

Cairde

Submission for UPR Ireland



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I. Background and Framework

1. Cairde is a non-government organization working to reduce health inequalities among ethnic minorities; and is committed to supporting the participation of minority communities in enhancing their health. Cairde works through a rights based approach believing that the absence of equality and respect for human rights is correlated to the existence of health inequalities. Cairde operates the Health Information and Advocacy Centre, which provides individual health advocacy and relevant, culturally appropriate health information to ethnic minority individual and groups. In 2010 the Health Information and Advocacy Centre supported 3249 individuals from ethnic minority communities who required individual health advocacy and support in accessing health and social services. As evident from Cairde's work, in the past three years there was a significant increase in numbers of migrants who required extensive health advocacy work: from 504 cases in 2008, to 1436 cases in 2009 to 3249 cases in 2010. Based on the issues, presented to Cairde's Health Information and Advocacy Centre by its ethnic minority clients, we would like to identify and highlight violations of human rights, particularly with regard to accessing healthcare in Ireland, which forms the basis for this submission.

2. The key points that Cairde wishes to focus are relating to the **violations of Right to Health with regard to the accessibility of Irish healthcare system to migrants, refugees and asylum seekers** and adherence to the **principles of 'equality and non-discrimination'** when making health social services accessible, in particular:

- **'Economic accessibility'** of Irish healthcare to particular categories of migrants, refugees and asylum seekers.
- **'Information accessibility'** of Irish healthcare to migrants, refugees and asylum seekers whose first language is not English or who belong to specific ethnic or faith group.

In this submission, we focus upon the Irish Government's performance of its human rights obligations and commitments as they relate to ethnic minorities' Right to Health – principally under the International Covenant on Economic, Social and Cultural Rights.

II. Promotion and Protection of Human Rights on the Ground

A. Cooperation with human rights mechanisms

3. The extent of the Irish State cooperation with human rights mechanisms in the Right to Health area and incorporation of these international obligations into domestic national law or policy leaves significant room for improvement. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which Ireland is a party to, states that *'the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. ...'* At present Irish healthcare system provides no framework, which clearly establishes a person's right to healthcare and there is no explicit right to health or protection of health to be found in the Irish Constitution.

4. The *'vision'* of the National Health Strategy 2001 is for a health system that is *'fair'*, that is founded on the principles of *'equity and fairness'*; *'a people-centred service'*; *'quality of care and clear accountability'*¹. Yet, this national healthcare strategy does not contain or reflect the human rights framework, especially when resources and funding allocation are concerned. Ireland also has committed itself to equality of health outcomes for the population in the *'Quality and Fairness: A Health System for You'*. Yet no provisions made for *'equality-proofing'* or equality reviews/assessments within healthcare planning, design and delivery processes and mainstreaming of equalities throughout the health service is not implemented. There is an absence of clear equality policy specific to healthcare delivery.

¹ Quality and Fairness-a health system for you, Department of Health and children, 2001

5. The Equality Authority advises on the matters of the equality legislation and provides guidance on the implementation of anti-discrimination practices in Ireland has sustained recent significant cut in state funding. The Equality Authority recognized the importance of equality-centered approach in the delivery of health care in Ireland and in 2005 it has published ‘Equal Status Acts 2000 and 2004 and the Provision of Health Services’, a document which discusses the equality issues in the provision of health services. The document outlined a model of an equalities competent health service within the framework of the general equality legislation that currently applies in Ireland. In particular, this document stresses the importance for health service providers to move away from ad-hoc reactive responses to issues of equality, leading towards a planned and coordinated approach in which equality becomes at heart of an organizational ethos. Unfortunately, this approach has not been adopted by the Irish healthcare system. The current thinking on equitable access to health services sees the equality in provision of healthcare as one of the leading factors in equality of health outcomes in Ireland, but in practice, there is a long way to go before strategies for healthcare provision will actively promote and monitor procedures to ensure the equality proofing of health their policies and mainstreaming of equality training for healthcare staff.

