the part of services to engage with them and administrative personnel can be unhelpful. Financial contribution can also be a significant barrier, even where this is small, as many homeless people may simply not have the money. Lack of knowledge about entitlements also constitutes a barrier, as without this some homeless people feel that they don't know what they are entitled to in the line of healthcare and services. If they were better informed they would be more confident about trying to access them.

In terms of acceptability and quality, it is often the case that there is a very high dependence on emergency care among homeless people. Because they access these services on an ad hoc basis, often in a crisis situation, there is no continuity of care. What is more, in many countries, there is little or no integrated working between health and other social services, which can mean that homeless people are discharged onto the street, rather than put in contact with services.

Real life examples of challenges faced

In the UK, homeless people find it harder to register with a General Practitioner than members of the general public. Requests for a permanent address and other details can constitute a real or a psychological barrier.

In Germany, following the recent social reforms, a 10€ charge has been introduced in specialised health services for homeless people, which effectively means that many former clients are now unable to access these services, due to the financial barrier.

In many European countries there is inadequate infrastructure in the area of drug and alcohol treatment. This means long waiting lists and great difficulties accessing what is a vital treatment for many homeless people.

In many European countries, the health needs arising from dual diagnosis are inadequately met. This concurrence of mental health issues and substance dependence needs to be

treated in a holistic way, taking account of both dimensions of the problem. In practice, drug and alcohol services don't want to accept people with mental illness and mental health services don't want to engage with people with an addiction problem.

Specialist services also tend to be very inaccessible for homeless people across Europe. Despite severe needs in the areas of dentistry, podiatry and dermatology, homeless people are often unable to get specialist treatment due to a range of barriers.

What improvements or developments are needed?

It should be ensured that doctors and healthcare professionals are aware of the need to try and address all areas of the health needs of homeless people, both by direct treatment and referral to specialised services.

It is vital to avoid the phenomenon whereby homeless people end up shunted from service to service, without the whole of their situation being treated in a holistic way. This can be avoided if there is a strong sense of partnership between the health services and a commitment to acting in the best interests of the patient. Doctors and other healthcare professionals should ensure that a diagnosis of mental ill-health or dual-diagnosis does not lead to exclusion from other health and social services. There needs to be an adequate discharge procedure from hospitals and where possible, packages of appropriate care are brought together where an adherence to medication and treatment regimes should be strongly encouraged

A broad notion of health and health promotion must be applied when seeking to lay down policies for improving the health of homeless people. Health services, both primary and emergency, may be the point of contact for many homeless people. From there, they need to be integrated into the system of statutory social services and voluntary services that may be in place. Their needs must be met in as wide and holistic way possible that encompasses referral to housing services, to housing support schemes, to substance dependency schemes, to training, to counselling and finally, to social reintegration.

Testimonies from the field

Case study from the lesbian, gay, bisexual and transgender communities by
ILGA-Europe

The key issues for this target group when exercising their right to health

There are barriers to accessing health care that are specific to lesbian, gay, bisexual and transgender (LGBT) people. Those barriers experienced by other populations, e.g. lack of resources, geographic and social isolation, lack of information about and/or fear of medical procedures etc. may also pertain to LGBT people. However those which are specific to many LGBT include the fear of discrimination and stigma, which act to prevent them from seeking care for themselves or their families. Once in care LGBT people may withhold personal information that health care providers need in order to be able to give appropriate care. In addition, if a member of the LGBT community experiences homophobia and/or discrimination or feels that their needs are not being recognised or addressed, this less-than-satisfactory experience can result in them not going back for needed further care. Research shows that there is a high degree of ignorance on the part of health care providers, not only of the specific health needs of LGBT people, but also of the need to be aware of the sensitivities involved when LGBT engage with a system which is viewed by them with fear and suspicion.

