



EUROPEAN ROMA RIGHTS CENTRE

1386 Budapest 62, P.O. Box 906/93, Hungary
Phone: (36-1) 413-2200; Fax: (36-1) 413-2201

E-mail: office@errc.org

<http://errc.org>

October 22, 2007

Secretariat of the European Social Charter
Directorate General of Human Rights – DG II
Council of Europe
F-67075 Strasbourg CEDEX
France

Collective Complaint European Roma Rights Centre v. Bulgaria

Table of Contents

I. Admissibility

I.1. State Party

I.2. Articles Concerned

I.3. Standing of the European Roma Rights Centre

II. Subject Matter of the Complaint

II.1. Article 11, Article 13, Article E, and the Right to Health

II.2. The Factual Profile of Bulgaria's Violation of Articles 11 and 13

Independent of and/or in Conjunction with the Article E Ban on Discrimination

II.2.A. Legal Restrictions on Access to Health Insurance for Socially Vulnerable Individuals

II.2.B. Systemic Barriers for the Effective Exercise of the Right to Health Protection

II.2.C. Discrimination Against Roma in the Provision of Medical Care

II.2.D. Bulgarian Government Policies on Roma and Health Care

III. Conclusions

I. Admissibility

I.1. State Party

I.1.01. Bulgaria: High Contracting Party to the Revised European Social Charter (hereafter “RESC”) since August 1, 2000; and accepted supervision under the collective complaints procedure provided for in Part IV, Article D, paragraph 2 of the Charter in accordance with the Additional Protocol to the ESC providing for a system of collective complaints from 9 November 1995.

I.2. Articles Concerned

I.2.01. Article 11 -- The right to protection of health: “With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia:

- 1 to remove as far as possible the causes of ill-health;
- 2 to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
- 3 to prevent as far as possible epidemic, endemic and other diseases.”

I.2.02. Article 13, Paragraphs 1, 2 and 3 – The right to social and medical assistance¹: “With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

- 1 to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;
- 2 to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
- 3 to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want. [...]”

I.2.03. Read independently and/or in conjunction with:

Article E: “The enjoyment of the rights set forth in this Charter shall be secured without discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national extraction or social origin, health, association with a national minority, birth or other status.”

I.3. Standing of the European Roma Rights Centre

I.3.01. The European Roma Rights Centre (hereinafter “ERRC”) is an international non-governmental organisation, which has consultative status with the Council of Europe and is among organisations entitled to lodge collective complaints under the ESC/RESC mechanism. Under Part IV, Article D, referring to the provisions of the second additional protocol, Parties recognise the right of international non-governmental organisations which have consultative

¹ Bulgaria has not accepted para.4 of Art.13.

status with the Council of Europe and are listed as having standing before the ESC/RESC mechanism to submit collective complaints to the European Committee of Social Rights, irrespective of whether the organisations concerned come under the jurisdiction of any of the State Parties to the ESC/RESC. The ERRC has had standing with the ESC/RESC collective complaint mechanism since June 2002.²

I.3.02. In addition, under Article 3 of the Second Additional Protocol to ESC, the international non-governmental organisations referred to in Article 1(b) may submit complaints with respect to those matters regarding which they have been recognised as having particular competence.

I.3.03. The ERRC is a Budapest-based international public interest law organisation which monitors the human rights situation of Roma in Europe and provides legal defence in cases of abuse. Since its establishment in 1996, the ERRC has undertaken first-hand field research in more than a dozen countries, including Bulgaria, and has disseminated numerous publications, from book-length studies to advocacy letters and public statements. In 2006, the ERRC published the report “Ambulance Not on the Way: The Disgrace of Health Care for Roma in Europe” which is based, among others, on targeted research into access of Roma to health care in Bulgaria carried out in 2002-2005.³ The present Collective Complaint uses the findings of previous research in Bulgaria which has been updated and elaborated by analysis of the situation of Roma in the health care system carried out in 2006 by the ERRC in cooperation with the Sofia-based Bulgarian Helsinki Committee (BHC). The BHC is an independent non-governmental organisation for the protection of human rights. The objectives of the Committee are to promote respect for the human rights of every individual, to stimulate legislative reform to bring Bulgarian legislation in line with international human rights standards, to trigger public debate on human rights issues, to carry out advocacy for the protection of human rights, and to popularise and make widely available human rights instruments.

I.3.04. The ERRC has also undertaken extensive litigation activities in Bulgaria, including into matters related to the concerns raised in this Collective Complaint, and during the period 2004-2005 it has been involved in a targeted anti-discrimination litigation project in Bulgaria in cooperation with the Sofia-based Romani non-governmental organisation Romani Baht and the Bulgarian Helsinki Committee, with funding support from the Foreign and Commonwealth Office of the Government of the United Kingdom. ERRC publications on Bulgaria and other countries, as well as additional information about the organisation, are available on the Internet at: <http://www.errc.org>.

II. Subject Matter of the Complaint

II.1.01. Under the RESC Bulgarian government is obliged to ensure the protection of health by removing as far as possible the causes of ill-health; by providing advisory and educational facilities for the promotion of health; and by encouraging individual responsibility in matters of health (Article 11 (1,2,3,)). Furthermore, the government is obliged to ensure the right to social and medical assistance by ensuring that any person who is without adequate resources and who

² See letter from the Secretariat General of the Council of Europe to Mr Claude Cahn, European Roma Rights Center, 14 June 2002.

³ A hard copy of the report is appended to this complaint. The report can also be accessed through the ERRC website at: <http://www.errc.org/db/01/E6/m000001E6.pdf>.

is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition (Article 13 (1)).

II.1.02. At issue in this Collective Complaint is exclusion of large numbers of Roma from access to health care services due to exclusion from health insurance coverage; lack of systematic and effective government policies to address the disproportionate health risks affecting Romani communities; and lack of measures to eliminate widespread discriminatory practices against Roma in the provision of health services. The health status of Roma is markedly inferior as compared to the health status of other ethnic groups in Bulgaria. Persisting social and economic inequalities condition poor health among Roma and pose serious barriers for members of this minority to access health care. The impact of structural inequalities on the health of Roma is aggravated by adverse impact of health insurance legislation excluding many Romani individuals from health insurance coverage and from access to a range of health services respectively. Access to quality health services for Roma is furthermore frustrated by widespread discriminatory practices on the part of health care practitioners manifested as denial of medical assistance and/or provision of inadequate health services.

II.1.03. The ERRC claims that the Bulgarian state is in violation of its obligations under Articles 11 and 13, in relation to Article E of the RESC, because the Bulgarian state has failed to eliminate the disparate impact of health insurance legislation on certain groups in society as well as tolerates policies and practices which undermine the protection of health of members of the Romani communities in Bulgaria. In particular:

- Bulgarian legislation does not guarantee health insurance coverage for the most vulnerable individuals, especially long-term unemployed people, a disproportionate number of whom are Romani. Lack of health insurance restricts access to health care;
- The Government has not undertaken effective measures to mitigate the adverse effect on health status of Roma and their access to health services of socio-economic determinants such as poverty, poor housing and sanitary conditions, and low educational levels;
- Systematic discriminatory practices such as segregation of Romani women in maternity wards, denial of emergency aid services to Roma, and denial of other types of medical care are not addressed by the government.

