

Legal Implications of the Discontinuation of Compensation for Translation and Interpretation Services in the Dutch Health Care System

Legal Memorandum

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**LEGAL IMPLICATIONS OF THE DISCONTINUATION OF COMPENSATION FOR
TRANSLATION AND INTERPRETATION SERVICES IN THE DUTCH HEALTH CARE
SYSTEM**

Executive Summary

This memorandum presents a comprehensive analysis of the national and international legal implications of the decision of the Dutch government to discontinue compensation for interpretation and translation services in health care for individuals with low Dutch proficiency, which came into effect on January 1, 2012. The Dutch health care system consists of the health care provision market, the health care insurance market, and the health care purchasing market. Within each of these markets the memorandum identifies the roles and responsibilities of the following actors: the Dutch government, the municipalities, the supervisory bodies, the health care insurance companies, and the health care providers. This memorandum identifies and discusses the legal obligations of each actor involved in and affected by the discontinuation of compensation for interpretation and translation services in health care in light of the applicable national, international and/or regional legal framework.

Discontinuation of compensation for translation and interpretation services in Dutch health care re-introduces a barrier for individuals of low Dutch proficiency to enjoy their right to health care. At the national level, the Dutch government has obligations under the Dutch Constitution (*Nederlandse Grondwet, GW*), the Health Care Insurance Act (*Zorgverzekeringswet, Zvw*), the Long-term Care Act (*Wet Langdurige Zorg, Wlz*), and the Public Health Act (*Wet Publieke Gezondheid, Wpg*) to take measures to ensure access to health care. All of these national laws contain instruction-norms directed at the government and as such do not extend individual rights to be invoked in court. However, the 2015 *Urgenda* decision provides a framework for assessing whether the discontinuation amounts to an unlawful act in violation of Dutch civil law. Under the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the European Social Charter, the Dutch government also has an international legal obligation to protect and ensure equal access to health care services. The Dutch state has signed but not yet ratified the relevant Additional Protocol to the ICESCR, meaning that

the individual complaints procedure to the Committee on Economic, Social and Cultural Rights is not available to Dutch legal residents. Dutch courts have consistently refused individuals the ability to invoke the ICESCR or the European Social Charter before a Dutch court, which entails that the international legal obligations apply only indirectly in the assessment of the action of the Dutch government under Dutch civil law.

The discontinuation of compensation for translation and interpretation services in Dutch health care disproportionately affects individuals of low Dutch proficiency, which can be argued to amount to a prohibited form of indirect discrimination under the General Act on Equal and Treatment (*Algemene Wet Gelijke Behandeling, AWGB*), and the right to non-discrimination under international law.

Individuals of low Dutch proficiency are required to rely on informal translation by friends or relatives to receive the necessary health care if they cannot afford to procure a translator themselves. Not only does this pose a risk given the lack of quality assurance, it poses a threat to the confidentiality of the doctor-patient relationship. The right to privacy under the national and international law comes down to the issue of free and informed consent.

Dutch municipalities have a national legal obligation under the Public Health Act (*Wet Publieke Gezondheid, Wpg*), the Community Act (*Gemeentewet, Gw*), the Societal Support Act (*Wet Maatschappelijke Ondersteuning, Wmo*), and the Youth Act (*Jeugdwet, Jw*) to take measures to ensure access to health care independently from the Dutch government. Under the Wpg and Gw, municipalities must protect public health. Under the Wmo and Jw, they must provide societal support and youth care facilities to those who cannot live self-reliantly or participate in society without them. Such facilities may include translation and interpretation services.

The insurance companies have a broadly construed obligation to ensure the quality and accessibility of the care. However, the relevant provisions of the Health Care Insurance Act (*Zorgverzekeringswet, Zvw*) suggest that it is unlikely that the insurance companies are under a direct legal obligation to

compensate for the interpretation and translation services in health care specifically. The broadly defined duty of care imposed upon the health care insurance companies under the Zvw, however, begs the question whether patients of low Dutch proficiency experience undesired obstructions in their access to care in violation of this duty.

This memorandum concludes with a comparative state practice section that identifies three groups of states: i) those that codify the right to interpretation and translation in health care in law, ii) those that develop policy solutions to address this issue, and iii) those that do not address it in a systematic manner or do not address it at all. States that recognize the right to translation and interpretation services in health care by law generally do so under non-discrimination legislation, whereas those states that provide compensation for translation and interpretation resemble the Dutch *modus operandi* prior to the discontinuation in 2012.

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List of Abbreviations

Abbreviation	Dutch, in full	English
AWBZ	Algemene Wet Bijzondere Ziektekosten	General Act on Special Health Care Costs
AWGB	Algemene Wet Gelijke Behandeling	General Act on Equal Treatment
Basispakket	Basispakket zorgverzekering	Basic package health care insurance
BIG	Wet Beroepen in de Gezondheidszorg	Professions in Individual Health Care Act
BW	Burgerlijk Wetboek	Dutch Civil Code
CBB	College voor Beroep voor het Bedrijfsleven	Trade and Industry Appeals Tribunal
CESCR	-	UN Committee on Economic, Social and Cultural Rights
CIZ	Centrum Indicatiestelling Zorg	Centre for Indication in Care
CRM	College voor de Rechten van de Mens	Dutch Institute for Human Rights
EA	-	United Kingdom Equality Act 2010
ECHR	-	European Convention on Human Rights

ECtHR	-	European Court of Human Rights
EO	-	United States Executive Order 13166
ESC	-	European Social Charter
GGD	Gemeentelijke Gezondheids Dienst	Municipal Health Services
GP	Huisarts	General Practitioner (GP), family doctor
GW	Nederlandse Grondwet	Dutch Constitution
Gw	Gemeentewet	Community Act
HHC	-	United States The Department of Health and Human Services
HSCT	-	Northern Ireland Health and Social Care Trust
ICCPR	-	International Covenant on Civil and Political Rights
ICESCR	-	International Covenant on Economic, Social and Cultural Rights
IGZ	Inspectie Gezondheidszorg	Health Care Inspection

IHR	-	WHO International Health Regulations
IMEA	-	International Medical Interpreters Association
Jw	Jeugdwet	Youth Act
LEP	-	Low English Proficiency
NZa	Nederlandse Zorgautoriteit	Dutch Care Authority
OCR	-	United States Office For Civil Rights
OHCHR	-	Office of the High Commissioner for Human Rights
TFEU	-	Treaty on the Functioning of the European Union
UDHR	-	Universal Declaration of Human Rights
UN	-	United Nations
VWS	Ministerie van Volksgezondheid, Welzijn en Sport	Ministry of Public Health, Welfare and Sport
Wbp	Wet Bescherming Persoonsgegevens	Personal Data Protection Act

WGBO	Wet op de Geneeskundige Behandelingsovereenkomst	Act on Health Care Services Agreement
WHO	-	World Health Organization
Wkkgz	Wet Kwaliteit Klacht en Geschillen Zorg	Quality, Complaints and Disputes in Health Care Act
Wlz	Wet Langdurige Zorg	Long-term Care Act
Wmo	Wet Maatschappelijke Ondersteuning	Societal Support Act
Wpg	Wet Publieke Gezondheid	Public Health Act
Wtz	Wet Toelating Zorginstellingen	Admission of Health Care Institutions Act
ZiN	Zorginstituut Nederland	Care Institute Netherlands
ZN	Zorgverzekeraars Nederland	Health Insurers Netherlands
Zvw	Zorgverzekeringswet	Health Care Insurances Act

LEGAL IMPLICATIONS OF THE DISCONTINUATION OF COMPENSATION FOR TRANSLATION AND INTERPRETATION SERVICES IN THE DUTCH HEALTH CARE SYSTEM

Statement of Purpose

The purpose of the memorandum is to analyze the legal implications of the Dutch government's decision to discontinue compensation for translation and interpretation services in Dutch health care. The first part of the memorandum describes the Dutch health care system. The second part of the memorandum analyzes the national, international and/or regional legal obligations of the Dutch central government, the municipalities, the health care insurance companies and the health care providers as the main actors in the Dutch health care system in turn. The third and final part of the memorandum considers comparative state practice in relation to translation and interpretation in health care.

Description of the Dutch Health Care System

Until 2006, the Dutch health care system consisted of a dual system of social and private health care insurance. Individuals with an income below a certain income threshold maintained a subsidized social health care insurance, whereas those with an income above the threshold maintained a private health care insurance. By the end of the 1990s, budget cuts in the subsidies for social health care insurances had caused a so-called waiting list crisis.¹ This crisis called for significant health care reforms. In 2006, these calls for health care reforms resulted in the adoption of, *inter alia*, the Health Care Insurance Act (*Zorgverzekeringswet, Zvw*).

The current Dutch health care system under de Zvw is a system of “regulated competition.”² The reforms abolished the previous distinction between social and private health care insurance in favor of a single, mandatory health care insurance for all Dutch residents. The current system enables and encourages health care insurance companies and health care providers to enter into competition on the health care purchasing market in order to increase productivity and efficiency in health care, to create universal coverage, and foster self-regulation. Some level of government regulation remains necessary to ensure the proper functioning of the market and to protect against undesirable market effects, such as

¹ OECD, FISCAL SUSTAINABILITY OF HEALTH SYSTEMS: BRIDGING HEALTH AND FINANCIAL PERSPECTIVES 246 (2015).

² OECD, FISCAL SUSTAINABILITY OF HEALTH SYSTEMS: BRIDGING HEALTH AND FINANCIAL PERSPECTIVES 246 (2015).

risk assessments by insurance companies when offering insurances to individuals or price inflation.³

Three Health Care Markets

The health care insurance companies, patients, and health care providers are the three main players on the health care market, with the government acting as the market regulator. Mandatory health care insurance creates sub-markets: (i) the market for health care insurance; (ii) the market for health care provision; and (iii) the market for health care purchasing.⁴

Health Care Insurance Market

On the health care insurance market, health care insurance companies offer insurance to Dutch citizens. Each citizen is obligated by law to maintain a “basic package” health care insurance (*basispakket zorgverzekering*), the content of which is determined by the government, with an insurance company of their own choosing.⁵ In addition, individuals are free to maintain additional insurances for care not included in the “basic package.” Customers pay an additional premium for such voluntary insurances on top of the premium for the “basic package” health care insurance.

Insurance companies are obliged to accept all customers and may not charge a different premium rate on the basis of a patient’s risk profile or medical history.⁶ Insurance companies are obliged to insure patients for all care contained in the “basic package.”⁷ The relationship between the insurer and the insured is rooted in private law and is essentially a contract that can only be ended by the insured, unless the insured does not meet his or her contractual obligations.⁸

Health Care Provision Market

On the health care provision market, health care providers offer health care to patients. The patients are free to choose the provider that best suits their needs. Because of mandatory health care insurance, the price of health care does not play

³ OECD, FISCAL SUSTAINABILITY OF HEALTH SYSTEMS: BRIDGING HEALTH AND FINANCIAL PERSPECTIVES 246 (2015).

⁴ For a visual illustration of these markets see Annex 1 and 2.

⁵ *Zorgverzekeringswet* art. 2 (The Netherlands, 2005), available in Dutch at <http://wetten.overheid.nl/BWBR0018450/2016-01-01>.

⁶ *Zorgverzekeringswet* art. 3 (The Netherlands, 2005), available in Dutch at <http://wetten.overheid.nl/BWBR0018450/2016-01-01>.