Real life examples of challenges faced

ILGA-Europe has recently conducted a survey on LGBT health in three countries: Hungary, Romania and the Republic of Moldova. Mental health is one of the most vulnerable issues for the LGBT people. Let us give you an example from Hungary. Reporting on stress, 88.4% of the respondents reported being frequently stressed, 79.3% anxious, and 46.2% think that they are depressed. Of those who answered these questions, 32.9% are of the view that their stress, anxiety or depression is related to their sexual orientation. Only 28.5% of these have turned to a mental health service provider for help, including the help-lines operated by NGOs. 71.5% have never sought help. This can be understood in part by a lack of trust in the doctor's confidentiality, since it is necessary to come out to the doctor/psychologist if someone is seeking treatment for related mental problems.

When asked about suicidal thoughts, 56.2% of the respondents report having such thoughts and 18.3% have attempted suicide. Among those who have attempted suicide, 65% viewed it as related to sexual orientation (and gender identity).

Table 1 Suicidal thoughts and suicide

	Yes	No	No Response
	Percent		
Have you ever had suicidal thoughts?	56.2	43.8	0
If yes, have you ever attempted suicide?	18.3	81.7	0
If yes, do you feel this was in anyway due to your own or other people’s feelings in relation to your sexual orientation or gender identity?	65	35	0

Abuse, harassment and violence are factors which can have an impact on health in general and on mental health in particular. Only 33.8% of respondents report not experiencing any of our listed forms of abuse. We also see that well over one half (59.2%) of responses were for name calling as a form of abuse. 21.1% percent of the responses related to the threat of physical violence.

What improvements or developments are needed?

In order to eliminate barriers to healthcare, two steps must be taken. First, at the level of the healthcare system, it is necessary to build awareness of LGBT needs and to develop the skills needed to meet these needs. Secondly, at the individual level, it is necessary to encourage self-confidence and self-esteem as well as developing advocacy strategies. Because individuals were unaware that they have the right to health care and did not know what institutions and services could help them secure their rights, very few people were aware of the lack of services.

The healthcare system must be structured and promoted as an inclusive and non-discriminatory environment for LGBT so as to increase the trust of LGBT clients. The most important aspect is to ensure confidentiality of client data, including information about sexual orientation and (trans)gender identity.

Testimonies from the field

Case study of undocumented migrants by PICUM

The key issues for this target group when exercising their right to health

Undocumented migrants make up a considerable part of the migrant population in Europe, and it is not very likely that their numbers will decrease in the near future. Nonetheless, few social policies are directly addressed to meet their needs. Many actors (e.g. NGOs, local authorities, health care personnel, etc.) stress that access to health care is the most pressing problem for undocumented migrants.

The following overview focuses primarily on the following two issues: **availability** - what each EU Member State's legislation determines concerning undocumented migrants' access to public health care; and **accessibility** - what the situation is in practice. PICUM has not collected enough information to properly present issues concerning the acceptability and quality of health care for this target group.

Legislation

EU Member States can *roughly* be divided into four different categories concerning the way their legislation addresses the issue of undocumented migrants' access to public health care.

- No mention at all in legislation about undocumented migrants gaining access to health care (meaning that undocumented migrants do not have access to public health care systems). (e.g. Austria, Denmark, Sweden)
- Legislation states that undocumented migrants can have access to health care only in life-threatening situations or in cases of contagious diseases. These countries provide access to undocumented migrants for “utilitarian” concerns: their main motivation is to ensure that undocumented migrants do not pose threats to public health. (e.g. Germany, United Kingdom)
- On the other hand, some countries have a “humanitarian” approach and promote health care for everyone, including undocumented migrants. (e.g. France, Italy, Spain)
- A fourth category is countries whose policies fall between the two previous categories. These countries offer “urgent health care” for undocumented migrants: this care is broader than emergency-only care, but is it not universal health care for all. (e.g. Belgium, the Netherlands)

Real life examples of challenges faced

While a number of EU Member States' legislation foresees some type of access to public health care systems for undocumented migrants, a number of problems prevent them from actually getting the care they need. The following **problems** should be highlighted:

Barriers:

- Health care staff have a duty to detect (United Kingdom) and denounce (Germany) undocumented migrants' irregular residence status to the authorities.
- Police can gain access to personal data on undocumented migrants who have registered at the town hall in municipalities in Spain. (To be able to access the health care system in Spain, undocumented migrants first have to register at the town hall).
- Undocumented migrants in France have to provide proof that they have been in the country for a minimum of three months if they wish to access the public health care system.