II.1.04. In its Conclusions XVII-2/2005, the European Committee of Social Rights (“the Committee”) made the following observation regarding Article 11 of the Charter: “In assessing whether the right to protection of health can be effectively exercised, the Committee pays particular attention to the situation of disadvantaged and vulnerable groups. Hence, it considers that any restrictions on this right must not be interpreted in such a way as to impede the effective exercise by these groups of the right to protection of health. This interpretation imposes itself because of the non discrimination requirement (Articles E of the Revised Charter and Preamble of the 1961 Charter) in conjunction with the substantive rights of the Charter. The Committee therefore assesses the conditions under which the whole population has access to health care, taking into account also the Council of Europe Parliamentary Assembly Recommendation 1626 (2003) on "reform of health care systems in Europe: reconciling equity, quality and efficiency", which invites member states to take as their main

criterion for judging the success of health system reforms effective access to health care for all, without discrimination, as a basic human right.”⁴

II.1.05. Recalling previous case law, the Committee has noted that “Article E not only prohibits direct discrimination but also all forms of indirect discrimination”. The Committee further stated that “indirect discrimination may arise by failing to take due and positive account of all relevant differences or by failing to take adequate steps to ensure that the rights and collective advantages that are open to all are genuinely accessible by and to all”. Furthermore, the Committee noted that “[...] in the case of Roma families, the simple guarantee of equal treatment as the means of protection against any discrimination does not suffice. As recalled above, the Committee considers that Article E imposes an obligation of taking into due consideration the relevant differences and acting accordingly. This means that for the integration of an ethnic minority as Roma into mainstream society measures of positive action are needed.”⁵

II.1.06. In its 2005 Conclusions on Bulgaria’s compliance with the RESC, the Committee found non-compliance with Article 11(1) of the RESC on the grounds, among others, that “infant mortality rate was manifestly too high”.⁶ As of the time this Collective Complaint was submitted, existing evidence indicates that the levels of infant mortality among Roma are much higher than among ethnic Bulgarians.⁷

II.1.07. Access to health care and healthy lifestyle for Roma is in direct relation to the housing situation of this minority group. The European Committee of Social Rights has already found Bulgarian state in violation of the RESC concerning the housing situation of Roma. In March 2007, the Committee announced its decision on the Collective Complaint *European Roma Rights Centre v. Bulgaria* which found a violation of Article 16 in relation to Article E of the RESC due to:

- Romani families being disproportionately affected by legislation which limits the possibility of legalising illegal dwellings;
- The inadequate housing conditions and lack of amenities experienced by Romani families; and
- The systematic eviction of Roma from their homes without providing them with adequate alternative housing.⁸

II.1.08. Prior to elaborating the facts relevant to the claimed violation of the RESC by the Bulgarian state, a discussion of the content of two key elements upon which the rationale of the complaint is based, follows below:

(i) The content of the right to the highest attainable standard of health under international law;

⁴ See General Introduction, European Social Charter European Committee of Social Rights Conclusions XVII-2 Volume 1, Council of Europe Publishing, pp. 10-11.

⁵ European Committee of Social Rights, *European Roma Rights Centre v. Bulgaria*, Complaint No 31/2005, Decision on the merits, 18 October 2006.

⁶ See European Committee of Social Rights, Conclusions 2005, Bulgaria, at: http://www.coe.int/t/e/human_rights/esc/3_reporting_procedure/2_recent_conclusions/1_by_state/Bulgaria_2005.pdf

⁷ See below discussion under II.2.B. Systemic Barriers for the Effective Exercise of the Right to Health Protection.

⁸ The full text of the decision is available at: <http://www.errc.org/cikk.php?cikk=2736&archiv=1>

(ii) The ban on discrimination -- including racial discrimination -- in access to health care;

The Right to Health

II.1.09. The right to health is guaranteed by a number of international law instruments. The most comprehensive statement is provided by the International Covenant on Economic, Social and Cultural Rights (ICESCR).⁹ Article 12.1 of the Covenant, States parties recognise "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". In its General Comment No 14, the UN Committee on the Economic, Social and Cultural Rights (CESCR) interprets the right to health, as defined in Article 12.1, as "an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health." The General Comment lists the following components of the right to health:

Availability. Functioning health care facilities, services, and programs, must be available in sufficient quantity within the country. These include safe and potable drinking water, adequate sanitation facilities, health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs.

Accessibility. Accessibility has four overlapping dimensions:

- Non-discrimination: health facilities, goods, and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact. For example, investments should not disproportionately favour expensive curative health services, which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.
- Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as women. Medical services, safe and potable water, and adequate sanitation facilities must also be within safe physical reach in rural areas and for persons with disabilities.
- Economic accessibility: health facilities, goods, and services must be affordable for all. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
- Information accessibility: everyone has the right to seek, receive and impart information and ideas concerning health issues.

Acceptability. All health facilities, goods and services must be respectful of medical ethics and sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned.

⁹ Bulgaria ratified the ICESCR on 3 January 1976.

Quality. Health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

II.1.10. As one of the internationally guaranteed social rights, the right to the highest attainable standards of physical and mental health is subject to progressive realisation, i.e. it is acknowledged that States may not be able to ensure instant realisation of the rights contained within the ICESCR due to the limits of available resources. The principle of non-discrimination in the exercise of the right to health is not subject to progressive realisation but has immediate effect. States have immediate obligations to guarantee that the right to health is exercised without discrimination of any kind and to take steps towards the full realisation of Article 12. Article 2.2 and Article 3 of the ICESCR proscribe any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The CESCR General Comment 14 provides that resource constraints cannot be a justification for not protecting vulnerable members of society from health related discrimination stressing that “many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information” (Paragraph 18). Non-discrimination further requires that equality of access to health care and health services has to be emphasised. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health (Paragraph 19).

In order to give effect to the right to health without discrimination, States are required to undertake the following:

- To abolish laws and policies which deny access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination and to abstain from enforcing discriminatory practices as a State policy (Paragraphs 19, 34, 50);
- To adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct (Paragraph 35);
- To adopt national health policies and detailed plan for realizing the right to health prioritizing the needs of vulnerable and disadvantaged individuals and communities (Paragraphs 20-27, 36)
- To undertake positive action in favour of individuals and communities unable, for reasons beyond their control, to realize the right to health themselves by the

means at their disposal, including by providing them with the necessary health insurance and health-care facilities (Paragraphs 19, 37, 52).

II.1.11. The prohibition of discrimination in the exercise of the right to health is further set out in the International Convention on the Elimination of All Forms of Discrimination (ICERD), the International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC).¹⁰ ICERD obliges States Parties to pursue, by all appropriate means and without delay, a policy of eliminating racial discrimination in all its forms.¹¹ Specifically, States Parties must guarantee the right of everyone, without distinction as to race or ethnicity, to equality before the law in the enjoyment of economic, social and cultural rights. This obligation applies expressly to the right to public health, medical care, social security and social services.¹² States parties to the CEDAW committed themselves to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality of men and women, access to health care services, including those related to family planning as well as to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.¹³ The CRC contains a general prohibition of discrimination in the exercise of the rights guaranteed by the Convention, irrespective of, among others, the child's or his or her parent's or legal guardian's race, national or ethnic origin, birth or other status¹⁴, as well as an obligation of States to ensure that no child is deprived of his or her right of access to health care services.¹⁵

II.1.12. Within the Council of Europe framework, Protocol No. 12 to the European Convention on Human Rights and Fundamental Freedoms (ECHR), which entered into force in April 2005, strengthens the guarantees with regard to equality and non-discrimination in the European Convention on Human Rights and Fundamental Freedoms (ECHR) by providing an independent prohibition of discrimination on a non-exhaustive list of grounds.¹⁶

II.1.13. Finally, at EU level, the Race Equality Directive includes an express prohibition of direct and indirect discrimination in a broad range of fields including social security and healthcare, and access to and supply of goods and services which are available to the public.¹⁷ The Directive defines direct discrimination to occur where one person is treated less favourably than another is, has been or would be treated in a comparable situation on grounds of racial or ethnic origin. Indirect discrimination occurs where an apparently neutral provision, criterion or practice would put persons of a racial or ethnic origin at a particular disadvantage compared with other persons, unless that provision, criterion or practice is objectively justified by a legitimate aim and the means of achieving that aim are appropriate and necessary.¹⁸

¹⁰ Bulgaria ratified the ICERD on 4 January 1969; the CEDAW on 10 March 1982; and the CRC on 3 July 1991.

¹¹ ICERD, Article 2.

¹² ICERD, Article 5(e)(iv).

¹³ CEDAW, Article 12.

¹⁴ CRC, Article 2(1).

¹⁵ CRC, Article 24.

¹⁶ Bulgaria ratified the ECHR on 7 September 1992. Protocol 12 of the ECHR has not been signed by Bulgaria as of the date this Collective Complaint was submitted.

¹⁷ Council Directive 2000/43/CE “implementing the principle of equal treatment between persons irrespective of their racial or ethnic origin”, Article 3(e). In 2003 Bulgarian Parliament adopted The Protection against Discrimination Act transposing the EC Directive 2000/43. The Act has been in force since 1 January 2004.

¹⁸ Council Directive 2000/43/CE, Article 2(a) and 2(b).