⁷ Willemijn Schäfer et. al., *The Netherlands Health System Review*, 12 HEALTH SYSTEMS IN TRANSITION 1, 172 (2012), available at http://www.euro.who.int/__data/assets/pdf_file/0008/85391/E93667.pdf.

a prominent role in the selection of health care providers. Instead, patients select their health care provider primarily on the basis of the quality of the care. For this system to work, it is crucial that patients have access to and can compare information on the quality of different providers. Therefore, the government provides information on waiting lists, prices, and quality of the care.⁹ In turn, health care providers are legally obliged to provide information on the performance, price, and waiting lists to the government.¹⁰ Patients may also take other factors into account, such as the geographical location or a personal relation with the provider.¹¹

Health Care Purchasing Market

On the health care purchasing market, insurance companies buy health care from providers for the benefit of their customers.¹² Insurers and providers enter into negotiations over the price of the care to be provided. For certain types of care, the government sets a maximum price. The results of the price negotiations can have an influence on the price of the insurance premium charged by the insurance companies to their customers and thus affect the patients indirectly. In addition to price, insurers and providers negotiate on the quality and amount of care to be provided.

Hypothetically, such negotiations could result in insurers only reaching agreements with certain health care providers. This could, in turn, affect the patients' choice of health care provider.¹³ Insurance companies only cover a patient's full health care expenses if the patient visits a care provider that the insurance company has concluded a health care agreement with. If a patient decides to visit a health care provider with whom his or her insurance company has not concluded a health care agreement, the insurance company will cover only 80 percent of the patient's expenses. This does not currently affect patients significantly as most insurance companies have agreements with almost all care providers for care included in the "basic package."¹⁴

⁹ For instance, the government has set up the 'Zorginstituut Nederland' (Health Care Institution Netherlands) for the dissemination of information on healthcare, see <https://www.zorginstituutnederland.nl/publications+in+english> (in English). In addition, the government has set a website for the comparison of care, see <http://www.kiesbeter.nl/> (only in Dutch).

¹⁰ Rijksoverheid, *Inzicht in Kwaliteit Zorg*, (2016), available in Dutch at <https://www.rijksoverheid.nl/onderwerpen/kwaliteit-van-de-zorg/inhoud/kiezen-in-de-zorg>.

¹¹ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSEL IN EEN NOTENDOP 12 (2011).

¹² Willemijn Schäfer et. al., *The Netherlands Health System Review*, 12 HEALTH SYSTEMS IN TRANSITION 1, 22 (2012), available at http://www.euro.who.int/__data/assets/pdf_file/0008/85391/E93667.pdf.

¹³ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSEL IN EEN NOTENDOP 12 (2011).

¹⁴ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSEL IN EEN NOTENDOP 84 (2011).

Actors

This section discusses the role of the different actors in the health care sub-markets. The Dutch health care system consists of many different actors and layers.¹⁵ The section below is a simplified explanation of the roles of the different actors. Each actor's legal obligations are identified and are addressed in order and in further detail throughout the remainder of this section of the memorandum.

Dutch Central Government

Government and parliament collectively create, regulate and implement the legal framework constituting the Dutch health care system. In addition, they arrange for the supervision of compliance with these legal norms.¹⁶ The actual supervision is delegated to (semi-)independent organs, which will be discussed separately below. The main governmental institutions involved in the regulation and implementation of health care are the Ministry of Public Health, Welfare, and Sport (*Ministerie van Volksgezondheid, Welzijn, en Sport, VWS*) and the municipalities.

The government's obligation to "promote" public health is laid down in Article 22 of the Dutch Constitution (*Grondwet, GW*). Art. 22 GW instructs the Ministry of VWS to create the legislation and enact policies to ensure the proper functioning of the health care system.¹⁷ In furtherance of this duty, the government adopted the Public Health Act (*Wet Publieke Gezondheid, Wpg*), for example, which obliges the Minister of VWS to "further the quality and effectiveness of public health care and take care of the maintenance and improvement of the national support-structure."¹⁸ The Ministry of VWS also determines the acceptable standards for the quality of care.¹⁹ For example, the Ministry of VWS is responsible for vetting and admitting health care providers to the market and for providing subsidies to certain medical institutions.²⁰

¹⁵ For a visual representation of the main actors and their way of interacting, see Annex 2.

¹⁶ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSE IN EEN NOTENDOP 15 (2011).

¹⁷ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSE IN EEN NOTENDOP 15 (2011).

¹⁸ *Wet publieke gezondheid* art. 3 (the Netherlands, 2008), available in Dutch at <http://wetten.overheid.nl/BWBR0024705/2016-01-01> (translated by author).

¹⁹ Ministry of Health, Welfare and Sport, *Healthcare in the Netherlands*, 11 (Jan. 2016), available at <https://www.government.nl/documents/leaflets/2016/02/09/healthcare-in-the-netherlands>.

²⁰ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSE IN EEN NOTENDOP 15 (2011).

The Ministry of VWS is divided into three “directorates-generals” (DGs) responsible for three different types of care: (i) curative care; (ii) long-term care; and (iii) public health. These DGs correspond with the main legal acts making up the Dutch health care system.

Curative care is regulated under the *Zvw* and constitutes approximately 60% of the government’s health care budget. The government determines the content of the “basic package” of mandatory insurance which are to be available to all Dutch citizens in accordance with the provisions of *Zvw*. The government includes care in the “basic package” if the care is considered necessary, assessed against demonstrable effect, cost-efficient, and calls for collective financing.²¹ In addition, the government creates a number of preconditions to ensure the social character of the health insurance.²² Otherwise, the government is not directly involved in the execution of the *Zvw*, which is primarily left to the private players in the health care provision market. The government is not involved in the provision of voluntary additional insurances, for example, which is of an entirely private character.²³

Patients requiring permanent supervision or 24-hour care fall within the realm of the Long-term Care Act (*Wet Langdurige Zorg, Wlz*). The *Wlz* replaced the General Act on Special Health Care Costs (*Algemene Wet Bijzondere Ziektekosten, AWBZ*) in January 2015. The insurance companies have delegated the arrangement of this type of care to “care-offices” (*Zorgkantoren*).²⁴ The Centre for Indication in Care (*Centrum Indicatiestelling Zorg, CIZ*) determines what type of care is required. *Wlz*-insurance is a mandatory universal coverage insurance that every citizen contributes to by paying income taxes.²⁵

Municipalities

The municipalities are primarily responsible for the provision of youth care and societal care. Societal care entails the provision of “support” to people with a mental, physical, or psychiatric disability under the Societal Support Act (*Wet Maatschappelijke Ondersteuning, Wmo*). The support focuses mainly on

²¹ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting*, 29763 nr. 3, 40 (Sept. 24, 2004), available in *Dutch* at <https://zoek.officielebekendmakingen.nl/kst-29763-3.html>.

²² Ralf Götze, *Changing Role of the State in the Dutch Healthcare System*, 141 *TRANSTATE WORKING PAPERS* 1, 13 (2010).

²³ Ministry of Health, Welfare and Sport, *Healthcare in the Netherlands*, 8 (Jan. 2016), available at <https://www.government.nl/documents/leaflets/2016/02/09/healthcare-in-the-netherlands>.

²⁴ Arjen van Rijn, *HET NEDERLANDSE ZORGSTELSEL IN EEN NOTENDOP* 76 (2011).

²⁵ Ministry of Health, Welfare and Sport, *Healthcare in the Netherlands*, 13 (Jan. 2016), available at <https://www.government.nl/documents/leaflets/2016/02/09/healthcare-in-the-netherlands>.

handicapped and elderly people and is aimed at allowing these people to participate in society and to live independently to the fullest of their abilities.²⁶ The mayor and city council members are responsible for regulating the provision and quality of the care and are supervised by the municipal parliament (*Gemeenteraad*).

Under the Youth Act (*Jeugdwet, Jw*), the municipality is furthermore responsible for the support, help, and care of children and youth with educational- or psychiatric issues or disorders. This does not include individuals who require long-term care as they fall under the *Wlz*.

In addition, the municipality is responsible for disease prevention, health promotion, and health protection in close cooperation with the government.²⁷ To that end, the municipalities have set up Municipal Health Services (*Gemeentelijke Gezondheids Dienst, GGD*). Private individuals and institutions offer all these types of care. The municipalities have a regulating and facilitating role similar to that of the central government in curative and long-term health care²⁸

Supervisory Bodies

The Dutch health care system consists of a number of supervisory and advisory bodies. These bodies operate to differing degrees of independence from the government. For the purpose of interpretation services, the three most important bodies are the IGZ, NZa, and the ZiN.

Part of the Ministry of VWS is comprised of the “State-supervision” (*Staatstoezicht*), which is primarily regulated by the Health Act (*Gezondheidswet*).²⁹ Staatstoezicht has its own tasks and competences aimed at securing the observance of the rules and the investigation of violations.³⁰ Within this system, the Health Care Inspection (*Inspectie Gezondheidszorg, IGZ*) ensures the safety and quality of health care through supervision, enforcement, and investigation. It has a general supervisory role aimed at all sectors of the health

²⁶ Ministry of Health, Welfare and Sport, *Healthcare in the Netherlands*, 17 (Jan. 2016), available at <https://www.government.nl/documents/leaflets/2016/02/09/healthcare-in-the-netherlands>.

²⁷ For an overview of these obligations, see: *Wet publieke gezondheid* (the Netherlands, 2008), available in Dutch at <http://wetten.overheid.nl/BWBR0024705/2016-01-01>.

²⁸ Ministry of Health, Welfare and Sport, *Healthcare in the Netherlands*, 22 (Jan. 2016), available at <https://www.government.nl/documents/leaflets/2016/02/09/healthcare-in-the-netherlands>.

²⁹ *Gezondheidswet* art. 36 (the Netherlands, 2014), available in Dutch at <http://wetten.overheid.nl/BWBR0002202/2014-02-15>.

³⁰ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSE IN EEN NOTENDOP 17 (2011).

care system.³¹ The IGZ can also conduct specific investigations in response to reports by health care providers or patients.

Another relevant supervisory body is the Dutch Care Authority (*Nederlandse Zorgautoriteit, NZa*).³² The NZa is not part of the ministry but is a separate state organ with its own competencies and responsibilities. However, the Minister of VWS is authorized to give the NZa general instructions. The NZa supervises the proper functioning of the three health care sub-markets. To that end, the NZa, *inter alia*, determines the product- and performance descriptions of health care services.³³ A health care provider may not charge for the provision of products or services that deviate from this description. A product description is required when no clarity exists on the precise products or services that the parties will be negotiating on. Descriptions facilitate the comparing of prices and serve to stimulate the market effects. The NZa can also set maximum prices for these products and services if free negotiations are not (yet) desirable.³⁴

The final relevant supervisory body is the Care Institute Netherlands (*Zorginstituut Nederland, ZiN*). The ZiN is organized under the Zvw and supervises the conduct of health care insurance companies. It may provide health insurance companies with guidelines on the health care services contained in the “basic package.” The ZiN further advises the Ministry of VWS on the content of the “basic package.”³⁵

Health Care Insurance Companies

Since the 2006 reform, health care insurers are allowed to make a profit yet the majority of health care insurers say to operate on a not-for-profit basis.³⁶ The market is dominated by four major players. Each have a number of daughter enterprises which makes the market appear more fragmented than it actually is. Health Insurers Netherlands (*Zorgverzekeraars Nederland, ZN*) is the umbrella

³¹ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSEL IN EEN NOTENDOP 18 (2011).

³² The Nza's responsibilities can be found in *Wet marktordening gezondheidszorg* (the Netherlands, 2006), available in Dutch at <http://wetten.overheid.nl/BWBR0020078/2016-01-01>.

³³ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 30 186 nr. 3, 24* (Jul. 26,2005), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-30186-3.html>.

³⁴ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 30 186 nr. 3, 24* (Jul. 26,2005), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-30186-3.html>.

³⁵ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSEL IN EEN NOTENDOP 19 (2011).