Complexity of procedure:

- Despite an official framework, the decision about what constitutes "urgent" health care (Belgium and the Netherlands) is often arbitrary and left up to individual doctors to determine. Moreover, undocumented migrants in these countries often have to run from one service to another to formalize their demand for health care, a lengthy and complicated process.

Lack of knowledge of official procedures:

- In many of the above-mentioned countries, there is a lack of knowledge of all actors (health care staff, local authorities, even NGOs) regarding undocumented migrants' right to health care and the procedure for gaining obtaining care. A lack of knowledge is reinforced by complex procedures.

What improvements or developments are needed?

The provision of urgent medical treatment - both preventive and curative - to undocumented migrants is the minimum requirement. States should take measures to ensure that this right is recognised formally in their laws and to eliminate the practical obstacles to its enjoyment by undocumented migrants.

States should nonetheless strive to provide holistic health care to undocumented migrants in conformity with the broader understanding of the right to health in the International Covenant on Economic, Social and Cultural Rights (ICESCR). Moreover, certain vulnerable groups of undocumented migrants, such as children, disabled

persons, pregnant women and the elderly, should be granted health care on equal terms with comparable national groups.

Testimonies from the field

Case study of Roma communities submitted by ERIO

The key issues for this target group when exercising their right to health

High infant mortality rates and a much-reduced life span are among the most salient features testifying the poor health condition of Roma in Europe. But this is just the tip of the iceberg. The health status of the Roma is characterized by the prevalence of chronic diseases such as cardiovascular illnesses, epidemic infections such as poliomyelitis and tuberculosis.

Poor living conditions including unhealthy housing and physical environment, malnutrition or starvation as well as discrimination with regards to access to health services are the main factors which contribute to the abysmal situation faced by Roma, but there are also other factors associated with the social exclusion of Roma such as the low level of education and widespread anti-gypsyism.

UNICEF reported in 2001 that the life expectancy of the Roma is the lowest of any group in Europe. More recently the UNDP Report "Avoiding the Dependency Trap" in 2003 describes the dramatic impact of poor health on child mortality and life expectancy:

"Roma children are a special risk group in terms of health. Infant mortality data are scarce due to the lack of consistent monitoring by ethnic groups. Still, various, albeit fragmentary, data show large discrepancies between majority and Roma populations. These data suggest that Roma child mortality rates in Romania are 3 to 4 times higher than those for the majority population or other ethnic groups. In the Czech Republic, Slovak Republic, and Hungary, Roma infant mortality rates are roughly double the national averages. In the Czech Republic, Roma children represented 2.5 percent of all live births and accounted for 4.9 percent of infant deaths; in Slovak Republic, these figures were 8.4 percent and 17.8 percent, respectively. The situation in Bulgaria is even worse: in 1989, the infant mortality rate for Roma children was 240 per 1000, compared to the national average of 40. These figures contrast dramatically with the average infant mortality rates for the five countries ... and are probably among the strongest arguments for more active sub-



national MDG monitoring and initiatives in pre-accession countries."

Real life examples of challenges faced

16 year old Irina is dying in the last stages of AIDS. Many years ago she went to the hospital for a blood transfusion and was given contaminated blood. The other children in the garbage dump like her a lot, and come to her to play and for her protection. She is usually with a baby or small child in her arms. Irina and the other over 130 people (7 families) live in conditions far worse than you can imagine in the garbage dump at Mofleni, outside of Craiova, a large city in Southern Romania. Her hands, face and clothes are filthy as she spends most of her time scavenging through garbage to help support her single mother who also has AIDS and her siblings, one also with AIDS. She lives in a tiny shack with just three walls and a cardboard roof, along with 7 other people. Irina receives medication to keep her healthy from a charity organisation in Belgium. When the medication runs out she gets sores which won't heal. Then she goes to the hospital in Craiova where they quickly send her away with medication which does little to help her.