II.2. The Factual Profile of Bulgaria's Violation of Articles 11 and 13 Independent of and/or in Conjunction with the Article E Ban on Discrimination

II.2.01. On the basis of first-hand information obtained from Roma individuals, health care professionals, and civil society organisations as well as analysis of relevant domestic legislation and policies, the ERRC contends that the Bulgarian state does not meet its obligations under the Revised European Social Charter to protect health and provide medical assistance to individuals without adequate resources, without discrimination on the basis of ethnicity. Many Roma in Bulgaria do not have health insurance due to unemployment, low income, and ineligibility for state-provided health insurance. Lack of health insurance for poor people means lack of access to a range of health services. The health status of Roma is drastically inferior as compared to non-Roma; lack of adequate governmental policy has contributed to the progressive social exclusion of Roma in the past 15 years and to high levels of poverty among the members of this ethnic minority. Exclusion from the labour market and discrimination in housing directly affect the access of Roma to health care services as well as increase the health risks for Roma. The government has not undertaken adequate measures to combat discriminatory practices against Roma in the health care system such as refusal of individual health care practitioners to provide medical services to Roma, failure of emergency services to go to Roma neighbourhoods, placement of Romani women in separate rooms in maternity wards, under inferior conditions, and others.

II.2.A. Legal Restrictions on Access to Health Insurance for Socially Vulnerable Individuals

II.2.02. Bulgarian law guarantees state-provided health insurance for socially vulnerable individuals. Eligibility for state-provided health insurance is conditioned on eligibility for social aid for the poor or eligibility for unemployment benefits. A large number of socially vulnerable individuals, and a disproportionately large number of Roma among them, do not receive social aid for the poor and are not registered as unemployed. These persons do not have access to state-provided health insurance. Many of these low income individuals cannot use health services, except emergency aid, due to the fact that, according to the Bulgarian Health Insurance Act, persons who have no health insurance pay for the medical services they receive. The high level and chronic nature of unemployment among the Roma results in high proportion of Romani individuals without health insurance. According to official estimates, around 46% of Roma are not covered by health insurance.¹⁹ According to information provided to the ERRC by Romani organisations in different towns throughout Bulgaria in 2005, the percentage of Roma without health insurance ranged between 40-90%.

II.2.03. Access of socially vulnerable individuals to health insurance and health care in general is further restricted by recent amendments to the Social Assistance Act. According to the Social Assistance Act, Article 12(b)(2) in force from 1.06.2006, socially vulnerable individuals receive social aid for a period of 18 months. After this period, they lose the right to social aid for one year. In case that persons formerly on social aid remain unemployed during the year in which they are not entitled to social aid, they will not have access to state-provided health insurance either, according to the provisions of the Health Insurance Act.

¹⁹ See *Health Strategy Concerning People in Disadvantaged Position, Belonging to Ethnic Minorities*, p.2. The document is available at: <http://www.ncedi.government.bg/en/HealthStrategyENG.htm>. Last visited 1 October 2007.

II.2.04. Health insurance coverage in Bulgaria is regulated by the Health Insurance Act²⁰ which provides for compulsory and voluntary health insurance. Compulsory health insurance guarantees free access to a package of health services, and is administered by the National Health Insurance Fund and carried out by its territorial divisions - the 28 Regional Health Insurance Funds. The voluntary health insurance is optional and is carried out by shareholder companies, registered according to the Commercial Law. Every Bulgarian citizen is subject to compulsory health insurance (Article 33) which is funded primarily from payroll-based contributions provided according to a ratio defined by law by employers and employees. For 2006 and 2007 this ratio was 65:35.

II.2.05. According to the Health Insurance Act, several groups of individuals are insured by the state and municipal budgets, including unemployed individuals who receive unemployment benefits (Article 40, para 1(8)) and individuals who meet the requirements for monthly social assistance for the poor (Article 40, para 2 (5)). These provisions do not benefit many Roma, especially long-term unemployed. Long-term unemployed individuals, a large number of whom are Roma, are not registered or dropped out of the registers of unemployed individuals, and therefore they do not receive unemployment benefits. Likewise, many Roma whose income would qualify them for monthly social aid have lost the right to receive such aid. Individuals who do not receive unemployment benefits and monthly social aid for the poor, are not eligible for state-provided health insurance either.

II.2.06. Although lack of health insurance is not only a problem affecting Roma, exclusion from health insurance disproportionately impacts the Romani population due to the fact that Roma are disproportionately represented among Bulgaria's unemployed and poor population.²¹ For poor people, lack of health insurance means in practice exclusion from access to health services, because individuals without health insurance are supposed to pay for all health services, except for emergency health care.²²

II.2.07. The reasons why many Roma, who are poor and should have the right to state-provided health insurance cannot exercise this right can be summarised as follows:

- Lack of information about the right to state-provided health insurance: With the entry in force of the 2003 Health Insurance Act amendments²³ on provision of health insurance for socially vulnerable people from the state budget, many Roma were not aware of the requirement to submit an application for state-provided health insurance in addition to the application for social aid. Persons who did not submit applications for state-provided health insurance were registered as persons who are self-insured. In the course of several months, in some instances more than a year, Roma who did not

²⁰ Health Insurance Act, Published in State Gazette, No 70 of 9.06.1998, available in Bulgarian language at the website of the Ministry of Health:

http://www.mh.government.bg/norm_acts/zakoni_05_06_2007/Zakon_zdravno_osiguryavane.rtf. Last visited 1 October 2007.

²¹ Ministry of Health Report *The State of Health of the Nation in the 21st Century* provides the following information: "Bulgarians constitute 40% of the poor people in the country, which means that the other ethnic groups constitute the remaining 60% of the poor population. Particularly high levels of poverty is found among Roma, who constitute almost half of the poor population (46.5%), while the Turks are 12.8%. In comparison to Bulgarians, a person of Romani background is ten times more likely to be poor." Ministry of Health, August 2004. (Unofficial translation from Bulgarian by the ERRC). Available in Bulgarian language at: http://www.mh.government.bg/program_and_strategies.php. Last visited 1 October 2007.

²² Article 52 of the Health Insurance Act.

²³ Amendment to the Health Insurance Act published in State Gazette No 119/2002 in force from 01.01.2003.

submit applications for state-provided health insurance but believed that their health insurance is paid by the state budget, accumulated debts to the health insurance fund. These individuals have to pay their debts before they can restore their health insurance rights. For people who are unemployed or have low income this is not possible.

- Lack of registration as unemployed in labour offices: Long-term unemployed persons, among whom Roma constitute a considerable part, have dropped out of the registration of unemployed persons in the labour offices. Many Roma have never even registered with labour offices. Consequently, these individuals do not qualify for the provision of state-provided health insurance according to Article 40(8), Health Insurance Act.
- Ineligibility for social aid: Many Roma have lost the right to social aid or receive it irregularly. According to the Health Insurance Act, only individuals who meet the requirements for monthly social aid are eligible for state-provided health insurance, Article (40, para 2(5)). The fact that many Romani individuals do not receive social aid, however, does not necessarily mean that they are not eligible for it or that they have sufficient income to be able to pay compulsory health insurance. Losing the right to social aid can result from a complex of reasons, including arbitrary decisions of civil servants responsible for making the assessment of social aid need.

II.2.08. While health insurance alone cannot ensure that patients will obtain all needed services, it can help protect individuals and families from the costs of illness and routine health maintenance. Lack of health insurance coverage and a usual source of care have both been associated with lower utilisation of preventive and disease management health services. A number of Roma interviewed by the ERRC in the course of research in 2005 declared that they had not used any medical services for one year or more due to lack of health insurance and lack of means to pay for such services: “Two years ago I was in hospital because I had problems with my thyroids. Since then I have not been to a doctor because I owe 800 leva [approximately Euro 400] for my health insurance. My GP²⁴ struck me off the list of his patients and if I went to a specialist, I would have to pay.”²⁵ Other uninsured Roma stated that they could pay for occasional checks by doctors but hospital care was unaffordable: “I have a breast cyst and often experience pain in my breast. I pay for consultations with a doctor almost every month. The GP in the neighbourhood also agreed to examine me although I do not have health insurance. However, I could not afford to go for surgery as recommended, because I am unemployed and a single mother and would have to pay out of my own pocket.”²⁶

II.2.09. ERRC/BHC research in the town of Sliven in 2006 revealed that in the Romani neighbourhood Nadezhda, there are around 12,000-13,000 individuals over 18 years, 6,000-8,000 of whom are of working age and capable to work. According to local experts and NGO activists, approximately 70% of the working age individuals should be in the social assistance system, and receive state-provided health insurance respectively. In fact, many of these individuals have lost the right to social aid and thence for state-provided health insurance. At the same time they have no regular job, i.e. are not insured by an employer. Due to the fact

²⁴ The General Practitioner – or “GP” – is a primary health provider offering a wide range of services to patients. Patients can register with a GP if they have health insurance or as private patients in which case they are supposed to pay for the GP’s services. It is a GP’s assessment whether the patient requires specialist care in which case the GP refers them to the respective health professional. GPs thus act as “gatekeepers” to the wider health system, such as hospitals and specialised clinics.