³⁶ Willemijn Schäfer et. al., *The Netherlands Health System Review*, 12 HEALTH SYSTEMS IN TRANSITION 1, 31 (2012), available at http://www.euro.who.int/__data/assets/pdf_file/0008/85391/E93667.pdf.

organization of the insurance companies and is considered an important stakeholder in the Dutch health care system.³⁷

On the basis of the Zvw, health care insurance companies have a “duty of care” (*zorgplicht*) towards their insured.³⁸ This duty of care is in first instance an obligation of result to provide those insured the care they are legally entitled to.³⁹ This duty of care extends to compensation for the costs of this care and, if requested, activities aimed at obtaining this care (care mediation).⁴⁰ The *travaux préparatoires* indicate that this duty of care includes the attainability for the insured, as well as timeliness and quality of care.⁴¹ The NZa concurs with this interpretation of the duty of care.⁴²

Health Care Providers

In the Netherlands, health care is provided either by individuals or by health care institutions.

Individual practitioners are governed by the Professions in Individual Health Care Act (*Wet op Beroepen in de Gezondheidszorg, BIG*) and the Act on Health Care Services Agreement (*Wet Geneeskundige Behandelingsovereenkomst, WGBO*). BIG defines what individual health care is, determines the professions covered and guards the competence of health care providers.⁴³ A BIG-register serves to ensure the competence of individual health care providers such as doctors, dentists, and midwives.⁴⁴ Those health care providers need to be registered in order to be allowed to exercise their profession. Individual health care providers are under a legal obligation to act as any reasonably acting and reasonably competent colleague would in the same circumstances, according to the state of the art and evidence-based.⁴⁵ Individual health care providers do so, *inter*

³⁷ Willemijn Schäfer et. al., *The Netherlands Health System Review*, 12 HEALTH SYSTEMS IN TRANSITION 1, 31 (2012), available at http://www.euro.who.int/__data/assets/pdf_file/0008/85391/E93667.pdf.

³⁸ *Zorgverzekeringswet* art. 11 (The Netherlands, 2005), available in Dutch at <http://wetten.overheid.nl/BWBR0018450/2016-01-01>.

³⁹ NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 9 (Dec., 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

⁴⁰ NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 4 (Dec. 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

⁴¹ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting*, 29 763 nr. 3, 42 - 44 (Sept. 24, 2004), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-29763-3.html>.

⁴² NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 5 (Dec. 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

⁴³ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSEL IN EEN NOTENDOP 48 (2011).

⁴⁴ *Wet op Beroepen in de Gezondheidszorg* art. 3 (the Netherlands, 1993), available in Dutch at <http://wetten.overheid.nl/BWBR0006251/2016-01-18>.

⁴⁵ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSEL IN EEN NOTENDOP 50 (2011).

alia, by organizing their practices in a patient-friendly manner, by providing the necessary materials, and by drafting codes of conduct. The treatment directives developed by the “profession organizations” – which most individual practitioners are a part of – are an important indicator of quality.⁴⁶

A pivotal and unique role in the Dutch health care system belongs to the general practitioners (GPs) as they serve as “gate-keepers” of the Dutch health care system. The gate-keeping principle entails that secondary care – which includes hospital and specialist care but excludes emergency care – is often only accessible after a referral by a GP. Some have argued that since GPs play such a key role in the health care system, quick and easy access to a GP is of critical importance for the proper functioning of the Dutch health care system in particular.⁴⁷

Health care institutions in the Netherlands must possess an “admission” or license granted by the Ministry of VWS under the Admission of Health Care Institutions Act (*Wet Toelating Zorginstelling, Wtz*) in order to provide insured care.⁴⁸ The Ministry of VWS grants the other institutions an admission if they meet the requirements for organizational structures and operational management.⁴⁹

The Quality, Complaints, and Disputes in Health Care Act (*Wet Kwaliteit, Klacht, en Geschillen Zorg, Wkkgz*) contains quality standards for health care provided by all health care providers and governs complaints procedures for care of insufficient quality.⁵⁰

Compensation for Translation and Interpretation in Health Care

In the 2010 Government Coalition Agreement (*Regeerakkoord*), the coalition partners agreed that the Ministry of VWS would cut back subsidies for health care by approximately €100 million. 6 months later, the government

⁴⁶ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSE IN EEN NOTENDOP 50-51 (2011).

⁴⁷ Willemijn Schäfer et. al., *The Netherlands Health System Review*, 12 HEALTH SYSTEMS IN TRANSITION 1, 149 (2012), available at http://www.euro.who.int/__data/assets/pdf_file/0008/85391/E93667.pdf.

⁴⁸ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSE IN EEN NOTENDOP 52 (2011).

⁴⁹ Arjen van Rijn, HET NEDERLANDSE ZORGSTELSE IN EEN NOTENDOP 53 (2011). For a full overview of the requirements see: *Beleidsregels Wet Toelating Zorginstellingen* (the Netherlands, 2009), available in Dutch at <http://wetten.overheid.nl/BWBR0026437/2009-09-30>.

⁵⁰ *Wet kwaliteit, klachten en geschillen zorg* (the Netherlands, 2016), available in Dutch at <http://wetten.overheid.nl/BWBR0037173/2016-01-01>.

decided to cut back an additional €100 million in the health care budget.⁵¹ The Ministry of VWS made subsidy cuts in a number of areas, one of which was the compensation for interpretation services in health care.

Previously, the budget for interpretation and translation services in health care fell under the responsibility of the Ministry of Justice and was part of a combined budget for use of such services in the legal and health care system. In 2004, the Government decided to split the budgets and transfer responsibility for the health care budget to the Ministry of VWS. Until 2012, the Ministry of VWS contracted with private translation and interpretation service providers and paid for any services or assistance procured by designated health care professionals for designated health care services.

In 2010, the Minister limited the number of services for which health care providers could request the assistance from the translation and interpretation service provider. However, additional budget cuts were required and in 2011 the Minister decided not to renew its contract with the private translation and interpretation service provider at all. The discontinuation of that arrangement, in effect the discontinuation of compensation for interpretation and translation services in Dutch health care, resulted in an estimated budgetary saving of €19 million on an annual basis.

The Ministry of VWS justified the discontinuation by arguing that patients are themselves responsible for mastering the Dutch language. The Minister of VWS argued that compensation for translation services did not correspond with this requirement and therefore discontinued the compensation as per 1 January 2012.⁵² According to the Minister, patients with inadequate command of the Dutch language should bring someone to translate for them or pay for a professional interpreter instead. Alternatively, the health care providers themselves could call upon a professional interpreter, according to the Minister.

The government continues to compensate interpretation and translation services for victims of human trafficking, asylum seekers, and women in societal

⁵¹ Tweede Kamer de Staten Generaal, *Brief van de Minister en Staatssecretaris van Volksgezondheid, Welzijn en Sport*, 32 500 XVI Nr. 143, 1 (May 25, 2011), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-32500-XVI-143.html>.

⁵² Tweede Kamer de Staten Generaal, *Brief van de Minister en Staatssecretaris van Volksgezondheid, Welzijn en Sport*, 32 500 XVI Nr. 143, 4 (May 25, 2011), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-32500-XVI-143.html>.

care.⁵³ Compensation for translation and interpretation services in health care services provided to asylum seekers in asylum seeker centers and victims of human trafficking is currently provided for under the budget of the Ministry of Justice. The Minister of Justice is of the opinion that such individuals cannot reasonably be expected to master the Dutch language sufficiently to enjoy their rights should such translations services not be available.⁵⁴ Once asylum seekers obtain a refugee residence status, they are responsible for finding and paying for their own translation services in order to have full access to health care. On the specific issue of women seeking shelter from domestic violence in safe houses the Minister compensates interpretation services to ensure the protection of data concerning the person's place of residence.⁵⁵

Refugees and migrants who are not citizens of the EU, Switzerland, Turkey, or the European Economic Area have the legal obligation to undergo a civic integration process (*inburgeren*).⁵⁶ The process entails learning the Dutch language and passing the so called NT2 state exam (*Staatsexamen NT2*). Migrants are obliged to find and pay for the courses themselves. Migrants that arrived in the Netherlands after 2013 can obtain a loan of maximum 10,000 euro from DUO (*Dienst Uitvoering Onderwijs*), the Education Executive Agency of the Dutch Ministry of Education, Culture and Science, to finance their language studies. If the naturalization process is completed within three years, the loan turns into a gift.⁵⁷ In light of the Dutch Ministry of Education's acknowledgment that mastering the Dutch languages takes time and reasonably requires between one to three years, the policy position of the Dutch Ministry of Health reveals an apparent inconsistency in Dutch policy. It appears inconsistent for the Dutch government to allow migrants up to three years to master the Dutch language, yet require them to master the Dutch language sufficiently in order to enjoy unimpeded access to health care as soon as they have received their official residency status, which can in some cases be received within days of arrival.

⁵³ Ministerie van Volksgezondheid, Welzijn en Sport, *Reactie Motie Voortman en Wolbert Inzake Tolken 162153-110640-MC*, (Oct. 23, 2013), available in Dutch at <http://www.medischcontact.nl/web/file?uuid=aa68c6b5-729c-4668-a8b6-7299431decce&owner=afab339f-0804-4530-b75f-b6ec287c0611>.

⁵⁴ For more information on the provision of translation and interpretation services for asylum seekers, please visit <https://www.rzasielzoekers.nl/home/tolk-nodig-.html> (available in Dutch).

⁵⁵ Tweede Kamer de Staten Generaal, *Brief van de Minister en Staatssecretaris van Volksgezondheid, Welzijn en Sport*, 32 500 XVI Nr. 143, 4 (May 25, 2011), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-32500-XVI-143.html>.

⁵⁶ Wet inburgering in het buitenland (the Netherlands, 2008), available in Dutch at <http://wetten.overheid.nl/BWBR0023204/2006-03-15>.

⁵⁷ Dienst Uitvoering Onderwijs, *INBURGEREN IN NEDERLAND*, available in Dutch at <https://inburgeren.nl/inburgeren-betalen.jsp#hoeveel-mag-u-lenen>.

In May 2013, the Minister of VWS reported on the consequences of the discontinuation of compensation for interpretation in health care. The report concluded that the discontinuation of compensation had not caused negative effects for the quality of health care, had led to increased use of “informal” translators, and that hospitals and GGZ institutions had made their own arrangements to cover for the costs of interpretation and translation services.⁵⁸

The Dutch Government

By discontinuing compensation for interpretation and translation services, the Dutch Government expects individuals with insufficient command of the Dutch language in need of health care services but unable to effectively communicate with health care providers to pursue one of two options. Either such individuals have to arrange and pay for professional interpretation and translation services themselves, or they have to arrange for a relative or acquaintance to provide informal interpretation and translation services. The first option may infringe upon the patient’s right to (economically) accessible health care as well as their right to equal treatment, whereas the second option raises questions with regard to the patient’s right to privacy. This section identifies the government’s obligations to respect and protect these rights under the domestic, international and regional legal framework.

The Right to Health Care

First, this section assesses the national legal framework applicable to the right to health care. Second, this section assesses the government’s duty of care in light of relevant domestic case law, specifically the *Urgenda* case. Lastly, this section analyzes the international and regional framework relating to the right to health care.

National Legal Framework

Article 22(1) GW obliges the Dutch government to “take measures for the promotion of public health.”⁵⁹ The Dutch legislator purposely adopted an open-ended formulation of this right and dismissed suggestions to adopt a more specific

⁵⁸ Ministerie van Volksgezondheid, Welzijn en Sport, *Inzet Tolken 119322-104128-MC*, 1-2 (May 28, 2013).

