EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

MEMO / 11 March 2013

Multiple discrimination in healthcare

1. What is multiple discrimination?

Multiple discrimination takes place when someone is discriminated against for more than one reason, for example on the basis of gender and religion, age and ethnicity, etc. It can be:

- Additive: when the specific effects can be distinguished. For instance, an elderly woman may be discriminated against in the workplace because of her sex and in accessing healthcare because of her age; or
- Intersectional: when discrimination is based on the combination of two or more characteristics. For example, when a Romani woman gives birth in a hospital, she may experience discrimination not only because she is a woman (not all women face such discrimination), and not only as Roma (not all Roma face such a situation), but because of the combination of two characteristics. **Intersectional multiple discrimination is the focus of this FRA report.**

2. What legal protection is there against multiple discrimination?

EU legislation prohibits discrimination on six grounds, namely sex, age, disability, religion or belief, race or ethnic origin, and sexual orientation. But EU law provides better protection against racial or ethnic discrimination and against sex discrimination than against discrimination on the other grounds. For example, in terms of access to healthcare, EU law explicitly protects against discrimination only on the grounds of sex and racial or ethnic origin. This creates an artificial 'hierarchy of grounds', whereby EU law protects more comprehensively against discrimination on some grounds than on others. A so-called 'horizontal directive' proposed by the European Commission in 2008 that would provide equal protection on all grounds is still under negotiation.

Neither EU law nor the majority of national laws specifically recognise or make provision for multiple discrimination. Only six out of 27 Member States address multiple discrimination in their legislation. Complainants, lawyers and judges are also often not aware of multiple discrimination and what it means.

3. How widespread is multiple discrimination in healthcare?

There is an absence of EU–wide data on multiple inequalities in healthcare, and it is therefore difficult to assess fully the extent of the problem. While gender and age are systematically recorded, this is rarely the case for ethnic origin and disability. The resulting lack of reliable health

statistics makes it difficult to obtain a true picture of multiple inequalities. However, data across all sectors from FRA's EU-MIDIS survey indicates that migrant and ethnic minorities are especially vulnerable to multiple discrimination. Some 14% of EU-MIDIS respondents said they had felt discriminated against on multiple grounds in the past 12 months in comparison with only 3% of the majority population (FRA, EU-MIDIS Data in Focus Report 5: Multiple discrimination).

In addition, the true level of discrimination – including multiple discrimination – in healthcare may also be hidden because many prefer to bring legal cases for reasons other than discrimination, such as for medical negligence or malpractice, because these are simpler to prove and can lead to higher compensation than discrimination cases.

4. What barriers to healthcare do victims of multiple discrimination face?

Communication and language barriers: Inadequate or non-existent interpretation often hampers healthcare delivery. Migrant women, who often follow their partners as family members, may have difficulty learning languages especially when they are only engaged in domestic work. Older migrants, who have spoken the language of the country of destination for a long time, may forget it for health reasons such as dementia. One area of particular concern is the impact of language barriers on people with psycho-social problems, or intellectual disabilities. This is especially a problem for people with a migrant background, as psychotherapy and cognitive tests usually needs to be carried out in the patient's mother tongue.

Lack of information on healthcare entitlements and services: While this can be related to language (both sign language and Braille), lack of information also relates to informed consent about procedures. Roma health users and Muslim women reported that they were not always provided with adequate explanations because healthcare professionals considered them to be too poorly educated to understand and communicate their problems.

Organisational barriers and accessibility: These can disproportionately affect certain types of healthcare users. Examples include: organisational inflexibility – such as making appointments on Fridays for Muslim women or not taking into consideration the needs of migrant mothers who have no family support to look after their children when seeking healthcare. Poor accessibility and lack of reasonable accommodation for people with disabilities is also a problem.

Working and living conditions: Fear of being reported to the authorities and deported, and fear of losing ones job in case of absence often prevents migrants from seeking healthcare. In addition, older migrants or those with a disability may be unable to work and/or excluded from social protection schemes unless they hold a permanent residency permit.

Cultural and psychological barriers: Lack of dignity and of respect for other cultures can also be a barrier. Migrant women, and especially Muslim women, can be uncomfortable with male doctors and nurses. This may prevent them from seeking healthcare. Children with intellectual disabilities in minority ethnic communities may also be kept at home because of the stigma associated with their disability within their community, leading social service providers to erroneously assume that they are being supported at home.

5. What did the report find?

The report shows how stereotypes, whether based on culture, sex, age, ethnicity, migrant background, religion or a combination of these characteristics, can lead to unequal treatment of different groups of healthcare users. There are some recurrent stereotypes that the research found

across the Member States studied. These include those related to: appearance, particularly of Muslim women wearing headscarves; disability; feigning illness, specifically among people belonging to a migrant or ethnic minority who are older or have disabilities; cultural stereotypes and the possible association of ethnic minorities with HIV/AIDS.

Patients and professionals interviewed mentioned mainly six ways through which people could be discriminated against in healthcare, including: delay of treatment; refusal of treatment; lack of dignity and stereotyping; poor quality of care; lack of informed consent; and harassment.

6. Where can victims go?

In principle, victims should go to national complaints bodies such as Ombuds institutions, equality bodies and the like. But in practice, this can be complicated, because some of these bodies deal with health complaints while others deal with discrimination. Furthermore, there is often a system of different equality bodies responsible for different grounds of discrimination. This complexity can leave victims unsure of where to go to seek redress.

7. What can be done?

FRA has identified a number of ways that could address the issue of multiple discrimination more effectively.

EU law: The adoption of the 'Horizontal directive' would remove the 'hierarchy of grounds' allowing Member States to tackle multiple discrimination issues more effectively through national law.

Equality bodies and courts: Compensation awarded in multiple discrimination cases should be higher than that for single-ground discrimination, in order to provide an incentive for victims and their lawyers to pursue such claims.

Promoting equality in healthcare: Member States could explore more effective ways for all healthcare users to be treated equally, with dignity and respect. This could include anti-discrimination training for healthcare professionals, free linguistic and mediation services and outreach programmes to minority ethnic groups and people with disabilities.

Access to justice: Member States should increase awareness among healthcare users of complaint mechanisms. In turn, complaints bodies should facilitate access to justice through better provision of information in different languages and formats. Referral mechanisms between health and discrimination bodies should also be strengthened.

Improve data collection: Data on ethnicity and disability should be collected in national surveys to help reveal multiple inequalities and disadvantage in healthcare.

The full report 'Inequalities and multiple discrimination in access to and quality of healthcare' can be found at: http://fra.europa.eu/
FRA's work on multiple discrimination, including a project factsheet can be found at: http://fra.europa.eu/en/project/2011/multiple-discrimination-healthcare

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