B. Implementation of Human Rights Obligations

(i) The Right to Health of Migrants, Refugees and Asylum Seekers

6. It is Cairde’s view that minority ethnic communities, which include migrant, refugees and asylum seekers, are not being adequately supported to achieve their full potential in terms of their health. People from ethnic minorities continue experience a range of difficulties in accessing health services, and ethnic minority women in particular, in accessing maternity services. The significant element of Article 12 is the entitlements found in the context of Article 12(2)(d) which requires States to create conditions in which all people are guaranteed access to medical care in the event of sickness. It is important to note that the General Comment 14, designed to clarify the character of the rights protected under Article 12, specifically states that it would be unlawful for States to introduce measures, which would result in people being denied access to health care on any discriminatory grounds such as race or social status.

7. At present, access to medical care in Ireland depends on person’s immigration status and income. Entitlement to free or subsidized public health services is mainly based on residency and means. The population of Ireland (including migrants, residing here legally, refugees and asylum seekers) is divided into *two groups* for the purposes of eligibility for health services - *medical card holders (category I or full eligibility)* and *non-medical card holders (category II or limited eligibility)*. In general, nationals of non-EU or non-EEA countries (with the exception of Switzerland), will be regarded as ordinarily resident in Ireland if they can show the Health Service Executive (HSE) Area that they intend to live in Ireland for at least a year. The HSE Area may look for evidence that the person is legally entitled to live in Ireland for at least a year. People who are considered ‘ordinarily residents’ if not entitled to Category I (medical card) would be considered as Category II and would be entitled to a range of public health services, that are free of charge or subsidized by the Irish Government.

‘Economic accessibility’

8. In economic terms, the Irish health system is structured so that access to medical services is primarily obtained through either the provision of medical cards to those who meet the income requirements or the purchase of private health insurance. This two-tier health system has become the *de facto* norm but in the same time has created significant difficulties for migrant population of Ireland. For many migrants the question raised is the rather basic question of gaining access to healthcare, and not that relating to the quality of the health services or care provided. In current economic climate, where rates and fees for health services are on the increase it is important to ensure

that the most vulnerable are not the ones who pay the most for their health. Unfortunately, in practice, this is not the case. Cairde's health advocacy casework have shown that significant obstacles are placed in the way of migrant communities seeking access to medical care and seeking to obtain what financial support that is available.

a) Lack of coherent process of establishing migrants' entitlement to free or subsidized public healthcare

9. Current practices of establishing eligibility to free or subsidized public healthcare of migrant communities differentiate dependent on healthcare setting. While there are some general guidelines on eligibility, provided by the Department of Health and Children, there is a great deal of confusion amongst health service providers about eligibility and, from Cairde's experience, eligibility is often established within the hospital at the point of admission by the personnel with little or no relevant training. In many cases, in acute hospital setting, ethnic minority patients from outside of EU will be directed to their local Health Service Executive office to seek clarification on their entitlement in mean time charging these patients 'economic rates' as short-term visitors from outside of EU. This results in people not being able to access essential medical treatment because of their inability to pay; or the treatment being refused because of their inability to pay. This lack of coherent process with regard to the ethnic minorities' entitlement to public healthcare leads to additional financial burden on many who are living in poverty or at risk of poverty.

Case study on access to public health services for non-EU migrants

Sergey, originally from the Eastern Europe, has been living and working in Ireland for the past four years. He is a holder of a work permit and he was in taxable full time employment. As a result of an accident at work, Sergey had sustained a broken arm. He had never accessed healthcare in Ireland before. Sergey has been brought to the Accident and Emergency Department by his work colleagues and subsequently admitted as in-patient. Sergey had a complicated recovery and he was out of work for over two months. After his treatment he received a substantial bill for the medical services from the hospital. It was suggested that Sergey 'as a non-EU citizen' has to pay an economic rate for the health services provided. Sergey could not afford to pay this bill and was thinking about leaving Ireland because of that. Cairde had intervened on Sergey behalf and helped him to apply for a medical card. Sergey did not qualify for a medical or GP visit card because his income was above the threshold but he received a letter from the Health Service Executive, stating that he is an ordinarily resident in the state and entitled to use free or subsidized public health services. Sergey's medical bill was subsequently reduced by the hospital to include the statutory charges only.