The smell in this area is terrible. When they burn the garbage the air is thick and sticky. Animals corpses rot just metres from the crooked shacks, where the children play. When it rains, the floors of the houses become mud. The rooms are full of flies and there is no electricity or running water.

Tirana, Albania

There were 8 children living in a shack, three of them have died in the last 4 years. The floor is made of horse manure, insects and rats are pets for the kids to play with. Their life expectancy is 25 to 30 years less than that of other Albanians. Eight year old Elvis looks like a child half his age. He has a worrying cough but they didn't take him to the hospital. His home was demolished in January 2005.

Pristina, Kosovo

The kids play in the old cars, there are lots of them lying around. Fleas, rats and cockroaches are companions in their daily play. The garbage dump is 100 meters away. Most of the children have open wounds and show effects of lead poisoning.

What improvements or developments are needed?

a. Eliminate discrimination of Roma with regards to access to health

- Ensure equal access and treatment to health services for Roma. Targeted programs ensuring access to basic health services should be set up in place based on the available positive examples (see joint report on social inclusion 2004).
- Adopt proper legislation, which makes sure that there is no discriminatory treatment in terms of access to health and quality of the services provided and provide appropriate instruments for its implementation. Provide specific training for doctors and other health personnel to raise their awareness on specific aspects of Roma culture and

living conditions that may have an incidence on health. Include clear and severe repercussions for racist behavior in the work contracts of health personnel.

- Provide a full and independent documentation of cases where the physical integrity and the patient rights were abused by doctors on racist grounds for example the forced sterilization of Roma women in Slovakia, Czech Republic and other countries. Make the culprits liable for legal punishment.
- Establish ombudspersons at every stage of the health system including at the level of the ministries who can deal with the many issues affecting the access to health of Roma.
- Commission reports on the health situation of Roma, meant to give a correct overview of the situation of Roma health by taking in consideration the multiple factors contributing to the generally much poorer than average health of Roma. Inclusion of Roma and Roma experts in the team conducting the needed research should be a priority in order to reduce the often-present bias from reports examining Roma's health.

b. Improve the healthcare situation of Roma

- Ensure proper basic healthcare free of charge for everyone. Initiatives with clear targets should be urgently implemented to establish inclusive basic health care system for Roma.
- Support the establishment of healthcare centers providing basic services in remote Roma settlements where the access to hospitals and doctors is difficult.
- Address the insalubrious housing conditions of Roma ghettos, one of the main reasons for the persistence and spread of infectious diseases.

c. Involve Roma in the health process (Capacity building)

- Establish affirmative action programmes aimed towards attracting Roma to health related jobs.
- Switch the actual focus of training programs for Roma in the field of health from health mediators to more ambitious targets. Roma should be encouraged to embrace professions such as those of nurses and doctors as it is here where they will be able to make a real difference.
- Appoint Roma mediators at the level of hospitals able to function as reliable links between doctors and patients and also capable of receiving and dealing with complaints about undue and discriminatory treatment.
- Assure a proper representation of Roma at any stage of the health system including at the level of ministries and other public institutions in charge of public health.
- In countries with a significant Roma population earmark specific funding for the improvement of the health situation of Roma.
- Organize public information campaigns and eventually health care training on issues such as basic health care, childcare, pregnancy and contraception, domestic violence,

drug abuse and communicable diseases.