⁵⁹ The NETHERLANDS CONST. art. 22 (1815), available at <https://www.government.nl/documents/regulations/2012/10/18/the-constitution-of-the-kingdom-of-the-netherlands-2008>.

formulation, such as the one set out in the Constitution of the World Health Organization.⁶⁰ This broad and general formulation of the right to health care allows the government to set priorities and pursue policies according to the means and resources available.⁶¹ In general, the term “promotion of public health” covers all government policy aimed at protecting and improving public health.⁶²

In 2007, the Amsterdam Court of Appeals considered the applicability of Art. 22(1) GW in a case brought by the Consumers Association (*Consumentenbond*) against the government. The Consumers Association argued that the government knew of the risks of legionella infection from exposure to water from whirlpools. As such, the government should have taken measures to prevent such health risks from materializing in furtherance of its duty of care as prescribed, amongst others, by Art. 22(1) GW according to the Consumers Association. The Consumers Association claimed that the government’s failure to take appropriate measures constituted a violation of Art. 22 GW.

The Amsterdam Court of Appeals, referring to the explanatory notes and legislative history of Art. 22 GW, held that the article constitutes an “instruction-norm” directed at the government only. It does not create a right to be invoked by citizens, according to the judge in the case.⁶³ The Amsterdam Court of Appeals therefore decided to dismiss the claim made by the Consumers Association.

This case clarifies that the purpose of Art. 22 is to provide a legal basis for adopting subsequent health care legislation and policies rather than extending individual rights to be invoked by citizens in court. Even if one would argue that “measures for the promotion of public health” should include measures to ensure accessibility of health care services,⁶⁴ individuals claiming that their right to health care has been violated cannot invoke Art. 22 GW directly. Art. 22 GW does, however, specify the general duty of care that befalls upon the government, which

⁶⁰ *Kamerstukken II 1976/77*, 13873, 7, 22, available in Dutch at <http://resolver.kb.nl/resolve?urn=sgd%3Ampg21%3A19761977%3A0002457>.

⁶¹ *Kamerstukken II 1976/77*, 13873, 7, 23, available in Dutch at <http://resolver.kb.nl/resolve?urn=sgd%3Ampg21%3A19761977%3A0002457>.

⁶² *Kamerstukken II 1976/77*, 13873, 7, 23, available in Dutch at <http://resolver.kb.nl/resolve?urn=sgd%3Ampg21%3A19761977%3A0002457>.

⁶³ *Gerechtshof Amsterdam* (Oct. 25, 2007), ECLI:NL:GHAMS:2007:BB6504, para. 4.2 and 4.8.6, available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:GHAMS:2007:BB6504>.

⁶⁴ F.M.C. Vlemminx, *Commentaar op artikel 22 van de Grondwet*, in *ARTIKELSGEWIJS COMMENTAAR OP DE GRONDWET*, (Ernst M.H. Hirsch Ballin en Gert-Jan Leenknecht, eds., 2016), available in Dutch at <http://www.nederlandrechtsstaat.nl/grondwet/artikel.html?artikel=22##artikel22>.

is relevant in the context of an unlawful act committed by the government as discussed in further detail below.

The Health Care Insurance Act

The Health Care Insurance Act (*Zorgverzekeringswet, Zvw*) obliges every Dutch resident to maintain health care insurance and regulates the provision thereof. The purpose of the Zvw is to improve the efficiency, accessibility and affordability of health care by reducing government involvement and allowing for a system of regulated competition.⁶⁵ The explanatory note to the Zvw clarifies that the government remains responsible for the overall accessibility, affordability, and quality of the health care system.⁶⁶ Notwithstanding the decentralization and introduction of competition in the provision of health care, the government bears responsibility to ensure that necessary health care of good quality is accessible to all Dutch people, regardless of their age, state of health, or income.⁶⁷ The question arises whether translation and interpretation services are services necessary for health care of good quality.

Art. 10 Zvw lists eight types of essential care covered by mandatory health care insurances: (i) curative care; (ii) dental care; (iii) pharmaceutical care; (iv) medical auxiliary instruments; (v) nursing; (vi) care-taking (including maternity care); (vii) hospitalization; and (viii) medical transportation. Only care or services that belong to one of these eight categories are included in the “basic package” of care each Dutch citizen must maintain an insurance for and is legally entitled to.⁶⁸

The government determines the specific goods and services included in the “basic package” by governmental decree (*Algemene Maatregel van Bestuur, AMvB*).⁶⁹ Care is included in the “basic package” if: (a) it can be classified as necessary care, assessed against demonstrable effect; (b) it is deemed cost-

⁶⁵ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting*, 29 763 nr. 3, 2 (Sept. 24, 2004), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-29763-3.html>.

⁶⁶ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting*, 29 763 nr. 3, 3 (Sept. 24, 2004), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-29763-3.html>.

⁶⁷ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting*, 29763 nr. 3, 7 (Sept. 24, 2004), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-29763-3.html>.

⁶⁸ *Zorgverzekeringswet* art. 10 (The Netherlands, 2005), available in Dutch at <http://wetten.overheid.nl/BWBR0018450/2016-01-01>; Tweede Kamer der Staten-Generaal, *Memorie van Toelichting*, 29 763 nr. 3, 101 (Sept. 24, 2004), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-29763-3.html>.

⁶⁹ *Zorgverzekeringswet* art. 11(3) (The Netherlands, 2005), available in Dutch at <http://wetten.overheid.nl/BWBR0018450/2016-01-01>; The current governmental decree on the content of the basic package is available at <http://wetten.overheid.nl/BWBR0018492/2016-01-01>.

efficient; and (c) collective financing of the care is necessary for its enjoyment.⁷⁰ The criteria indicate that the configuration of the basic package is the result of political deliberation informed by medical necessity.

ZiN advises the Minister of VWS, upon request, on the nature, content, and scale of the health care products (to be) included in the basic package.⁷¹ In addition, the ZiN has the task to signal, of its own accord, factual developments that could give rise to amendments in the insured package.⁷² The ZiN uses four criteria to advise the government on the content of the basic package: necessity, effectiveness, cost-efficiency, and practicability. “Necessity” is further divided into two separate criteria: (i) “burden of illness” and (ii) “necessity to insure.”⁷³ “Necessity to insure” is assessed on the basis of a number of questions. These questions aim to determine whether the care is “used generally,” whether individuals can carry the financial burden themselves, and whether non-insurance leads to undesirable under-consumption of the care.⁷⁴

The provisions of the Zvw itself do not contain any legal standards against which the government’s decision to include care in the “basic package” can be tested. The criteria that the government and regulatory bodies uses in assessing whether particular types of care should be included are based on policy guidelines rather than legally enforceable principles. As such, they do not constitute a legal obligation for the government to ensure that the “basic package” meets a particular standard or accessibility of care. The provisions of the Zvw allow the government a large margin of policy discretion to set the standard and protect the accessibility of care through determining what care is included in the basic package. Unless the administrative decision is challenged for constituting an unlawful act in violation of Art. 6:162 BW as discussed in detail below, it may be difficult to challenge the

⁷⁰ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting*, 29763 nr. 3, 40 (Sept. 24, 2004), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-29763-3.html>.

⁷¹ *Zorgverzekeringswet* art. 66(1) (The Netherlands, 2005), available in Dutch at <http://wetten.overheid.nl/BWBR0018450/2016-01-01>.

⁷² *Zorgverzekeringswet* art. 66(2) (The Netherlands, 2005), available in Dutch at <http://wetten.overheid.nl/BWBR0018450/2016-01-01>.

⁷³ College voor Zorgverzekeringen, *Rapport Pakketbeheer in de Praktijk deel 3*, 32 (Oct. 14, 2013), available in Dutch at <https://www.zorginstituutnederland.nl/binaries/content/documents/zinl-www/pakket/werkwijze-pakketbeheer/procedures-en-methodiek/procedures-en-methodiek/procedures-en-methodiek/zinl%3Adocuments%5B3%5D/1310-pakketbeheer-in-de-praktijk-deel-3/Pakketbeheer+in+de+Praktijk+%28deel+3%29.pdf>.

⁷⁴ College voor Zorgverzekeringen, *Rapport Pakketbeheer in de Praktijk deel 3*, 37 (Oct. 14, 2013), available in Dutch at <https://www.zorginstituutnederland.nl/binaries/content/documents/zinl-www/pakket/werkwijze-pakketbeheer/procedures-en-methodiek/procedures-en-methodiek/procedures-en-methodiek/zinl%3Adocuments%5B3%5D/1310-pakketbeheer-in-de-praktijk-deel-3/Pakketbeheer+in+de+Praktijk+%28deel+3%29.pdf>.

exclusion of translation and interpretation services in health care from the basic package before a court based on the provisions of the Zvw only.

The Long-term Care Act

The Long-term Care Act (*Wet Langdurige Zorg, Wlz*) governs the provision of long-term care or 24-hour assistance. The Minister of VWS has “ministerial responsibility” for the act, which entails a general responsibility for the functioning of the system, as well as the specific responsibilities bestowed upon the Minister by the act.⁷⁵ By AMvB the Minister can determine to what extent a regional Wlz-executor is involved in the administration and control of the provided care and can set additional conditions to the exercise of such administration and control.⁷⁶ The Wlz further contains a relatively detailed description of the type of care that is covered by the Wlz insurance, which does not include medical translation or interpretation services. The nature, content, and volume of insured care can be further specified by AMvB.⁷⁷ This is similar to the determination of the “basic package” under the Zvw. The Wlz also stipulates that the insured has a right to care adjusted to his needs, characteristics, and abilities in as far as he is reasonably reliant upon this care because he has a somatic or psychogeriatric disorder or a mental, physical, or sensorial handicap.⁷⁸ The application of the Wlz is thus limited to people who suffer from such an illness. The “right to care” of the insured is determined by the Centre for Care Indication (*Centrum Indicatiestelling Zorg, CIZ*) and matches the “need of the insured.”⁷⁹

The Public Health Act

The 2008 Public Health Act (*Wet Publieke Gezondheid, Wpg*) governs the provision of public health care, the control and prevention of infectious diseases, and the isolation of persons or objects that pose a risk to international health.⁸⁰ The current Wpg is the result of the national implementation of the 2005 World Health Organization International Health Regulations (IHR). The IHR contain core

⁷⁵ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting Wlz*, 49 (Mar. 10, 2014), available in Dutch at <https://www.rijksoverheid.nl/onderwerpen/zorg-in-zorginstelling/documenten/kamerstukken/2014/03/10/memorie-van-toelichting-wet-langdurige-zorg>.

⁷⁶ *Wet Langdurige Zorg* art. 4.2.4 (2) to 4.2.4 (3) (The Netherlands, 2016), available in Dutch at <http://wetten.overheid.nl/BWBR0035917/2016-01-01>.

⁷⁷ *Wet Langdurige Zorg* art. 3.1.1 (The Netherlands, 2016), available in Dutch at <http://wetten.overheid.nl/BWBR0035917/2016-01-01>.

⁷⁸ *Wet Langdurige Zorg* art. 3.2.1 (The Netherlands, 2016), available in Dutch at <http://wetten.overheid.nl/BWBR0035917/2016-01-01>.

⁷⁹ *Wet Langdurige Zorg* art. 3.2.3 (The Netherlands, 2016), available in Dutch at <http://wetten.overheid.nl/BWBR0035917/2016-01-01>.

⁸⁰ RIVM, *Wet publieke gezondheid*, available in Dutch at http://www.rivm.nl/Onderwerpen/W/Wet_publieke_gezondheid.

capacity requirements aimed at ensuring states' ability to discover, assess, and report serious public health risks.⁸¹ Public health care should be distinguished from the provision of curative health care. The former is focused on prevention whereas the latter is focused on treatment.⁸² Art. 1 Wpg defines public health care as the "health-protecting and health-promoting measures for the population or specific groups thereof, including the prevention and early detection of diseases."⁸³

The main responsibility for the provision of public health care lies with the municipalities.⁸⁴ However, Art. 3 Wpg provides that the Minister of VWS shall promote the quality and effectiveness of public health care.⁸⁵ According to the explanatory notes to the Wpg, the Minister is responsible for combatting the spread of infectious diseases in four "narrowly defined" cases.⁸⁶ One of those cases concerns the implementation of WHO recommendations and is only applicable in case such recommendations would include the need to provide for professional translation and interpretation services in public health prevention. The other three cases concern the repression of specific types of infectious diseases that calls for a coordinated, centralized response.