²⁵ ERRC interview with 46-year-old A.C., Novi Pazar, Bulgaria.

²⁶ ERRC interview with 32-year-old D.K. from Plovdiv, Bulgaria.

that these individuals live on low and irregular income they cannot pay their compulsory health insurance.

II.2.10. The problem with lack of health insurance is recognised by the government *Health Strategy Concerning People in Disadvantaged Position Belonging to Ethnic Minorities* which formulated as one of its strategic objectives, “Expansion of the coverage of health insured people in disadvantaged position, belonging to ethnic minorities by undertaking of legislative initiatives in respect of the health insurance of socially weak people, inclusive of permanent unemployed ones.”²⁷ This strategic objective is replicated in the Action Plan of the *Health Strategy 2006-2007* which envisages legislative initiatives to settle the issue of non-contributory health insurance for poor and socially weak people. As of the date this Collective Complaint was submitted, the measures undertaken in this direction are two government decrees, adopted in 2006 and 2007, providing coverage of hospital treatment costs for persons with no income. These measures are not efficient because they do not provide a long-term solution to the problem and do not ensure adequate access to health care for persons who do not have health insurance. The measures and their effect are explained in the paragraph below.

II.2.11. In 2006 and 2007, Bulgarian government adopted two decrees for the allocation of funds for hospital treatment of persons with no income.²⁸ The effect of these measures on ensuring access to health care for Roma and other poor people without health insurance has been minimal. In the first place, the nature of the legislative act by which this issue is regulated does not guarantee a long-term solution to the problem. Each of the decrees has been issued for a term of one year only.

Furthermore, the two decrees have a limited scope covering expenses for hospital treatment only. Other expenses, including but not limited to primary outpatient medical and dental care and specialised outpatient medical and dental care, are not covered according to the decrees. Hospitalisation of a patient, except for emergency situations, is to be recommended by a specialist. Referral to a specialist is to be issued by the General Practitioner (GP). Thus, if a person does not have health insurance and cannot afford the cost of an examination by a GP and/or by a specialist, he/she is not likely to have access to hospital either.

Finally, it is alleged that a complicated bureaucratic procedure for reimbursement of the hospital treatment costs has made the decrees’ measures ineffective. The beneficiaries must fulfil numerous requirements in order to prove that they have no means to cover the treatment themselves. The decrees are applied only for inpatient medical care expenses that had already been provided, i.e. the patient must have been already admitted for treatment. However, people often do not know that such option exists and they do not even ask or seek inpatient treatment due to lack of money. For example, according to Dr Panayotov, a General Practitioner serving Roma from the Romani neighbourhood Nadezhda in the town of Sliven, not more than 25 people from the neighbourhood succeeded in taking advantage of this assistance in 2006, while about 50% of all Roma from the neighbourhood, or approximately 4,000-5,000 individuals, did not have health insurance.²⁹ Dr Panayotov further testified that

²⁷ See *Health Strategy Concerning People in Disadvantaged Position, Belonging to Ethnic Minorities*, p.12.

²⁸ Council of Ministers Decree No 13/30.01.2006 published in State Gazette No 12/7.02.2006 and Council of Ministers Decree No17/31.01.2007 published in State Gazette No 13/9.02.2007 defining the terms for the spending of designated means for diagnostics and treatment in medical establishments for hospital aid of Bulgarian citizens with no income and/or personal property.

²⁹ ERRC/BHC interview with Dr Stefan Panayotov, October 25, 2006.

due to the complicated bureaucratic procedure, Roma without health insurance who need hospital treatment receive ambulatory treatment instead which leads to complications of their health condition.

II.2.12. Failure of the government to ensure universal access to health insurance coverage denies a large number of Roma access to health care. This problem remains unaddressed by the government despite the fact that it is acknowledged in various government documents. Unless the problem of access to health insurance is solved, various measures aimed at improving access to health care for Roma are bound to have only minimal effect. Romani activists commented on the situation:

The municipality pays for a medical room close to one of the Romani neighbourhoods in the town. It is true that this is more convenient than going to a doctor in the centre of the town, but the problem is that people without health insurance cannot use the services of the General Practitioner who is based in the neighbourhood. No one pays the doctor to serve uninsured people and most of the Roma here do not have health insurance.³⁰

II.2.B. Systemic Barriers for the Effective Exercise of the Right to Health Protection

II.2.13. High levels of social exclusion have resulted into a steadily deteriorating health status of Roma. The average life expectancy of Roma is more than 10 years lower than the average for the country. Death occurs among Roma much earlier than among the rest of the population. The mortality peak among them is between 40 and 49 years of age. The infant mortality rate for the period 2001 – 2003 among Roma was 28.0 per 1000 births; among ethnic Bulgarians it was 9.9/1000; and among ethnic Turks it was 17/1000.³¹

II.2.14. According to the summarised data of a survey conducted by the demoscopic Fact-Marketing agency on the basis of 1,527 Romani households, in about 80% of the households there was a person with a disease; in half of the households there was a chronically ill person; and in one-fifth of the households there were two or more chronically ill persons.³²

II.2.15. During the last years, as a consequence of progressive impoverishment, malnutrition and poor hygiene in the compact Romani neighbourhoods, the problem of infectious diseases among the Roma in Bulgaria became very pressing. A central place among these diseases is occupied by tuberculosis. According to a 2002 study, Roma were most frequently affected by tuberculosis, after the return of this disease in Bulgaria in the beginning of the 1990s. Data from the Sofia city hospital specialised for treatment of tuberculosis provided by researchers

³⁰ ERRC interview with Nikolay Yankov, Neve Drom organisation, June 2005, Shumen, Bulgaria.

³¹ Data from the National Statistics Institute quoted in the government *Health Strategy Concerning People in Disadvantaged Position Belonging to Ethnic Minorities*.

³² Fakt Marketing, *Osiguriavane dostapa na maltsinstvata do zdraveopazvane 2002-2003*, p. 17.

According to the survey the ten most frequently encountered health problems and diseases are: arterial hypertension (8 percent), pneumonias (5 percent), discopathies (4 percent), pyelonephritis (3%), ischemia of the heart (3%), renal calculus disease (3 %), viral hepatitis, chronic bronchitis, bronchial asthma (2 percent), ulcer of the duodenum (2 percent). About 1 percent of those living in the visited Roma households was registered with tuberculosis. In one fourth of the visited households there was a person with a certain degree of disability (invalidity of 50 percent or more).

indicate that 30 percent of the patients with tuberculosis were Roma.³³ According to the testimony of Dr Mimi Dimitrova from the specialized hospital for active treatment of pulmonary diseases in Sliven, 60% of the patients were Roma.³⁴

II.2.16. Poverty is a key determinant of Roma access to health care as well as of their health status. Usually, poor people cannot take proper care of their health and except in case of emergency cannot afford the services of a doctor, let alone hospital treatment. A number of studies on poverty have indicated the ethnic dimension of poverty in Bulgaria. For example, in 2002 the World Bank has noted that, “The differences in the level and depth of poverty across ethnic minorities are remarkable, particularly for Roma. A Roma individual is ten times more likely to be poor than an ethnic Bulgarian, while poverty rates for Bulgarian Turks are four times higher than for ethnic Bulgarians. Although Roma only represent 8.8 percent of the individuals in the sample, they constitute half of the poor. As well as being more likely to be poor, Roma are also much poorer on average than their non-Roma counterparts, as they alone are responsible for almost three quarters of the poverty depth index.”³⁵