Testimonies from the field

Case study of socio-economic inequalities in health by EuroHealthNet

The key issues for this target group when exercising their right to health

Inequalities in health amongst different socio-economic income groups are a pervasive feature in all EU Member States. Specifically, health inequalities refers to:

- The systematic and avoidable differences in health outcomes between social groups such that poorer and/or more disadvantaged people are more likely to have illnesses and disabilities and shorter lives than those who are more affluent.¹⁸ (Mackenback, 2005)
- An important feature of health inequalities is that it is not simply the poorest that experience less than optimal health; there is a gradient of risk across the whole population. Health inequalities can therefore be categorised in three ways: 1) the poor health of socio-economically disadvantaged people vis-a-vis the rest of the population 2) health gaps between different groups and 3) social gradients across whole populations.¹⁹

The systematic differences in health status across social class is contrary to the fundamental values of equity, universality and solidarity that underpin health systems throughout the EU.

Real life examples of challenges faced

The following are some examples of how health inequalities manifest themselves in different EU Member States:

- Death rates from Coronary Heart Disease in England are three times higher among low skilled than among highly skilled men.
- Health damaging behaviours such as smoking are two to three times higher among low-income than among high-income women in Northern European Countries.
- In the Netherlands, there is a 14-year difference in healthy life expectancy among the highest and the lowest socio-economic groups.
- In countries of Central and Easter Europe, mortality rates have since 1989 been correlated with changes in income inequalities.

¹⁸ Mackenback, J.P. Health Inequalities in Europe: Overview of Patterns and Trends, Erasmus MC, Rotterdam, 2005

¹⁹ Graham, H. Tackling Inequalities in Health in England: Remedying health Disadvantages, Narrowing Health Gaps or Reducing Health Gradients? Journal of Social Policy, 33:1, p.115-131, 2004

Such inequalities result from the varying degrees and quality of exposure amongst different social groups to the factors that affect health. Access and availability of health care is but one, although very important, such health determinant. Evidence indicates that richer, better-educated people find their way to medical specialists and dentists more easily and more frequently, while people with less income tend to use more GP and emergency services. Lower socio-economic groups also tend to postpone preventative and curative care, affecting their perspective of receiving adequate health services, their prognosis for recovery and ultimately their overall health.

These findings reflect that inequity in access to and the affordability of health care continues to be a feature across EU health systems, in spite of the fact that most countries have long achieved rather universal and comprehensive degrees of health insurance coverage. Such inequities in access to health care can contribute to the overall, systematic differences in health status amongst people from different social classes.²⁰

What improvements or developments are needed?

Meeting the challenges posed by health inequalities requires a range of cross-sector actions to address the social and economic determinants of health. Since health inequality is the product of many different factors, governments have a wide array of choice about how to address these. Of importance is that the actions taken involve the redistribution of resources and opportunities in ways that are relevant to the nature of health inequality in a particular context.

Tackling health inequalities is currently high on the political agenda in the UK, leading England's Chief Medical Officer, Sir Liam Donaldson to share his ideas on what is needed to address them: a cross governmental plan, with clear, measurable objectives; belief, or the conviction that you can do something about it; and 'joined-up government'.

Currently, many EU countries seek to improve the health of the most socio-economically disadvantaged groups, most commonly through a socio-inclusion focus. Others are attempting to narrow the health gap between the most and the least socio-economically disadvantaged. No EU member state has yet, however, made a concerted effort to implement the most radical approach to health inequalities, namely a reduction in the health gradient, whereby health is related to the position of social groups (and individuals within these groups) at every level of society.²¹ (Judge, Platt, Costongs, Jurczak, 2005)

²⁰Tamsma N, and Berman B.C. The Role of the Health Care Sector in Tackling Poverty and Social Exclusion in Europe. European Health Management Association (EHMA), 2004

²¹ Judge, K. Platt, S. Costongs, C. and Jurczak, K. Health Inequality Policies in Europe: Overview of National Strategies. Interim Report (in press) for UK Presidency Summit, 17-18 October, 2005 "Tackling Health Inequalities, governing for