The latter group of cases prompts the question whether the government's coordinating role in combatting infectious diseases under the Wpg requires the government to provide interpretation and translation services in order to be able to detect infectious diseases before an epidemic materializes. However, the explanatory notes specify that the obligation primarily entails instructing municipalities to draft repression-plans and practice "potential scenarios."⁸⁷ Neither the IHR nor the Wpg indicate that the government is required to provide interpretation and translation services as a means to effectively detect infectious

⁸¹ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 31 316 nr. 3, 4* (Jan. 14, 2008), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-31316-3.html>.

⁸² Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 31 316 nr. 3, 32* (Jan. 14, 2008), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-31316-3.html>.

⁸³ *Wet publieke gezondheid* art. 1 (the Netherlands, 2008), available in Dutch at <http://wetten.overheid.nl/BWBR0024705/2016-01-01>.

⁸⁴ *Wet publieke gezondheid* art. 2 (the Netherlands, 2008), available in Dutch at <http://wetten.overheid.nl/BWBR0024705/2016-01-01>.

⁸⁵ *Wet publieke gezondheid* art. 3 (the Netherlands, 2008), available in Dutch at <http://wetten.overheid.nl/BWBR0024705/2016-01-01>.

⁸⁶ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 31 316 nr. 3, 24* (Jan. 14, 2008), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-31316-3.html>.

⁸⁷ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 31 316 nr. 3, 24-25* (Jan. 14, 2008), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-31316-3.html>.

deceases. Instead, the IHR leaves states significant policy freedom to organize public health as they see fit.⁸⁸

Dutch Case Law

On 24 June 2015, the District Court in The Hague handed down its judgment in the case brought by the Urgenda Foundation against the Dutch government.⁸⁹ In sum, Urgenda accused the Dutch state of violating its duty of care – based on Art. 21 GW and a number of international treaties – to ensure sufficient reduction of emission of greenhouse. Art. 21 GW provides that the Dutch state should take care to ensure the environmental livability of the country and various international treaties specify how this is to be achieved. The District Court awarded the claim by Urgenda and found that the Dutch state had violated its duty of care. This subsection explains how the District Court came to its decision as it explains the legal ramifications of the government’s duty of care. The District Court’s reasoning enables those affected to challenge a variety of social economic policies pursued by the government. Therefore, this sub-section applies this framework to the issue of translation and interpretation services in health care based on the similarities between Art. 21 and Art. 22 GW.

Urgenda claimed that the current Dutch policy aims of reducing levels of emission of greenhouse gasses by 17% in 2020, at best, compared to 1990 would contribute to an increase of the global temperature of more than 2 degrees Celsius.⁹⁰ A policy aimed at such a small reduction of greenhouse gasses emissions is unlawful, according to Urgenda.⁹¹ Urgenda invoked Art. 21 GW, amongst other legal grounds, and pleaded to the District Court to hold the Dutch state accountable for its failure to aim to reduce emissions by at least 25%.⁹² Art. 21 GW instructs the government to “keep the country habitable and to protect and

⁸⁸ World Health Organization, *International Health Regulations*, 59 (2005), available at http://apps.who.int/iris/bitstream/10665/43883/1/9789241580410_eng.pdf.

⁸⁹ Rechtbank Den Haag (Jun. 24, 2015) ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

⁹⁰ Rechtbank Den Haag (Jun. 24, 2015) para. 3.1-3.2 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

⁹¹ Rechtbank Den Haag (Jun. 24, 2015) para. 3.2 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

⁹² Rechtbank Den Haag (Jun. 24, 2015) para. 3.2 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

improve the environment.”⁹³ The District Court assessed the claim on the basis of the tort law provision Art. 6:162 Dutch Civil Code (*Burgerlijk Wetboek, BW*).⁹⁴

Art. 6:162 BW reads that any person (legal or natural) committing an unlawful act towards another is liable for the damage caused. An act or omission is unlawful if and when all following five conditions are met: (i) the conduct is in violation of a legal obligation; (ii) the conduct is attributable (in this case to the state); (iii) damage arises; (iv) a causal relationship exists between the conduct and the damage; and (v) the violated norm serves to protect the claimant’s interests.⁹⁵

(Illegal Act) Under Dutch civil law, both (i) violations of law and (ii) acts and omissions that infringe upon a duty imposed by law or that which customary law regards as proper social conduct in absence of a justification for this act are considered illegal acts.⁹⁶ Urgenda argued that the Dutch state had violated Art. 21 GW and various international treaty obligations as well as the duty of care that befalls upon the government as a matter of customary (“unwritten”) law.⁹⁷

The District Court found, however, that neither Art. 21 GW nor various international treaties and principles contain specific legal obligations a violation of which Urgenda could invoke before a court.⁹⁸ Art. 21 GW is to be understood as an instruction norm directed at the government similar to Art. 22 GW discussed earlier. Instruction norms in the Dutch legal system do not extend a right to individuals to claim violations thereof. Furthermore, under public international law the Dutch state is only answerable to other sovereign states for violations of international law and not to individuals represented by Urgenda for its international legal obligations arising from the various applicable treaties (unless the treaty allows for an individual complaint’s procedure). Therefore, the government’s omissions did not constitute a violation of law as per the first category of an illegal act.

⁹³ The NETHERLANDS CONST. art. 21 (1815), *available at* <https://www.government.nl/documents/regulations/2012/10/18/the-constitution-of-the-kingdom-of-the-netherlands-2008>.

⁹⁴ Rechtbank Den Haag (Jun. 24, 2015) para. 4.53 ECLI:NL:RBDHA:2015:7145 *available in Dutch at* <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

⁹⁵ *Dutch Civil Code Book 6* art. 162 (The Netherlands, 1992), *available in Dutch at* <http://wetten.overheid.nl/BWBR0005289/2015-06-19>.

⁹⁶ *Dutch Civil Code Book 6* art. 162(2) (The Netherlands, 1992), *available in Dutch at* <http://wetten.overheid.nl/BWBR0005289/2015-06-19>.

⁹⁷ Rechtbank Den Haag (Jun. 24, 2015) para. 4.35 ECLI:NL:RBDHA:2015:7145 *available in Dutch at* <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

⁹⁸ Rechtbank Den Haag (Jun. 24, 2015) para. 4.52 ECLI:NL:RBDHA:2015:7145 *available in Dutch at* <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

However, the District Court accepted that the state has a duty of care arising out of “proper social conduct,” the second possible ground for finding an illegal act.⁹⁹ Whether the state violated this duty of care – in this case by failing to take sufficient measures to prevent dangerous climate change – depends in turn on: (i) whether there is a situation of unlawful endangerment (*onrechtmatige gevaarzetting*) by the state, and (ii) the extent of policy freedom of the state.¹⁰⁰

Endangerment (*gevaarzetting*) refers to the creating or enduring of a dangerous situation. Endangerment is illegal when the likelihood of an accident is so great that the person who created or controlled the dangerous situation should have reasonably refrained from acting in a way that perpetuated the danger.¹⁰¹

To determine the extent of the policy freedom of the state, the District Court looks at the legal obligations and duties given to the state, as well as to the aims and principles laid down in the UN Climate treaty and the Treaty on the Functioning of the European Union (TFEU).¹⁰² Even though such sources do not contain legal obligations to be invoked by individuals in court, they can be used in the configuration of the duty of care the Dutch government. This is also referred to as “*reflexwerking*,” which assumes that the state wishes to abide by its international duties.¹⁰³ The District Court refers to principles found in international agreements, and finds a principle of prevention in Art. 191 (3) TFEU and Arts. 2 and 3 UN Climate Treaty.¹⁰⁴ When determining the extent of the duty of care, the District Court takes the following specific aspects into account: (i) the nature and extent of the damage that climate change will cause; (ii) the knowledge and foreseeability of the damage; (iii) the likelihood that the danger will materialize; (iv) the nature of the act/omission of the state; (v) the (financial) burden of taking

⁹⁹ *Dutch Civil Code Book 6* art. 162(2) (The Netherlands, 1992), available in Dutch at <http://wetten.overheid.nl/BWBR0005289/2015-06-19>.

¹⁰⁰ Rechtbank Den Haag (Jun. 24, 2015) para. 4.53 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹⁰¹ Hoge Raad (Mar. 28, 2003) para. 3.11 ECLI:NL:HR:2003:AF2679 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:HR:2003:AF2679>.

¹⁰² Rechtbank Den Haag (Jun. 24, 2015) para. 4.55 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹⁰³ Rechtbank Den Haag (Jun. 24, 2015) para. 4.43 and 4.55 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹⁰⁴ Rechtbank Den Haag (Jun. 24, 2015) para. 4.56 and 4.60 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

precautionary measures; and (vi) the extent of discretionary power of the state when executing its public duty, taking into account international principles.¹⁰⁵

The District Court concludes that, due to the seriousness of the effects of climate change and the likelihood that dangerous climate change will occur if insufficient mitigating measures are taken, there is a duty of care for the state to take mitigating measures sufficiently.¹⁰⁶ The District Court does note that if taking sufficient matters would place such a financial burden on the state that that it cannot reasonably be expected to take such measures.¹⁰⁷ However, since the state admitted that it is possible to increase the aim of reduction, the court concluded that the state's current climate change policy violated the state's duty of care.¹⁰⁸

(Attribution) Since it lies within the power of the state to prescribe rules or take other measures to promote a transition to a sustainable society and reduced emission of greenhouse gases, the District Court finds that the acts (including failure to act) are attributable to the state.¹⁰⁹

(Damages) With regard to damage, the District Court finds that the negative effects of climate change are already materializing in the Netherlands.¹¹⁰ If the global emission, including the emission of the Netherlands, does not decrease, it will lead to dangerous climate change.¹¹¹ The District Court concludes that the current and future damages are extensive and material enough to find that the state should take adequate measures based on its duty of care to prevent the climate change.¹¹²

¹⁰⁵ The District Court based its reasoning here on the criteria of endangerment set out in the *Kelderluik* case. Rechtbank Den Haag (Jun. 24, 2015) para. 4.63 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹⁰⁶ Rechtbank Den Haag (Jun. 24, 2015) para. 4.63 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹⁰⁷ Rechtbank Den Haag (Jun. 24, 2015) para. 4.86 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹⁰⁸ Rechtbank Den Haag (Jun. 24, 2015) para. 4.86 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹⁰⁹ Rechtbank Den Haag (Jun. 24, 2015) para. 4.87 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹¹⁰ Rechtbank Den Haag (Jun. 24, 2015) para. 4.89 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹¹¹ Rechtbank Den Haag (Jun. 24, 2015) para. 4.89 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹¹² Rechtbank Den Haag (Jun. 24, 2015) para. 4.89 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

(Causal Link) Although climate change is a global issue and the contribution of the Netherlands is minor in comparison to the contribution of other countries, every state's greenhouse gas emission contributes to an increased CO₂ level in the atmosphere and thus contributes to a dangerous climate change.¹¹³ The Dutch state is responsible for determining the emission reduction of the Netherlands.¹¹⁴ The District Court thus accepts a causal relationship between the emission of greenhouse gases, and the effects thereof on global climate change and the Dutch climate.¹¹⁵

(Relativity) The aspect of relativity means that the norm that is allegedly infringed is written to protect the violated interest. In the *Urgenda* case, the District Court argued that the government's duty of care to ensure a safe living climate extends at least over the territory of the Netherlands.¹¹⁶ Since *Urgenda* represents the interests of the people who live on this territory (now and in the future), the District Court finds that the violated norm serves to prevent the possible damage that *Urgenda* experiences and thus that the relativity requirement is also met.¹¹⁷

Based on the above, the District Court ultimately concludes that the state acted in violation of its duty of care and thus unlawfully against *Urgenda* when assuming a reduction target of the emission level of less than 25% in 2020.¹¹⁸

The question that arises is whether the government has a similar duty of care in relation to health care and whether the discontinuation of compensation for translation and interpretation services amounts to a violation of that duty of care.