II.2.17. The disproportionate impact of poverty on Roma access to health care is also explained by the Bulgarian government in the document *Health Strategy Concerning People in Disadvantaged Position Belonging to Ethnic Minorities*: “The poverty with people of Turkish community is three times more frequent than with Bulgarians and with people of Roma origin it is 11 times higher than the one with people of the Bulgarian ethnic community. This fact directly affects the state of health with the representatives of such minority communities, who more often eat inadequately, experience more difficulties to self-insure in the cases when they are not insured at the expense of the state budget, and they hardly can find money to pay the medical cares and medications. In 2002 the share of the people not able to pay the needed medical cares and drugs, reached up to 47% with Bulgarian citizens of Turkish origin and up to 62% with those of Roma origin.”³⁶

II.2.18. Exclusion of Roma from the labour market is directly responsible for the high levels of poverty and social exclusion in general. The government document Operational Program “Human Resources Development”, acknowledged that long-term unemployment among Roma is the reason why 65-70% of this population lives under the poverty line.³⁷ There is no effective government policy to combat exclusion of Roma from the labour market. Programmes targetting the supply side – Roma of working age, are fragmented, short-term and have not produced any visible reduction of the numbers of Roma excluded from the labour market. On the other hand, the Bulgarian government has not created legal and policy mechanisms to ensure that employers – public and private – undertake proactive measures to include underrepresented groups in their workforce.³⁸

³³ Turnev, I., Kamenov, O., Popov, M., Makaveeva, L., Alexandrova, V. 2002. "Common Health Problems Among Roma - Nature, Consequences, and Possible Solutions." Open Society Foundation, Sofia, p.12

³⁴ *Ibid.*

³⁵ Bulgaria Poverty Assessment, October 29, 2002, Report № 24516, Document of the World Bank, p.17

³⁶ See *Health Strategy Concerning People in Disadvantaged Position, Belonging to Ethnic Minorities*.

³⁷ Ministry of Labour and Social Affairs. Operational Program “Development of Human Resources, 2007-2013”. June 2007, p. 22.

³⁸ For an analysis of the government policies on Roma in the field of employment in Central and Eastern Europe, see the ERRC report “The Glass Box: Exclusion of Roma from Employment”, available at: <http://www.errc.org/db/02/14/m00000214.pdf>.

II.2.19. A further barrier for poor people to access health care is posed by the out of pocket costs for health care services which are to be paid in addition to health insurance.³⁹ According to Fact Marketing's data, the "user fee" of 1 BGN⁴⁰ (equivalent to Euro 0.5 in 2001 when the research was made) was a problem for many Roma: 21.4% of the Roma declared they are not able to pay it, compared to 4.1% ethnic Bulgarians and 7.3% ethnic Turks. About 30% of the ethnic Bulgarians, 20% of the Turks and only 10% of the Roma pay without difficulties the total sum of several fees of 1 BGN, payable when the patient needs to make tests and to visit a specialist.⁴¹

II.2.20. Each seventh of the respondents in the Fact Marketing survey expressed concern about the prices of medicines. Where the medicines are really vital, in the households with a chronically ill person, the discrepancy between the income and the costs for treatment also gives rise to anxiety. Among the Turks the share of those, who cannot pay for the needed medical services and medicines, reaches 34 percent, while among the Roma it is 45 percent. Nine tenths of the Roma in the poorest neighbourhoods complain that due to the prices of the medicines they frequently cannot afford any treatment. If the children are ill, the parents try to buy at least some of the medicines."⁴²

II.2.21. Poor living conditions of the prevailing part of Roma in Bulgaria, including substandard housing, unhygienic environment, and segregated communities excluded from public services, are another key determinant of access to health and health status.

II.2.22. The *National Programme for Improvement of the Living Conditions of Roma in the Republic of Bulgaria for the period 2005-2015* provides a fair summary of the living conditions of many Roma: "During the last 15 years the living conditions of increased number of Roma have permanently deteriorated. The prevailing part of the buildings has been constructed with available materials, illegally, in violation of the organizational plans (where such plans exist), the street network and the public utility infrastructure are in bad condition and this turns the Roma districts in ghettos. The overcrowded dwellings and the increase of the population density put a pressure on the servicing systems, which themselves are insufficient and provide services to only 46 % of the population in the Roma districts. This further results in bad hygiene conditions and health risks for the population, as well as in social tension. There is a great difference between the levels of the public utilities provision for Roma dwellings and for the dwellings countrywide. By level of provision with infrastructure the Roma districts can be divided into two groups – those having only electricity supply and those having electricity and water main, but no sewage system."⁴³

II.2.23. Compact Romani neighbourhoods are characterised by poor sanitary conditions. A 2002 research on the health problems of Roma made the following observations: "In the Roma ghettos the garbage is deposited into big rotting heaps on the narrow streets and is constantly carried around by dogs, pigs and children, and the space behind the homes is often used as "an open air closet". On many places, because of cracked pipelines, water is gushing among mounds of garbage and small children are drinking it. In many Roma neighbourhoods

³⁹ One of the official out of pocket costs is the user fee. It is fixed at 1 percent of the minimal monthly remuneration and is payable by the patient on each visit to a doctor.

⁴⁰ The amount of the user fee is 1% of the minimal salary for the country. In 2007, the user fee is BGN 1.80 (approximately Euro 0.90).

⁴¹ Data quoted in Fact Marketing, *Osiguriavane dostapa na maltsinstvata do zdraveopazvane 2002-2003*.

⁴² Ibid., Appendix 4, p. 140.

⁴³ See "National Programme for Improvement of the Living Conditions of Roma in the Republic of Bulgaria for the Period 2005 – 2015", accessible at: <http://www.ncedi.government.bg/>

in the small towns and in many villages, the Roma still do not have electricity. Such horrible hygiene conditions may be found in many of the Roma ghettos around the country: the neighbourhood “Nadezhda” in Sliven, the “Sixth” neighbourhood in Nova Zagora, “Rayna Knyaginya” in Yambol, “Humata” in Lom etc.” Therefore (because of the bad hygiene conditions in the majority of the Roma neighbourhoods) – the infectious diseases are much more frequent in the Roma neighbourhoods.”⁴⁴ The researchers further noted that according to more than half of the interviewed Roma (approximately 55 percent), the municipality (or the contracted private companies) take no care of maintaining the hygiene in the neighbourhood, where they live. Just one out of ten persons asked estimated the activities, related to cleaning the neighbourhood, as sufficient.⁴⁵

II.2.24. As a result of poor sanitary conditions, Roma neighbourhoods often experience outbreaks of viral infections such as hepatitis, poliomyelitis and diphtheria. In 2006, three Romani neighbourhoods in Plovdiv were affected by hepatitis A epidemic. By November 2006, over 1,400 individuals from the three neighbourhoods, mostly children, were infected; 980 individuals were hospitalised, out of which over 800 were children. While the first cases of hepatitis were discovered in late June 2006, vaccines from the Ministry of Health were provided only in the beginning of October 2006.⁴⁶

II.2.25. According to reports, in 1994, about 90 Romani children from Nadezhda neighbourhood in Sliven, the village of Sotirya and the town of Straldja were affected by poliomyelitis. The epidemic reportedly took a very grave course and most of the affected children remained permanently handicapped. In 1993 once again there was a diphtheria epidemic in the same locations.⁴⁷

II.2.26. For many Roma, physical access to health facilities is a problem which deters them from using health care services. Restructuring of health care facilities in Bulgaria, has resulted in creating disproportionate obstacles for Roma to access health care services. In a number of places throughout Bulgaria, policlinics in the Roma neighbourhoods were closed and with their closure the nearest health facilities were accessible only by public transportation. Such is the case with the Nadezhda neighbourhood in the town of Sliven, home to about 20 000 Roma. In 2000, the policlinic in proximity to the Roma neighbourhood was closed down. The nearest policlinics are located at about 4 kilometres away. According to Dr Stefan Panayotov, many Roma cannot afford transportation costs and have to walk to the policlinics carrying their children.

II.2.27. Similarly, in Stolipinovo neighbourhood of Plovdiv, which is the biggest compact ethnic minority neighbourhood with about 40,000 inhabitants, the local policlinic with specialists in various fields and a child care ward was closed down in 2000. This change rendered access to specialised medical services for the prevailing part of the neighbourhood’s population practically unavailable because the cost for transportation to the hospitals in the city, at a distance of 15-20 km, is unaffordable for many in the neighbourhood.