Such an approach would imply focussing on socio-economic differentials (the systematic relationship between socio-economic position and health) in order to address 'systematic differences in life chances, living standards and lifestyles associated with people's unequal positions in the socio-economic hierarchy'. (Graham, 2004)

Additional information on health inequalities is also available in the following reports:

Stegeman, I and Costongs, C. Health, Poverty and Social Inclusion in Europe. Literature review on concepts, relations and solutions, EuroHealthNet, 2003

Stegeman I and Costongs, C. Promoting Social Inclusion and Tackling Health Inequalities in Europe. An overview of good practices from the Health Field, EuroHealthNet, 2004

Speaker Biographies

John Martin

Dr Martin, Director of the WHO Office at the European Union since May 2002, steers the collaboration between the WHO and the European institutions, the OECD and the Council of Europe. He has worked at WHO since 1985 holding a range of senior positions. Before joining WHO, he worked for the Save the Children Fund in Bangladesh; as Deputy Community Physician in the Docklands area of London (Newham); as Primary Health Care Adviser, Government of Zambia; as Associate Professor of International Health at the Nordic School of Public Health (Gothenburg, Sweden); and as a consultant to the Swedish International Development Authority (SIDA). Dr Martin is a Fellow of the Faculty of Public Health of the Royal College of Physicians, UK.

Aleid Bos

Aleid Bos has a background in international human rights law, with both academic and governmental working experience. She studied international law at the University of Amsterdam, with special interest in human rights law, the administration of justice in developing countries and the UN supervisory mechanisms. She started her professional career at the Van Vollenhoven Institute for Law, Governance and Development. Subsequently, she taught international law and international human rights law for a number of years at Utrecht University and University College Utrecht. Aleid considerably broadened her working experience at the Dutch Ministry of Foreign Affairs, including participation in the Netherlands delegation to the UN Commission on Human Rights. During the EU Presidency she organized - in co-operation with Dutch and international NGO's - the 6th Annual EU Human Rights Discussion Forum (The Hague, December 2004) on the implementation of the EU Guidelines on Human Rights Defenders, resulting in a manual.

Dearbhal Murphy

Dearbhal Murphy is Communications Officer at FEANTSA, the European Federation of National Organisations Working with Homeless People. She is also responsible for FEANTSA's policy work in the area of health and is coordinator of the FEANTSA transnational working group on Health and Social Protection. This group works on issues related to the health of homeless people across Europe and on addressing homelessness from a health perspective. Dearbhal Murphy will be closely involved in coordinating FEANTSA's work in 2006, when the organisation's annual theme will be "making access to health a reality for homeless people". FEANTSA will look at a variety of questions related to health and homelessness in the course of the year and will hold a conference on this theme in Wroclaw in Poland in October 2006.

Maxim Anmeghichean

A graduate of the Moldovan State University in the field of journalism and communication sciences, Max has linked all of his professional life with the LGBT movement. He has over five years of experience within the Moldovan LGBT movement (Information Centre "GenderDoc-M"), helping to build and develop the organisation. At national level, Maxim was also a member of the NGO Council, founding member of the National AIDS Network, and board member of the National Youth Council of Moldova (NYCM), where his mandate included capacity building and organisational development. For the past three years he has been actively involved with ILGA-Europe as a board member, taking part in development of IE's Eastern European work, lobbying before the Council of

Europe and the European Union and fundraising. His new post with ILGA-Europe is combines advocacy work before three major European institutions (OSCE, Council of Europe and the EU), development of the Eastern European LGBT movement and work on transgender issues.

Nele Verbruggen

Nele Verbruggen is coordinator of PICUM, the Platform for International Cooperation on Undocumented Migrants, since 2000. She is currently responsible for general coordination of the secretariat and for advocacy work.

Cristi Mihalache

Cristi Mihalache is the Program coordinator of the Roma Health Program within the Open Society Institute's Network Public Health Program. He has previously worked for the European Roma Rights Centre in Budapest, an EU-funded program developed by the Romanian Government and Delegation of the European Commission in Romania for the improvement of the Roma situation, as well as for a Roma organization in Romania, Romani Criss.