The government has a duty to take measures to promote the public health as laid down in Art. 22 GW.¹¹⁹ On the basis of the *Urgenda* case, one could argue

¹¹³ Rechtbank Den Haag (Jun. 24, 2015) para. 4.90 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹¹⁴ Rechtbank Den Haag (Jun. 24, 2015) para. 4.90 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹¹⁵ Rechtbank Den Haag (Jun. 24, 2015) para. 4.79 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹¹⁶ Rechtbank Den Haag (Jun. 24, 2015) para. 4.91 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹¹⁷ Rechtbank Den Haag (Jun. 24, 2015) para. 4.91 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹¹⁸ Rechtbank Den Haag (Jun. 24, 2015) para. 4.93 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

that even though Art. 22 GW is considered an instruction-norm allowing the government a margin of policy discretion and does not extend rights to individuals, this article and international treaties and agreements may limit this policy freedom and inform the government's duty of care in accordance with proper social conduct. Similar to the Urgenda case, this may amount to a violation of proper social conduct as prescribed by customary law rather than any codified laws. Even though they cannot be directly invoked in court by individuals, international legal and the constitutional norms can be used to define the proper social conduct as prescribed by customary law.

As discussed before, Art. 12(1) ICESCR is interpreted as setting out the right to enjoy a variety of facilities, goods, services, and conditions to achieve the highest attainable standard of health.¹²⁰ Based on Art. 12(2)(d) ICESCR the state is obliged to create “conditions which would assure to all medical service and medical attention in the event of sickness.”¹²¹ Further, health care under the ICESCR contains an element of accessibility, meaning that health facilities and services must be accessible to every person in an indiscriminate manner.¹²² One dimension of this accessibility element is economic accessibility, or in other words, affordability to all.¹²³ Another dimension of the accessibility element is “information accessibility,” which includes the “right to seek, receive and impart information and ideas concerning health issues” without impairing the “right to have personal health data treated with confidentiality.”¹²⁴ The Office of the High Commissioner for Human Rights (OHCHR) has also explained that the right to health care as laid in for example the UDHR and ICESCR encompasses that states

¹¹⁹ The NETHERLANDS CONST. art. 22 (1815), *available at* <https://www.government.nl/documents/regulations/2012/10/18/the-constitution-of-the-kingdom-of-the-netherlands-2008>.

¹²⁰ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 9, UN Doc. E/C.12/2000/4, (Aug., 11, 2000), *available at* <http://www.refworld.org/docid/4538838d0.html>.

¹²¹ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 7, UN Doc. E/C.12/2000/4, (Aug., 11, 2000), *available at* <http://www.refworld.org/docid/4538838d0.html>.

¹²² Committee on Economic, Social and Cultural Rights General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 12, UN Doc. E/C.12/2000/4, (Aug., 11, 2000), *available at* <http://www.refworld.org/docid/4538838d0.html>.

¹²³ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 12(b), UN Doc. E/C.12/2000/4, (Aug. 11, 2000), *available at* <http://www.refworld.org/docid/4538838d0.html>.

¹²⁴ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 12(b), UN Doc. E/C.12/2000/4, (Aug., 11, 2000), *available at* <http://www.refworld.org/docid/4538838d0.html>.

“should, for instance, adopt legislation or other measures ensuring equal access to health care provided by third parties.”¹²⁵

The discontinuation of compensation for interpretation and translation services in health care might compromise this right to health care for certain groups, as it limits the enjoyment of those with low Dutch proficiency of facilities or services due to a language and financial barrier. Further, as a State Party to the ICESCR, the Netherlands has an international legal obligation to progressively achieve the full realization of the right to health to the maximum of its available resources and refrain from retrogressive actions.¹²⁶ By discontinuing the compensation for interpretation and translation services in health care, the Dutch government re-introduces a barrier for non-Dutch speaking persons’ access to health care services. It follows that it can be argued that, following the lead of the District Court in the Urgenda judgment, Art. 22 GW should be interpreted as a limitation to the policy freedom of the state to decide how to fill its duty of care by the obligation to take progressive measures that ensure access to health care. The argument goes that by creating a financial or language barrier for those with low proficiency of the Dutch language, the discontinuation of compensation for interpretation and translation services in health care has done precisely the opposite and thus violated this duty of care as a violation of proper social conduct. The fact that Art. 12 ICESCR is not regarded as a provision binding upon every citizen (*een ieder verbindende bepaling*) and thus cannot be directly invoked by individuals due to Arts. 93 and 94 GW¹²⁷ does not hinder the interpretation of customary law in light of this article.¹²⁸

Upon accepting that the discontinuation of compensation does indeed amount to an illegal act in violation of proper conduct as prescribed by customary law, the question whether the state violated this duty of care will turn to two

¹²⁵ Office of the United Nations High Commissioner for Human Rights (OHCHR), *The Right to Health: Fact Sheet* No. 31, 1 and 28 (Jun. 2008), available at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>.

¹²⁶ International Covenant on Economic Social and Cultural Rights, art. 5, Dec.16, 1966, 993 U.N.T.S. 3 (1966), available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

¹²⁷ The NETHERLANDS CONST. art. 93 and 94 (1815), available at <https://www.government.nl/documents/regulations/2012/10/18/the-constitution-of-the-kingdom-of-the-netherlands-2008>; Centrale Raad van Beroep (Dec. 14, 2010) para. 4.5 ECLI:NL:CRVB:2010:BO6734 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:CRVB:2010:BO6734>.

¹²⁸ See for example Centrale Raad van Beroep, (Mar. 29, 2005) ECLI:NL:CRVB:2005:AT3468 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:CRVB:2005:AT3468> where the Administrative High Court interpreted a national law in light of the Convention on the Rights of the Child. For this interpretation of national law in accordance with the convention, rather than the direct application of the convention itself, it was not necessary to assess whether the cited convention provisions were binding upon anybody as required by article 93 and 94 of the Constitution.

aspects in particular: (i) whether the discontinuation creates a situation of unlawful endangerment, and (ii) the extent of the state's policy freedom.¹²⁹ A court will have to balance the unlawful endangerment against the freedom of policy choices and financial means of the state.

Several doctors have expressed that they feel it is impossible for them to deliver proper and adequate health care due to the discontinuation of compensation for translation and interpretation services.¹³⁰ They have highlighted that a lack of proper communication renders it impossible to deliver proper treatment and that having children step in to help communications between doctors and their parents is undesirable. Furthermore, doctors have expressed the fear that patients will stay away from doctors for a lack of being able to communicate with them effectively. In addition, many organizations warned the government of the potential effects of discontinuing compensation, attesting to the fact that any endangerment was foreseeable.¹³¹ Although further research would be required to know the full extent of these problems, it seems like the nature and extent of the damage are severe, that this can cause dangerous situations for individuals who need health care and for society that needs protection against potential bearers of contagious diseases, and more generally creates societal issues that may well be larger than the costs of its remedy.

In assessing whether the Dutch state committed an unlawful act, consideration is also given to the financial burden put upon the government to address the illegal endangerment. If such a burden is to be considered unreasonable, the government cannot be expected to act accordingly and its acts or omissions may not amount to an unlawful act. Even though the discontinuation came about as a result of budget cuts, numerous stakeholders have indicated that compensating for translation and interpretation services may in fact be more cost-effective than not doing so. Health care providers that make use of professional translation services are in a better position to set the right diagnosis in a shorter period of time. Anecdotal evidence indicates that health care providers, general

¹²⁹ Rechtbank Den Haag (Jun. 24, 2015) para. 4.53 ECLI:NL:RBDHA:2015:7145 available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:RBDHA:2015:7145>.

¹³⁰ KPMG maintains an online portal where they collect experiences of medical professionals. Among these testimonials are testimonials of doctors who explicitly state that they cannot deliver proper health care or treat a patient because they cannot understand each other. See for example the testimonial of H.E. Kattenbusch from Jan. 5, 2012 and other testimonials available in Dutch at <http://www.knmg.nl/Nieuws/Overzicht-nieuws/Nieuwsbericht/108393/Einde-tolkenvergoeding-geef-hier-uw-knelpunten-en-tips-door.htm>.

¹³¹ KNMG, *KNMG: stopzetten vergoeding tolkdiensten slecht idee* (Jun. 1, 2011) available in Dutch at <http://www.knmg.nl/Nieuws/Overzicht-nieuws/Nieuwsbericht/97677/KNMG-stopzetten-vergoeding-tolkdiensten-slecht-idee.htm>.

practitioners or family doctors in particular, become more cautious when providing services to patients of low Dutch proficiency in absence of professional translation services and are more likely to refer patients to specialist care that may not be strictly medically necessary. They do so out of caution, wishing to prevent being accused of inadequately serving a patient of low Dutch proficiency.¹³² However, the Minister of VWS denies this effect and has submitted that there is no support for the claim that the discontinuation of compensation for translation services has resulted in more referrals by general practitioners or family doctors.¹³³

International Legal Framework

Various international human rights treaties recognize the right to health and health care. The Universal Declaration of Human Rights (UDHR) considers medical care as part of a standard of living adequate to a person's health and well-being, to which everyone has a right.¹³⁴ Its provisions formed the basis of the International Covenant on Economic, Social and Cultural Rights (ICESCR),¹³⁵ which is the primary legally binding international instrument on the realization of the individual right to health.¹³⁶

Art. 12(1) ICESCR recognizes the right of all to “the enjoyment of the highest attainable standard of physical and mental health.”¹³⁷ In General Comment No. 14, the UN Committee on Economic, Social and Cultural Rights (CESCR) explains Art. 12(1) ICESCR not as the right to be healthy, but as the right to enjoy a variety of facilities, goods, services, and conditions to achieve the highest attainable standard of health.¹³⁸

¹³² I. Doorten & J. W. Meeding, *Focusgroeponderzoek in het kader van het adviesproject ‘De bomen en het bos: de patiënt, zijn vraag en het landschap*, RAAD VAN VOLKSGEZONDHEID & ZORG 9 (Aug. 2012), available in Dutch at: https://www.raadrvs.nl/uploads/docs/Verslag_Focusgroepen.pdf.

¹³³ Minister of Health, Welfare and Sport, *Inzet tolken*, MINISTRY OF HEALTH, WELFARE AND SPORT, 2 (May. 28, 2013), available in Dutch at <https://www.rijksoverheid.nl/binaries/rijksoverheid/documenten/kamerstukken/2013/05/28/kamerbrief-over-inzet-tolken/kamerbrief-over-inzet-tolken.pdf>.

¹³⁴ Universal Declaration of Human Rights, art. 25(1), Dec. 10, 1948, U.N. Doc A/810 (1948), available at <http://www.un.org/en/universal-declaration-human-rights/index.html>.

¹³⁵ Harry J. Steiner, Philip Alston, Ryan Goodman, INTERNATIONAL HUMAN RIGHTS IN CONTEXT 125 (2008).

¹³⁶ Ben Saul, David Kinley & Jacqueline Mowbray, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: COMMENTARY, CASES AND MATERIALS 978 (2014).