b) Difficulties in accessing medical cards for certain categories of migrants

10. **Asylum seekers who are housed under Direct Provision** system are in receipt of the weekly payment of €19.10 per adult; they are also given a medical card. Asylum seekers who are choosing to leave the Direct Provision accommodation for the variety of reasons to live with friends/relatives are facing difficulties in accessing medical cards. They are effectively excluded from receiving supplementary welfare or rent allowances on a legislative basis by the virtue of Habitual Residency Condition introduced by section 17 of the Social Welfare (Miscellaneous Provisions) Act 2004. This ruling had a knock off effect on the ability to access medical card as asylum seekers who left the Direct Provision usually cannot provide sufficient evidence of their income since they do not receive any payments from the state and supported by their friends/relatives. The difficulties in satisfying 'means test' usually result in the refusal of the medical card. This means that this most vulnerable group of people effectively has no access to primary care and general practitioner service, as the costs of accessing these services are prohibitive. **Migrants who are here on student visas** as 'ordinarily residents' are eligible to access medical cards, but will face problems with renewal of their student visa as one of the conditions for renewal is a provision of private medical insurance and non-recourse to public funds. Many students who are already studying in Ireland are struggling to access general practitioner services because of costs involved.

Case study on access to a medical card for asylum seekers

*Maria is an asylum seeker. She has a teenage son who has mental health problems. They both were initially living in Direct Provision accommodation centre, but had to leave the centre due to son's mental health. The living conditions of the Direct Provision had negatively impacted on his mental health status and he had attempted suicide. Maria had chosen to refuse to be housed under direct provision and went to live with friends. Maria's weekly welfare payment (direct provision rate of 19.50 euro per week) was immediately stopped. She applied for Supplementary Welfare Allowance but was refused on the grounds that the family needs could be effectively met under direct provision. The Habitual Residency Condition was also stated as a ground for refusal. In meantime Maria's medical card had expired. Without medical card, Maria's son could not receive treatment he needed. Maria supplied her new details to the medical card section, but her medical card was refused on the grounds that Maria could not produce 'evidence of means'. As an asylum seeker, Maria did not have a bank account and was not allowed to work. Therefore she had no source of income. If Maria was in receipt of Supplementary Welfare Allowance she could use it as an evidence of her financial status. Cairde supported Maria to appeal the refusal of Supplementary Welfare Payment which was granted through the Social Welfare Appeals Office because **'the evidence indicated the existence of exceptional circumstances'**. Consequently, Cairde supported Maria to re-apply for a medical card which was also granted.*

c) Undocumented migrants and access to healthcare

11. **Undocumented migrants** have no entitlement to a medical card, as one of the requirements is to submit the evidence of your lawful presence in the state. This effectively excludes undocumented migrants from accessing primary and as consequence – secondary care in Ireland. Undocumented migrants have no entitlement to public healthcare in Ireland and in practice they have no access to the public health system either because of the requirement to prove your legal immigration status. The only recourse is to access the healthcare on private fee-paying basis (such as general practitioner service), which many cannot afford. They can also access emergency care for which they will be required to pay the full cost.