⁴⁴ Turnev, I., Kamenov, O., Popov, M., Makaveeva, L., Alexandrova, V. 2002. *Common Health Problems Among Roma - Nature, Consequences, and Possible Solutions*. Open Society Foundation, Sofia, p. 2

⁴⁵ *Ibid*, p. 19

⁴⁶ Information provided by the Regional Inspectorate for Protection of Public Health, Plovdiv at their website: www.riokozpd.com, last visited November 2006.

⁴⁷ *Common Health Problems Among Roma - Nature, Consequences, and Possible Solutions*, pp. 14 – 15.

II.2.C. Discrimination against Roma in the provision of medical services

II.2.28. Racial discrimination against Roma in the provision of health care occurs at many levels within the health care system and ranges from overt denial of medical services to more complex forms of discrimination resulting in the provision of inferior medical services. This part of the Collective Complaint details examples of discrimination which are not related to the broader systemic inequalities causing exclusion of Roma from access to health care but have occurred at individual patient-provider level and were perceived by Roma and/or their relatives as motivated by biased, stereotypical and prejudicial attitudes of health care providers to Roma. Discriminatory practices include egregious forms of negligent and/or inappropriate medical treatment leading to the death of the patient or to deleterious effects on the patient's health; denial of medical services and segregation of Roma in hospital facilities.

II.2.29. According to a 2003 survey on the basis of a national representative sample of Romani individuals, every third Romani person described an occasion of denial of medical services. In most cases at issue was refusal of General Practitioners to refer the patient to specialised care.⁴⁸ According to the same survey, 56.2% of the interviewed Roma believed that they receive medical services of inferior quality compared to ethnic Bulgarians.⁴⁹

II.2.29. According to a 2005 survey on the basis of a representative sample of 327 Romani individuals in six Bulgarian cities, nine out of every ten individuals surveyed declared that they have been denied medical care because they are Roma.⁵⁰

II.2.30. In some instances Romani patients have been victims of reported negligent medical care and treatment which resulted in the death of the patient or in irreparable damage to her health. Since medical malpractice affects also non-Romani patients and given the lack of any studies examining the frequency of preventable medical errors among Roma and non-Roma, it is difficult to infer discriminatory treatment from the facts of a single case or even several cases. In a number of cases of extreme human rights abuse of Romani patients by medical professionals however, Romani patients or their relatives reported humiliating remarks referring to the patient's ethnicity made by health care providers. ERRC therefore has reasons to believe that Roma have been victims of inferior treatment precisely because of their ethnicity.

II.2.31. In the following instance, racially offensive language used by a doctor indicates that the treatment of the patient may have been influenced by racial prejudice. According to information provided to the ERRC by the Sofia-based Bulgarian Helsinki Committee (BHC), on May 1, 2004, 22-year old Mr. Mihail Tsvetanov, a Romani man from the northeastern Bulgarian town of Ispereh, died in his home. The previous day Mr. Tsvetanov was released from hospital and, according to the information provided by the medical personnel to his parents, he was in good condition.

Mr. Tsvetanov was admitted to the hospital with stomach pains on April 16, 2004. He

⁴⁸ Without such referral the patient should pay for the specialised medical service.

⁴⁹ Fact Marketing, *Osiguriavane dostapa na maltsinstvata do zdraveopazvane 2002-2003*, Appendix 4, p. 142.

⁵⁰ The survey is part of a larger national representative survey "Bulgari i romi: Mezhduetnicheski naglasi, socialni distancii i cennostni orientacii" commissioned by the Bulgarian Helsinki Committee and carried out by BBSS Gallup International. The larger survey was conducted among 1,112 ethnic Bulgarians and 1,104 Roma at ages 18-70.

was held for several days, without a diagnosis. In the morning of April 21, Mr. Tsvetanov complained of an acute stomach ache to his father Mihail Todorov, who was visiting. Despite repeated requests by the father that a doctor should see his son, only at 6:30 PM did a doctor examine Mr. Tsvetanov. The examining doctor established that Mr. Tsvetanov had a perforated ulcer and required an emergency operation. After the operation, Mr. Tsvetanov was released on April 30. Ms Anguelina Todorova, mother of Mihail Tsvetanov, testified to the BHC lawyer that that Dr Krastev informed her that her son was in good condition.

At around 3:00 AM on May 1, Mr. Tsvetanov's condition deteriorated. His parents called an ambulance, which arrived only one hour later and after a second phone call, although the family live less than one kilometre from the emergency aid service. When the ambulance arrived, the medical team established the death of Mihail Tsvetanov.

On May 3, Mr Todorov met Dr Krastev at the hospital to ask for his son's medical file. Mr. Todorov demanded that Dr Krastev explain why, after he stated Mr. Tsvetanov was in good health, his son had died shortly after release from hospital. Dr Krastev then allegedly stated, "It is not a big thing – one Gypsy less." In the following days, Mr. Todorov went to the hospital several times to obtain the medical file but each time was denied access by Dr Krastev who claimed that the father did not need the document.⁵¹

II.2.32. Exclusion from the health care system has a disproportionate impact on Romani women's health, especially where reproductive and maternal health is concerned. Romani women who do not have health insurance cannot avail themselves of pre-and postnatal medical services.

II.2.33. In October 30, 2004, Mr Plamen Tsankov testified to the ERRC that his sister-in-law, Ms Rusanka Mateva, a Romani woman from the southern Bulgarian town of Pazardjik, died on October 17, 2004, in the Pazardjik Regional Hospital, after giving birth. The death was caused by loss of blood. At the beginning of October, Ms Mateva's health insurance coverage was reportedly terminated as a result of unpaid dues. Mr Tsankov reported that Ms Mateva was admitted to the emergency ward of the hospital to deliver her baby and, following the delivery, doctors left her without any medical supervision for several hours. Mr Tsankov also informed the ERRC of his belief that Ms Mateva's ethnicity factored into her inadequate medical treatment.

II.2.34. In November 2004, the ERRC documented the case of Neviana Miroslavova, a 23-year-old Romani woman from the north-eastern Bulgarian town of Shumen. In October 2004, four months pregnant, she went to her GP, to ask for an appointment to a gynaecologist. The GP reportedly refused to examine Neviana, because she had not paid her health insurance for the previous four months. Neviana Miroslavova used to work as a street cleaner for one year in the government public works scheme "From social benefits to employment". After her contract was terminated, she registered herself as unemployed and was presumably entitled to state-provided health insurance. However, she was in practice unable to avail herself of this benefit.

⁵¹ In June 2004, Ms Anguelina Todorova, mother of the diseased Mihail Tsvetanov, filed a complaint against the hospital in Ispereh under the Bulgarian Protection against Discrimination Act. The complaint was turned down by the district court due to lack of legal interest by the plaintiff. Ms Todorova did not want to proceed with an appeal of the district court's decision and the case was dropped.

II.2.35. According to the testimony of Sabka Sabeva, 24, from Shumen, on August 17, 2005, while pregnant, she started bleeding. She got pregnant after two-year treatment of her ovaries. She reportedly called the emergency aid and was told that she needed a referral from a GP. Ms Sabeva went to her GP, Dr Panayotova, who was not in her office although it was during her working hours. On the following day, Sabka went to the GP again and requested to be given a referral to a specialist. She explained to the GP that she was bleeding and she wanted to check the state of her pregnancy. The GP then reportedly explained that she could not refer her to a gynecologist because she kept the referral documents only for emergencies. On August 19, Sabka borrowed money from her sister and went to see a gynecologist. The gynecologist sent her to hospital, where she was examined and it was established that she had a spontaneous abortion. She underwent a surgical abortion and on August 23, was released from hospital. Sabka Sabeva then filed a written complaint to the regional department of the National Health Insurance Fund. She received a letter stating that her complaint had been reviewed and the GP had been sanctioned for violation of the Health Care Act. She received no further information, nor any form of compensation.⁵²

II.2.36. In February 2002, Ms Stefka Dimitrova had a spontaneous abortion and needed emergency medical assistance. The doctors at the St Sofia hospital in Sofia, Bulgaria, refused to provide her with the necessary treatment unless she paid them 5 leva (approximately 2.5 Euro). At the same time, according to the testimony of Ms Dimitrova, an ethnic Bulgarian woman was accepted for consultation without any conditions. Ms Dimitrova returned home to take money with her and went back to the hospital with two relatives. By the time she reached the hospital, her condition had deteriorated. She was profusely bleeding and her clothes were stained with blood. She explained to the doctors that she had undergone spontaneous miscarriage. At this point doctors refused her medical treatment again requiring her to pay a larger amount of money – 20 leva (approximately 10 Euro). Since Ms Dimitrova had only 5 leva with her, she had to return home. On the evening of the same day, her condition became critical – she had high fever and was suffering from severe pain. Ms Dimitrova sought assistance from a nongovernmental organisation in Sofia and was taken to the Medical Academy in Sofia, where she was accepted for treatment. A woman at the non-governmental organisation reportedly told Ms Dimitrova that the medical practitioners in St. Sofia maternity hospital demanded as a matter of practice that Romani women who reported spontaneous abortions pay the amount of 20 leva. The motivation for this practice was reportedly that Romani women intentionally provoke spontaneous abortions to avoid paying the regular tax of 20 leva which is due in cases of surgical abortions.⁵³

Health Care in Segregated Conditions

II.2.37. Segregation of Romani women in hospital facilities is reported to be a persistent practice in several places throughout Bulgaria. In a number of hospitals in the country, Romani women are reportedly placed in separate rooms – “Gypsy rooms” as they are known to patients and hospital staff. The “Gypsy rooms” are reported to be in worse sanitary conditions and the Romani women attended to less by medical professionals.