¹³⁷ International Covenant on Economic, Social and Cultural Rights, art. 12(1), Dec. 16, 1966, 993 U.N.T.S. 3 (1966), available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

¹³⁸ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 9, UN Doc. E/C.12/2000/4, (Aug. 11, 2000), available at <http://www.refworld.org/docid/4538838d0.html>.

Art. 12(2) ICESCR lists the steps States Parties must take in order to ensure the full realization of this right. States Parties should take steps necessary for “the creation of conditions, which would assure to all medical service and medical attention in the event of sickness.”¹³⁹ The CESCR determines that the right the health contains the following essential and interrelated elements: (i) availability; (ii) accessibility; (iii) acceptability; and (iv) quality.¹⁴⁰

The element of “accessibility” requires all health care facilities, as well as the services and products they offer, to be equally accessible to every person in the jurisdiction of the respective state. Accessibility can be broken down into the following four overlapping principles: (i) non-discrimination; (ii) physical accessibility; (iii) economic accessibility, and (iv) information accessibility.¹⁴¹

Under the first principle, everyone should have indiscriminate access to health care, especially marginalized and vulnerable groups. There must be no discrimination on any of the prohibited grounds enumerated in Art. 2(2) ICESCR, which include, *inter alia*, language.¹⁴²

Under the third principle, health care must be economically affordable for all. This entails that payment for health care services, and services related to the underlying determinants of health, “has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.”¹⁴³ This also means that poorer sections of the society must not be burdened in a disproportionate manner with health expenses, compared to wealthier sections of the society.¹⁴⁴

¹³⁹ International Covenant on Economic, Social and Cultural Rights, art. 12(2)(d), Dec. 16, 1966, 993 U.N.T.S. 3, (1966), available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

¹⁴⁰ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 12, UN Doc. E/C.12/2000/4, (Aug. 11, 2000), available at <http://www.refworld.org/docid/4538838d0.html>.

¹⁴¹ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 12(b), UN Doc. E/C.12/2000/4, (Aug. 11, 2000), available at <http://www.refworld.org/docid/4538838d0.html>.

¹⁴² Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 12(b), UN Doc. E/C.12/2000/4, (Aug. 11, 2000), available at <http://www.refworld.org/docid/4538838d0.html>.

¹⁴³ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 12(b), UN Doc. E/C.12/2000/4, (Aug. 11, 2000), available at <http://www.refworld.org/docid/4538838d0.html>.

¹⁴⁴ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 12(b), UN Doc. E/C.12/2000/4, (Aug. 11, 2000), available at <http://www.refworld.org/docid/4538838d0.html>.

Although Art. 2(1) ICESCR provides for the progressive realization of these rights, some obligations are of immediate effect.¹⁴⁵ For instance, States Parties have an immediate obligation under Art. 2(2) ICESCR to ensure the rights enumerated in the ICESCR without discrimination of any kind, including race, color, sex, language, religion, political, or other opinion, national or social origin, property, birth, or other status.¹⁴⁶ Steps taken in this regard must be deliberate, concrete, and targeted towards the full realization of the right.

The principle of progressive realization imposes an additional obligation to not take retrogressive measures in relation to ICESCR rights, and is implicit in Art. 2(1) ICESCR, as well as Art. 5 ICESCR. The provisions express that a state must not engage in any activity or act that destroys or limits any of the rights provided for in the Covenant.¹⁴⁷ The Office of the High Commissioner for Human Rights recognizes this obligation in its authoritative Handbook for National Human Rights Institutions¹⁴⁸, alongside the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights.¹⁴⁹ Finally, General Comment No. 14 provides that States must not take retrogressive measures, and if such measures are taken the State must prove that they are justified by reference to the totality of rights in the ICESCR, in the context of the full use of the State's maximum available resources.¹⁵⁰ Therefore, depriving or limiting citizens in the exercise of the rights that they used to have under the ICESCR or lowering the standard of those rights could constitute a violation of the Covenant.

The Netherlands is a state party to the ICESCR¹⁵¹ and thus has an international legal obligation to take any necessary steps to progressively achieve the full realization of the right to health to the maximum of its available

¹⁴⁵ Committee on Economic, Social and Cultural Rights, General Comment No. 3, The Nature of States Parties' Obligations, para. 1, UN Doc. E/1991/23, (Dec. 14, 1990), *available at* <http://www.refworld.org/docid/4538838e10.html>.

¹⁴⁶ Committee on Economic, Social and Cultural Rights, General Comment No. 19, The Right to Social Security, para. 40, UN Doc. E/C.12/2000/4, (Nov. 27, 2007), *available at* <http://www.refworld.org/docid/47b17b5b39c.html>.

¹⁴⁷ International Covenant on Economic Social and Cultural Rights, art. 5, Dec. 16, 1966, 993 U.N.T.S. 3 (1966), *available at* <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

¹⁴⁸ Office of the High Commissioner for Human Rights, *Economic, Social and Cultural Rights Handbook for National Human Rights Institutions*, 28, UN Doc HR/P/PT/12, (2005), *available at* <http://www.ohchr.org/Documents/Publications/training12en.pdf>.

¹⁴⁹ *Maastricht Guidelines On Violations of Economic, Social and Cultural Rights* Guideline 14.e, (Jan. 22-26, 1997), *available at* https://www1.umn.edu/humanrts/instree/Maastrichtguidelines_.html.

¹⁵⁰ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 32, UN Doc. E/C.12/2000/4, (Aug. 11, 2000), *available at* <http://www.refworld.org/docid/4538838d0.html>.

¹⁵¹ Office of the High Commissioner for Human Rights, *Status of Ratifications*, (1978), *available at* <http://indicators.ohchr.org>.

resources.¹⁵² The discontinuation of compensation for interpretation and translation in health care may violate the Dutch state's obligations under Art. 12(2)(d) ICESCR as it constitutes a regression on the non-discriminatory access and economic accessibility of the right to health care. By discontinuing the compensation for interpretation and translation services in health care, the Dutch government re-introduces a barrier for non-Dutch speaking persons' access to health care services. Health care is no longer economically accessible to all because only those of low Dutch proficiency with the financial means to afford private translation services can gain access to adequate health care without having to rely on friends or relatives to provide informal translation services. Those who cannot speak Dutch, arguably a particularly vulnerable minority group in Dutch society, therefore become burdened in a disproportionate manner compared to native speakers or those with greater financial means. By extension, this discontinuation of compensation for translation services indirectly discriminates against, on the basis of language as provided for in Art. 2(2) ICESCR, those who do not speak Dutch or speak it insufficiently.

States parties to the ICESCR are under an obligation to submit periodic reports to the CESCR identifying steps they have made to ensure the full realization of rights under the ICESCR.¹⁵³ The Netherlands submitted their latest report in 2009,¹⁵⁴ to which the CESCR provided concluding observations in 2010.¹⁵⁵ In their Concluding Observations the CESCR specifically urged the Netherlands to pay particular attention to the situation of migrants within its territory and identify any difficulties these groups face in accessing health care.¹⁵⁶

¹⁵² International Covenant on Economic, Social and Cultural Rights, art. 2, Dec. 16, 1966, 993 U.N.T.S. 3 (1966), available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

¹⁵³ International Covenant on Economic, Social and Cultural Rights, art. 16(1), Dec. 16, 1966, 993 U.N.T.S. 3 (1966), available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

¹⁵⁴ Economic and Social Council, *Implementation of the International Covenant on Economic, Social and Cultural Rights, Combined fourth and fifth periodic reports submitted by States parties under articles 16 and 17 of the Covenant: The Netherlands*, UN Doc E/C.12/NLD/4-5 (Jul. 17, 2009), available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fNLD%2f4-5&Lang=en.

¹⁵⁵ Economic and Social Council, *Consideration of reports submitted by States parties under articles 16 and 17 of the Covenant, Concluding observations of the Committee on Economic, Social and Cultural Rights The Kingdom of the Netherlands*, UN Doc E/C.12/NLD/CO/4-5 (Dec. 10, 2010), available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fNLD%2fCO%2f4-5&Lang=en.

¹⁵⁶ Economic and Social Council, *Consideration of reports submitted by States parties under articles 16 and 17 of the Covenant, Concluding observations of the Committee on Economic, Social and Cultural Rights The Kingdom of the Netherlands*, para. 12(a), UN Doc E/C.12/NLD/CO/4-5, (Dec. 10, 2010), available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fNLD%2fCO%2f4-5&Lang=en.

The CESCR called upon the Netherlands to adopt and implement targeted programs to improve the situation of foreigners in relation to health care¹⁵⁷ and required the Dutch government to provide statistical data on the enjoyment of these rights in their next report.¹⁵⁸ The discontinuation of translation services in health care arguably does not correspond with the recommendations from the CESCR. Dutch residents of low Dutch proficiency now face an additional burden of having to incur expenses for interpreters in order to enjoy adequate health care. Alternatively, they are to depart of their right to privacy in a medical setting and ask relatives or friends to translate for them. The Netherlands submitted their sixth periodic report to the CESCR in February 2016, but did not touch upon this issue of discontinuation of translation services in health care.¹⁵⁹

The Optional Protocol to the ICESCR (2008) establishes a complaint and inquiry procedure for violations of the rights provided by the Covenant.¹⁶⁰ The Netherlands has signed but has not ratified the Protocol, which means that Dutch residents cannot make use of this complaints procedure.¹⁶¹

In the Dutch legal system, international treaties can be invoked before a Dutch court under Art. 94 GW as long as they constitute rules that are binding upon all citizens.¹⁶² However, the Dutch judiciary has consistently held that the ICESCR lacks such binding force.¹⁶³ This position taken by the Dutch Courts

¹⁵⁷ Economic and Social Council, *Consideration of reports submitted by States parties under articles 16 and 17 of the Covenant, Concluding observations of the Committee on Economic, Social and Cultural Rights The Kingdom of the Netherlands*, para. 12(b), UN Doc E/C.12/NDL/CO/4-5, (Dec. 10, 2010), available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fNLD%2fCO%2f4-5&Lang=en.

¹⁵⁸ Economic and Social Council, *Consideration of reports submitted by States parties under articles 16 and 17 of the Covenant, Concluding observations of the Committee on Economic, Social and Cultural Rights The Kingdom of the Netherlands*, para. 12(e), UN Doc E/C.12/NDL/CO/4-5, (Dec. 10, 2010), available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fNLD%2fCO%2f4-5&Lang=en.

¹⁵⁹ Kingdom of the Netherlands, *Sixth periodic report to the International Covenant on Economic, Social and Cultural Rights*, (Feb. 2006), available at <https://www.rijksoverheid.nl/binaries/rijksoverheid/documenten/rapporten/2016/02/01/international-covenant-on-economic-social-and-cultural-rights/international-covenant-on-economic-social-and-cultural-rights.pdf>.

¹⁶⁰ Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, art. 1, Dec. 10, 2008, U.N. Doc. A/63/435 (2008), available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCESCR.aspx>.

¹⁶¹ Office of the High Commissioner for Human Rights, *Status of Ratifications*, (2008), available at <http://indicators.ohchr.org>.

¹⁶² The NETHERLANDS CONST. art. 94 (1815), available at <https://www.government.nl/documents/regulations/2012/10/18/the-constitution-of-the-kingdom-of-the-netherlands-2008>.