Case study on access to healthcare for undocumented migrants

*Alina was trafficked into Ireland for unpaid labour and eventually ran away from her employer. She was undocumented at this stage as her visa had expired and she never had a work permit. Alina presented with several mental health issues, including depression and sleep problems which were result of her extremely stressful situation. She was also homeless. Alina also needed additional medical care but had no money to pay for the general practitioner or other health services. As undocumented migrant she normally would not be entitled to a medical card. Cairde supported Alina to lodge an application for medical card and to negotiate with Medical Card section that this application will be fast tracked because of the client's **exceptional circumstances**.*

d) Access to maternity services for migrant women

12. Pregnant migrant women are often facing difficulties in accessing maternity services free of charge. Maternity hospitals are setting up their own rules that are varied from hospital to hospital what evidence ethnic minority (or non-Irish national) women have to present to be entitled to free maternity care. Women who cannot produce a medical card or the documents clarifying their immigration status are often required to pay for the maternity services, often at the point of registering with the hospital or on the first visit. This requirement is putting undue pressure on women who are already in a very vulnerable situation to the point that they believe that they would not be able to access maternity services because of their inability to comply with hospital requirements (i.e. to provide required information or pay the fee). Women from Romania and Bulgaria are routinely asked to present their work permits if they want to access free maternity care. This presents an additional problem for those who are self-employed; are not in employment or are employed without work permits. This requirement contradicts the State's guidelines on 'ordinarily resident' entitlement to free or subsidized public care as the decisions are made based on women's nationality and immigration status.

Case study on access to maternity services

Irena, originally from Romania, had recently given birth to her first baby in one of the maternity hospitals in Dublin. Irena has been living and working in Ireland for the past two years. She is a citizen of European Union and has a right to live in Ireland but in order to work she needs to have a work permit. Irena received a substantial healthcare bill from the maternity hospital for using maternity services. When she contacted the hospital, she was asked to produce a work permit. Until that moment, Irena was not aware that she needs a work permit in order to work in Ireland. Maternity hospital refused to accept letters from work and evidence that she paid taxes for the past two years from the Revenue. Irena contacted Cairde in distress because she could not afford to pay this bill. Cairde advised Irena that she needs to be assessed whether she is an 'ordinary resident' in Ireland. Cairde had contacted the Health Service Executive on behalf of Irena and subsequently she had applied for a medical card. Irena was awarded a GP visit card which proves that she is an 'ordinary resident' in the state. Nevertheless the hospital refused to accept this evidence retrospectively as a proof of her entitlement to public maternity service.

'Information accessibility'

a) Communications barriers when accessing primary care

13. There are significant communications barriers arising from the lack of provision of interpretation services when accessing primary care services and general practitioner services in particular. Migrants, including those with medical cards, often experience difficulties in communicating with primary care level disciplines, such as general practitioners or community welfare officers. To date there is no provisions for access to interpretation services at a primary care level have been put in place. From Cairde's experience, ethnic minority patients who have poor command of English have been asked to bring family, friends and sometimes their children to act as interpreters when accessing their general practitioners. In some instances, people were refused service because their inability to communicate with their GP. While many hospitals have developed and implemented their own interpretation policies, the situation at primary care level remains critical because interpretation services are simply not available.

III. Key National Priorities

14. The key national priorities that Cairde recommends to the government to improve the situation for migrants, refugees and asylum seekers with regard to the right to health are:

- Obligation on health service and other providers to mainstream ethnic equalities and ensure that they meet obligations under the equality laws. This is not yet the case in Ireland where legal obligations on service providers are limited to the obligation not to discriminate on ethnic or racial grounds.
- Right to healthcare to be given an explicit priority in the National Health Strategy, which should be reviewed to incorporate Right to Health and its framework.
- The government should ensure that all people living in poverty should have access to healthcare regardless of their immigration status and irrespective of their nationalities.
- The government should develop and implement a clear universal policy on access to public healthcare for all people living in Ireland. Voluntary, private and state bodies, responsible for the healthcare delivery should be monitored in terms of compliance with this policy.
- Improve access to public healthcare for marginalized and vulnerable groups including migrants, asylum seekers and refugees. Asylum seekers should have an automatic right to a medical card that does not depend on residing under Direct Provision system. All pregnant women living in the state irrespective of their immigration status should have access to free public maternity care. The measures should also include access to free accessible interpreting service when accessing all public health and social services, including general practitioners.
- Consultative mechanisms need to be developed further to involve ethnic minority communities in the planning of services and to enable patients to articulate their needs and give feedback on the quality of services received.