⁵² ERRC interview with Sabka Sabeva, August 25, 2005, Shumen, Bulgaria.

⁵³ On April 20, 2006 the Sofia District Court rejected the civil claim against St. Sofia hospital filed by Ms Dimitrova with support from the ERRC. The Court held that there was no evidence supporting the claim that the refusal of free medical assistance to Ms Dimitrova was based on her ethnic origin. Further, the Court ruled that there was no illegal act with respect to the claimant because it was not established that she needed emergency medical assistance. The decision of the Sofia District Court was appealed before the Sofia City Court on May 8, 2006. As of the date this Collective Complaint was submitted, the case has been pending before the Sofia City Court.

II.2.38. In Sofia, four Romani women who filed a complaint against the maternity hospital St. Sofia for racial discrimination, described the situation in the following way: “In the period 2001-2002, we were admitted in St. Sofia hospital. All of us were placed in room 15 on the 5th floor and in a room at the 2nd floor, which are known to the patients and to the medical personnel as ‘the Gypsy rooms’. All women in these rooms were Romani and other Romani women who were admitted in the hospital during this period were placed in these rooms. We learned that the placement of Romani women in separate rooms is a routine practice in this hospital. We also learned that pregnant Romani women who stay in the hospital with some problems during their pregnancy are also placed in separate rooms. The sanitary conditions in the so called ‘Gypsy rooms’ were worse than in the other rooms where ethnic Bulgarian women were placed because they were rarely cleaned. Visitors were not admitted in these rooms while in the rooms where the ethnic Bulgarian women stayed, visitors were freely admitted. We learned from other Romani women that in the winter months ‘the Gypsy rooms’ did not have heating. In October 2001, Gergana Hristova requested to put her own electric heater in her room because the central heating was not on. She was not allowed to do that although there were electric heaters in the other rooms. The medical personnel was rude with us – they yelled at us and sometimes slapped us.”⁵⁴

II.2.39. In Pazardjik, a town in southeast Bulgaria, Romani activists reported that the practice of segregating Romani women in maternity wards existed in the past twenty years. Evidence of segregation is also reported from Sliven, south east Bulgaria.⁵⁵

Refusal to Provide Emergency Aid

II.2.40. There are numerous reports from different parts of Bulgaria that emergency aid ambulances do not go to Romani neighbourhoods or arrive with a big delay. In a number of instances such practice had caused death or serious health injury to Romani patients. The number of such reports as well as the fact that in most cases personnel at the emergency aid service can immediately recognise that the call comes from a Romani neighbourhood by the address of the patient, indicate the discriminatory nature of this practice.

II.2.41. On August 3, 2007, Anka Vesselinova, 50, died after a brain insult in the Third City Hospital of Sofia. According to the testimony of Slavcho Petrov, nephew to the diseased woman, to the Sofia-based Romani Baht Foundation, Anka Vesselinova was suffering from a heart condition. She was offered hospitalisation a month earlier but refused to stay in hospital. At around 5 pm on August 3, Mr Petrov and other relatives found the woman lying unconscious in the yard of her house in the Romani neighbourhood Fakulteta in Sofia. The relatives called the emergency aid immediately, at around 5:10 pm, and were told to wait. When no car arrived ten minutes later, the relatives called again; and then several more calls

⁵⁴ Excerpts from the civil claim by Roza Anguelova, Irina Ilieva, Draga Kirilova and Gergana Hristova filed against First Specialised Obstetrics-Gynecological Hospital St. Sofia in Sofia, before the Sofia District Court on November 15, 2002. (Document on file with the ERRC.) The applicants relied on the prohibition of discrimination on racial grounds in the International Convention on the Elimination of All Forms of Racial Discrimination, in the International Covenant on Economic, Social and Cultural Rights, on the European Social Charter as well as on the Bulgarian Constitution and the Bulgarian Health Insurance Act. As of the date this Collective Complaint was submitted, the case has been pending before the Sofia District Court. An appeal against the decision of the Sofia District Court to reject partially the civil claim in the part requesting the Court to issue an injunction barring separation of Romani women in the hospital in the future, has been pending before the Bulgarian Supreme Court of Cassation as of the date this Collective Complaint was submitted.

⁵⁵ ERRC and BHC interviews in 2005 and 2006.

were made. The ambulance reportedly arrived only around 7 pm. Anka Vesselinova was taken to hospital where she died one hour later.⁵⁶

II.2.42. In February 2006, staff members of the Plovdiv-based Roma Foundation provided the following information to the ERRC: In 2005, sixty-two-year-old Mr B.C. from Stolipinovo Romani neighbourhood of Plovdiv had an acute headache, speech disturbances, was vomiting and had lost coordination. His son called the emergency aid, and when he told them that the ambulance should go to Stolipinovo neighbourhood, the doctor on duty demanded to talk to the patient. B.C.'s son explained that his father's condition was critical and he cannot talk. Then the doctor on duty said that there were no cars and that the patient should wait. After several calls to the emergency aid service, it was not clear whether a car would be sent. At that point the son requested a neighbour – an ethnic Bulgarian – to call the emergency service. The doctor on duty then demanded that the Bulgarian woman should guarantee the security of the emergency aid team. Finally, an emergency aid team arrived but before checking the patient, the doctor demanded to be paid 20 leva (approximately Euro10). The doctor established high blood pressure and a brain insult and called for a car to send the patient to the intensive care ward of the second city hospital. A complaint about the incident filed with the regional department of the National Health Insurance Fund was left without response.⁵⁷

II.2.43. Residents of the Stolipinovo neighbourhood of Plovdiv, reported to the ERRC that in some instances emergency aid doctors demand that the patients show proof of health insurance or pay in cash in order to receive emergency aid. A woman told the ERRC: “The emergency aid does not send ambulances in time. They ask whether we are insured, who is our GP, and whether we can pay for the services if we are not insured.”⁵⁸

II.2.44. During ERRC research in 2005 in the town of Novi Pazar, northeast Bulgaria, nine Romani individuals from different families declared that the ambulances did not go to their neighbourhood.⁵⁹ A Romani woman testified to the ERRC: “I have had several instances when I called the emergency aid for myself and my child. They refused to come to our neighbourhood and made me go to them. In some cases when they hear the address, they simply hand up.”⁶⁰

II.2.45. In an earlier case in Novi Pazar, Ms Brigita Hristova testified to the ERRC that at around 11:00 PM on March 29, 2004, Mr Mitko Asenov, a Romani man from the Romani neighbourhood in Novi Pazar, called an ambulance when his 3-year-old daughter Emiliya Mitkova fell seriously ill, but the ambulance did not arrive. After some time, Mr Asenov brought Emiliya, who was experiencing a high fever and stomach pains, to the hospital in a car he borrowed from a neighbour's guest. According to Ms Hristova, doctors at the hospital told Mr Asenov and his wife Zyulbie Asenova, that they might have lost Emiliya had they arrived later.⁶¹

II.2.D. Bulgarian Government Policies on Roma and Health Care

⁵⁶ Information provided to the ERRC by the Sofia-based Roma rights advocacy organization Romani Baht. The case was also reported by Bulgarian media.