Ingrid Stegeman

Ingrid Stegeman is policy officer at EuroHealthNet. She has a Bachelor degree in International Studies from Vassar College and a Masters in Political Science from the University of Amsterdam. Her previous research and work experience lie in the areas of globalisation and children's rights (child labour and child participation). She began working at EuroHealthNet three years ago, where she focuses on the issues of health inequalities and social inclusion.

Petra Wilson

Dr Petra Wilson is the Deputy Director of the European Health Management Association (EHMA), a membership organisation committed to improving healthcare in Europe by raising standards of managerial performance in the health sector. EHMA was created in 1980 and has a membership of over 240 institutions active in health service delivery, organisation and support as well as health management research. Petra Wilson is a public health law academic who has published widely on health policy in journals and books, on issues such as access to health services, privacy and confidentiality in health care, HIV and discrimination in health care, and on the use of new technologies in health services provision. Prior to joining EHMA she spent 7 years at the European Commission where she was responsible for co-ordination of inter-departmental activities on eHealth, in particular Quality Criteria for Health Related Websites. She also spent a number of years engaged as a lecturer and researcher in public health law at Nottingham University in the United Kingdom.

Georg Fischer

An economist by qualification, Georg Fischer is currently Head of Unit for "Social Protection: Pensions and Health" in the European Commission's Directorate General for Employment and Social Affairs. His responsibilities include, among others, the Open Method of Coordination on pensions and health and long-term care. Previously Head of Unit for "Employment Analysis" within the same Directorate General. His responsibilities included: economic analysis of European labour markets, labour market monitoring and projections (Lisbon employment targets); employment impact of community policies; labour markets and employment policies and enlargement. Mr Fisher's previous posts include the Organisation of Economic Co-operation and Development (OECD),

the Austrian Government, the Social Science Centre Berlin and for the Economic Cooperation Foundation in Tel Aviv, Israel.

John O'Toole,

John O'Toole is the Health Counsellor at the Permanent Representation of Ireland to the European Union and was centrally involved in the design and delivery of the Irish EU Health Presidency in 2004. He holds a Master's Degree in Economics, as well as a Master's Degree in Public Sector Analysis, and studied at the French Ecole Nationale d'Administration. Prior to his appointment in Brussels, John O'Toole held various responsibilities in the Department of Health in Ireland and previously he worked in the Finance Ministry and in the Revenue. He has written several works on the operation of the machinery of government and has presented papers at many international conferences.

Mia Honinckx

Mia Honinckx is a medical coordinator for FEDASIL, the Belgian federal authority for asylum seekers, and has worked as a physician in centres for asylum seekers for the past 14 years. She is a qualified medical doctor and graduated in 'de heel-genees- en verloskunde' from KU-Leuven in June 1984.

Right to Health - links for further information

- CESCR General Comment No.14 on the Right to Health

<http://www.ohchr.org/english/bodies/cescr/comments.htm>

- UN Special Rapporteur on the Right to Health, Paul Hunt

<http://www.ohchr.org/english/issues/health/right/index.htm>

- The Right to Health: A Resource Manual for NGOs; By: Judith Asher

<http://www.huridocs.org/poprthea.htm>

- The Right to Health as a Human Right in International Law; Brigit Toebes, School of Human Rights Research Series, Volume 1, Hart Intersentia, Antwerpen- Groningen- Oxford, 1999

- The 'Right to Health' in European Union Law, in: Economic and Social Rights under the EU Charter of Fundamental Rights, Hervey and Kenner eds., Hart Publishing, Oxford-Portland Oregon, 2003

- International Federation of Health and Human Rights Organisations

<http://www.ifhhro.org>

- '25 questions on health and human rights' by the WHO

<http://www.who.int/hhr/activities/publications/en/index.html>