⁵⁷ ERRC interview with Asen Karagyozev, Roma Foundation –Plovdiv, June 2005, Plovdiv and telephone interview February 2006, Budapest.

⁵⁸ ERRC interview with 32-year-old D.K., June 28, 2005, Plovdiv, Bulgaria.

⁵⁹ According to unofficial estimates, the Romani population in Novi Pazar is 3,000-4,000 individuals.

⁶⁰ ERRC interview with 41-year-old B.S., May 26, 2005, Novi Pazar, Bulgaria.

⁶¹ ERRC interview with Ms Brigita Assenova, April 4, 2004, Novi Pazar, Bulgaria.

III.01. Since 1999, Bulgarian government adopted a number of policy documents on the integration of Roma. These documents list goals and measures in various social fields, including health care.⁶² Overall, it can be said that government policy documents identify accurately the major barriers for Roma in the health care system and most of the measures listed in them are relevant to the existing problems.

III.02. However, one significant omission in the evaluation of the problems facing Roma in access to health care is the recognition of discriminatory treatment of Roma by medical practitioners. Despite the fact that government-commissioned studies indicated high levels of perceived discrimination against Roma in the provision of medical services, the issue of discriminatory treatment of Roma by health care providers is systematically downplayed. Consequently, no measures have been designed to monitor, document and reverse discriminatory practices against Roma in the provision of health care.

III.03. Acknowledgement of the barriers for the integration of Roma however has not yet resulted in any effective measures to deal with the problems. Government measures in general as well as in the field of health care, are not systematic, long-term interventions but fragmented, one-time events, often responding to emergency situations rather than aimed at systematic and comprehensive health promotion. Partially, this is the result of lack of sufficient or any funding from the state budget as well as lack of adequate administrative structures to coordinate the implementation.

III.04. Until recently, health programming for Roma relied mainly on funding secured from PHARE projects, while funding from the state budget was minimal or non-existent. For example, the funds from the state budget envisaged for the implementation of the Health Strategy in 2006 was BGN 500 000 (approx. Euro 250 000), while the actual amount allocated for that year was BGN 30 000 (approx. Euro 15 000).⁶³ This funding policy resulted in the implementation of sporadic and fragmentary activities, which were often discontinued with the end of the project. For example, prophylactic examinations, including TB screening, are carried out only for the population which is included in the geographic coverage of the project. Roma who live outside the designated towns/areas covered by the project are not included in these examinations.⁶⁴

III.05. The obstacles for the realisation of government policy posed by insufficient funding from the state budget are illustrated by the implementation of the health mediator programmes. Since 2004 several dozens of health mediators were trained in various PHARE and NGO projects. The role of the health mediators is to provide support for Romani families

⁶² Legal and policy measures to tackle the problems facing Roma in access to health care and in maintaining a healthy lifestyle are elaborated in several government documents, including among others, The Framework Programme for Equal Integration of Roma, adopted by the Council of Minister in April 1999; the Health Strategy Concerning People in Disadvantaged Position Belonging to Ethnic Minorities, adopted by the Council of Ministers on September 8, 2005; and the National Action Plan for the Decade of Roma Inclusion 2005-2015, adopted by the Council of Ministers on June 12, 2006.

⁶³ Information provided in *the Citizens' report on the implementation of government measures according to the recommendations of the European Commission in its report from May 16, 2006 in the area of human rights and integration of vulnerable groups according to the Political Criteria for EU accession*, prepared by the platform of civil society organisations Family "Human Rights" and presented to the public on October 10, 2006 (in Bulgarian language).

⁶⁴ Such for example is the 2003 PHARE project "Medical Integration of Vulnerable Minorities with a Focus on Roma" the implementation of which started in 2006. The project activities cover 5 out of total of 28 regions in Bulgaria.

to access health care. Despite the considerable investment in the training of health mediators, before 2006 there was no employment of persons who have obtained this qualification. In 2006, 13 health mediators were reportedly employed, however, not within the health care system but as part of the public works scheme From Social Assistance to Employment designed for providing temporary subsidised jobs for long-term unemployed people. Only in 2007 the issue of the health mediators' employment status was resolved with the allocation of central budget funds which allowed for the employment of 50 health mediators in 27 municipalities in Bulgaria (out of total of 263 municipalities).⁶⁵

III.06. Similar to policy approaches in other fields, Roma health policies tend to be designed and implemented outside the mainstream health policy framework of the government. The effect of implementing separate health policies on Roma while not integrating solutions to Roma health problems in mainstream policies is to diminish the impact of Roma-specific health policies and in some cases to render such policies effectively meaningless. While the government have developed and in many cases begun implementing actions to ensure better access for Roma to health services, mainstream health policies in some instances tend to work in the opposite direction – creating obstacles for Roma to access health care services. An example is the case of exclusion of Roma from access to health insurance. Mainstream health policies have operated in such a way as to exclude large numbers of Romani individuals from health insurance coverage and as a result, denying access of Roma to primary and specialised health care.

III.07. While in recent years the government did undertake some activities to improve the health status of Roma, little effort has been made to evaluate the impact of these activities and to use the evaluation for improving further policy-making. The government has not commissioned independent evaluation of the impact of various measures. Evaluation of government measures is precluded by the fact that government policy documents on Roma do not provide targets which identify measurable improvements that are to be made over a set period of time.

III.08. Finally, health programming on Roma and impact assessment of programmes is not possible without reliable data on the health and utilization of health services by Roma disaggregated by ethnicity and gender. Such data is not being collected systematically in the health sectors as well as in other sectors. While there are a number of studies on the health status of Roma, such information is not regularly collected. Moreover, there is no data about factors which are crucial for access to health care of Roma such as physical access to health care facilities; rates of usage of primary and preventive health care; access to treatment of non-communicable diseases with high health risks such as cardiovascular diseases and others. Existing studies do not make clear to what extent certain health problems of Rom are due to factors of social exclusion, and how much can be ascribed to factors relating to being members of an ethnic minority – that is, factors such as racism by health care providers, and discriminatory barriers to accessing the health care system.

⁶⁵ See *Citizens' report on the implementation of government measures pursuant to the recommendations by the European Commission in its report from September 26, 2006 in the area of human rights protection and integration of minorities and vulnerable groups according to the Political Criteria for EU accession*, June 2007, p. 61 (in Bulgarian language).

III. Conclusions

IV.01. When taken as a whole, the foregoing reveals a state of affairs of deep concern, namely the systemic exclusion of Roma from key aspects of health care. The exclusion of Roma from vast areas of the health care system should in principle constitute among the country's most significant social inclusion policy concerns. To date, however, the interface between Roma and the health care system has received limited policy attention, in particular by comparison with several other key areas.

IV.02. The European Roma Rights Centre respectfully requests that the European Committee of Social Rights review with the utmost gravity the facts presented in this Collective Complaint and to find Bulgaria in violation of Article 11 and Article 13 of the Revised European Social Charter read together with and/or independently of the non-discrimination provisions in Article E of the Charter, and to urge the Bulgarian government to:

- Review health policies and assess the impact of existing mechanisms on Roma and other vulnerable groups. In particular, undertake to amend health care legislation to ensure that provisions for health insurance and out-of-pocket payments for health care do not have a disparate impact on access to health care for Roma and others in socially vulnerable positions. Legislative measures should provide exemption of Roma and other vulnerable groups from such payments where there is a clear evidence of extreme duress.
- Create an official system of data collection in line with international standards on data protection to document the situation of Roma in all sectoral fields, including health care, and record forms of discrimination. Such data should be disaggregated by ethnicity and gender in order to allow analysis of the extent, causes and manifestations of social exclusion of Roma as well as effects of measures already taken to address the situation.
- Ensure that health policy programmes are developed with an intersectorial perspective to address the impact of housing, education, social services and other factors on health status and access to health care. Such programmes should identify ways in which health authorities can support other governmental bodies that are responsible for sectors affecting health and access to health services.
- Establish a special mechanism for monitoring and assessment of health care services to deal specifically with discrimination in the health care system;
- Ensure physical access to health care, including emergency care, through the provision of adequate roads, communication, and services for Romani communities.
- Conduct on a regular basis anti-discrimination training of public and private health care providers and include anti-discrimination training subjects in the curricula of medical universities and colleges.

On behalf of the European Roma Rights Centre,

Vera Egenberger,
Executive Director