¹⁶³ Centrale Raad van Beroep (Dec. 14, 2010) [ECLI:NL:CRVB:2010:BO6734] available in Dutch at <http://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:CRVB:2010:BO6734>.

seems inconsistent with the view expressed by the CESCR in General Comment No. 14. The CESCR calls upon State Parties to ensure that any person who has had their right to health violated must have an effective judicial or other appropriate remedy available to them at the national level.¹⁶⁴ However, General Comments are not legally binding and merely serve as interpretative guidelines.¹⁶⁵

Regional Legal Framework

Within the European human rights framework, the European Social Charter (ESC) is a binding treaty that provides an extensive system of protection of fundamental social and economic rights.¹⁶⁶ Art. 11(1) ESC guarantees the right to protection of health. Under this article, States Parties have to take all appropriate measures as to “remove as far as possible the causes of ill-health.”¹⁶⁷ The Preamble of the ESC outlines the conditions necessary for the attainment of all the rights it contains. One of these conditions repeats the ICSECR and states that “[e]veryone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable.”¹⁶⁸

The European Committee of Social Rights is a human rights body established on the basis of Arts. 24 and 25 of the ESC.¹⁶⁹ It serves as a complaint and oversight mechanism. It includes a national reporting system whereby States Parties have to submit annual progress reports detailing their implementation of the rights under the ESC;¹⁷⁰ and a collective complaints procedure based on the Additional Protocol to the European Social Charter Providing for a System of Collective Complaints.¹⁷¹ Non-governmental organizations, international organizations of employers and trade unions, as well as representative national organizations of employers within the jurisdiction of the Contracting Parties can

¹⁶⁴ Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, para. 59, UN Doc. E/C.12/2000/4 (Aug. 11, 2000), *available at* <http://www.refworld.org/docid/4538838d0.html>.

¹⁶⁵ Ben Saul, David Kinley & Jacqueline Mowbray, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: COMMENTARY, CASES AND MATERIALS 5 (2014).

¹⁶⁶ The European Social Charter (revised), (1996), *available at* <http://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cf93>.

¹⁶⁷ European Social Charter (revised), art. 11(1), (1996), *available at* <http://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cf93>.

¹⁶⁸ European Social Charter (revised), part I(11) (1996), *available at* <http://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cf93>.

¹⁶⁹ European Social Charter (revised), arts. 24 & 25 (1996), *available at* <http://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cf93>.

¹⁷⁰ European Social Charter (revised), arts. 21-23 (1996), *available at* <http://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cf93>.

¹⁷¹ Optional Protocol to the European Social Charter Providing for a System of Collective Complaints, art. 1, (1995), *available at* <http://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cdad>.

file complaints alleging unsatisfactory application of the ESC.¹⁷² It should be noted that this is a system for collective complaints and not for individuals.

Discontinuation of compensation for interpretation and translation services in Dutch health care may decrease the quality of health care for the persons with low Dutch language proficiency,¹⁷³ and thereby constitute a cause for ill-health or a barrier for attaining the highest possible standard of health, which may amount to a violation under the ESC.

The Netherlands has signed and ratified both the ESC and the Additional Protocol providing for the system of collective complaints, which means that lodging a collective complaint under the ESC is possible.¹⁷⁴ The admissibility requirements for filing a collective complaint to the ESC provide a low threshold for admissibility.¹⁷⁵ Art. 4 of the Additional Protocol simply requires that the collective complaint be in writing, relate to a provision of the Charter accepted by the Contracting Party concerned and indicate in what respect the latter has not ensured the satisfactory application of this provision.¹⁷⁶ There is no need to exhaust all domestic remedies and the claimant party does not have to be a victim of the relevant violation.¹⁷⁷ In addition, the Explanatory Report to the Additional Protocol highlights that violations of the ESC caused by provisions in national legislation or a State Party's practical implementation of the ESC can form the basis of an admissible complaint.¹⁷⁸

The Right to Equal Treatment

¹⁷² Optional Protocol to the European Social Charter Providing for a System of Collective Complaints, art. 1(d), (1995), available at <http://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cdad>.

¹⁷³ Pharos Expertisecentrum Gezondheidsverschillen, *Zorg, ondersteuning en preventie voor nieuwkomende vluchtelingen: Wat is er nodig?*, 39 & 52 (Mar. 2016), available in Dutch at <https://www.rijksoverheid.nl/documenten/rapporten/2016/06/01/zorg-ondersteuning-en-preventie-voor-nieuwkomende-vluchtelingen-wat-is-er-nodig>.

¹⁷⁴ Council of Europe, *Signatures and Ratifications*, (Mar. 21, 2016), available at <http://www.coe.int/en/web/turin-european-social-charter/signature-ratifications>.

¹⁷⁵ Council of Europe, *Explanatory Report to the Additional Protocol to the European Social Charter Providing for a System of Collective Complaints*, para. 31 (Nov. 9, 1995) available at <http://www.worldlii.org/int/other/COETSER/1995/3.html>.

¹⁷⁶ *Optional Protocol to the European Social Charter Providing for a System of Collective Complaints* art. 4 (1995) available at <http://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cdad>.

¹⁷⁷ *Optional Protocol to the European Social Charter Providing for a System of Collective Complaints* art. 4 (1995) available at <http://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cdad>.

¹⁷⁸ Council of Europe, *Explanatory Report to the Additional Protocol to the European Social Charter Providing for a System of Collective Complaints*, para. 31 (Nov. 9, 1995), available at <http://www.worldlii.org/int/other/COETSER/1995/3.html>.

The discontinuation of compensation for interpretation services in health care disadvantages people of low Dutch proficiency who seek access to health care. This measure can be argued to a form of indirect discrimination under Dutch law. This section outlines the domestic and international legal framework on the prohibition of discrimination. It subsequently assesses how that framework can be applied to the case at hand.

National Legal Framework

Art. 1 GW holds that “all persons in the Netherlands shall be treated equally in equal circumstances. Discrimination on the grounds of religion, belief, political opinion, race or sex or on any other grounds whatsoever shall not be permitted.”¹⁷⁹ The aim of this provision is the “prohibition of distinction on the ground of characteristics or features of persons, which are not reasonably relevant for the determination of rights and obligations in a certain area of societal life (labor, education, housing, health care, etc.).”¹⁸⁰ The inclusion of the words “on any other ground whatsoever” confirms the non-exhaustive nature of the list of protected grounds. “Societal reality” will determine which characteristics and determinations are prohibited grounds for distinction.¹⁸¹ The making of an (indirect) distinction is not contrary to Art. 1 GW if that distinction is based on “objective and reasonable” grounds, sometimes referred to as a “legitimate aim.” Courts judge the objectiveness and reasonableness of the grounds on the basis of the facts of the case.¹⁸²

The General Act on Equal Treatment (*Algemene Wet Gelijke Behandeling, AWGB*) is an elaboration of Art. 1 GW.¹⁸³ The AWGB prohibits discrimination on the grounds of religion, belief, political opinion, race, sex, nationality, sexual orientation, or civil status. The AWGB covers all of the protected grounds listed in Art. 1 GW and adds a number of additional protected grounds. It does not

¹⁷⁹ The NETHERLANDS CONST. art. 1 (1815), available at <https://www.government.nl/documents/regulations/2012/10/18/the-constitution-of-the-kingdom-of-the-netherlands-2008>.

¹⁸⁰ *Nota naar aanleiding van het verslag*, Tweede Kamer, 16 905, nr. 5, 16 (1981-1982), available in Dutch at <http://resolver.kb.nl/resolve?urn=sgd%3Ampg21%3A19811982%3A0003389>.

¹⁸¹ *Nota naar aanleiding van het verslag*, Tweede Kamer, 16 905, nr. 5, 16 (1981-1982), available in Dutch at <http://resolver.kb.nl/resolve?urn=sgd%3Ampg21%3A19811982%3A0003389>.

¹⁸² Raad van State (Jun. 29, 2011) para. 2.10.4. ECLI:NL:RVS:2011:BQ9684, available in Dutch at <http://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:RVS:2011:BQ9684>.

¹⁸³ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 22 014 nr. 3, 2* (1990-1991), available in Dutch at http://ressourcessgd.kb.nl/SGD/19901991/PDF/SGD_19901991_0006831.pdf; S.C. van Bijsterveld, *Commentaar op artikel 1 van de Grondwet*, in ARTIKELSGEWIJS COMMENTAAR OP DE GRONDWET, (E.M.H. Hirsch Ballin en G. Leenknecht, eds., 2016), available in Dutch at <http://www.nederlandrechtsstaat.nl/grondwet/artikel.html?categorie=1#>.

however include reference to “on any other ground.” Unlike Art. 1 GW, the AWGB provides for an exhaustive list of protected grounds in the interest of legal certainty. Violations under the AWGB must therefore always be linked to one of the protected grounds listed. The legislative history of the AWGB clarifies that a number of the protected grounds mentioned in Art. 14 of the European Convention on Human Rights (ECHR) and Art. 26 ICCPR – such as language – were considered of insufficient relevance to the Netherlands to warrant an explicit mentioning.¹⁸⁴

The AWGB covers direct as well as indirect discrimination. Direct discrimination is understood as treating someone differently because of his or her personal qualities or characteristics.¹⁸⁵ Indirect discrimination means that a seemingly neutral rule or action affects people with a certain religion, belief, political opinion, race, sex, nationality, sexual orientation, or civil status particularly, in comparison to others.¹⁸⁶ The AWGB prohibits any form of direct discrimination, unless the law provides for the possibility of an exception. Indirect discrimination is also prohibited unless an “objective justification” exists. According to the Dutch Institute for Human Rights (*College voor de Rechten van de Mens, CRM*), the goal of a distinction and the means used to achieve that goal determine whether the distinction is objectively justified. The goal must be legitimate, as in sufficiently significant, or answer to a real need. Furthermore, a legitimate goal cannot have a discriminatory intent. The means used to achieve this goal must be fitting and necessary. A means is fitting if it is appropriate to reach the goal. A means is necessary if the goal cannot be reached by a means that does not lead to distinction or at least is less burdensome. A necessary means must furthermore be in proportion to the goal.¹⁸⁷

Art. 7a was added to the AWGB as a result of the implementation of EU Council Directive 2000/43/EC.¹⁸⁸ Art. 7a AWGB prohibits a distinction on the basis of race in social protection, including social security, and social

¹⁸⁴ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 22 014 nr. 3, 5* (1990-1991), available in Dutch at http://ressourcessgd.kb.nl/SGD/19901991/PDF/SGD_19901991_0006831.pdf.

¹⁸⁵ *Algemene wet gelijke behandeling* art. 1(1)(c) (the Netherlands, 1994), available in Dutch at <http://wetten.overheid.nl/BWBR0006502/2015-07-01>.

¹⁸⁶ *Algemene wet gelijke behandeling* art. 1(1)(c) (the Netherlands, 1994), available in Dutch at <http://wetten.overheid.nl/BWBR0006502/2015-07-01>.

¹⁸⁷ College voor de Rechten van de Mens, Oordeelnummer (Sep. 26, 2014) par. 3.10, 2014-228, available in Dutch at <https://www.mensenrechten.nl/publicaties/oordelen/2014-118/detail>.

¹⁸⁸ Directive 2000/43/EC of the Council of 29 June 2000 Implementing the Principle of Equal Treatment between Persons Irrespective of Racial or Ethnic Origin, available at <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32000L0043:en:HTML>.

advantages.¹⁸⁹ The term social protection must be further defined in reference to the EU Directive. Art. 3(e) of the EU Directive includes health care under the term social protection.¹⁹⁰ Furthermore, the legislator explicitly confirmed that “all aspects of health care” fall under the term social protection.¹⁹¹ The government has the possibility to further define the terms social protection, social security, and social advantages by ministerial decree but has not used this possibility.¹⁹²

On 3 March 2016, the CRM delivered a relevant opinion in a case of a company refusing to offer its services to a customer seeking mortgage advice because of his command of the Dutch language.¹⁹³ The CRM judged that this language requirement set by the service provider amounted to a form of indirect discrimination based on race.¹⁹⁴ In accordance with previous case law on the matter, it adhered to a broad interpretation of race, including discrimination based on skin color, origin, and command of language.¹⁹⁵ As the language requirement applied to all customers equally, the measure did not amount to a form of direct discrimination. The CRM argued that the language requirement did, however, disadvantage persons with a non-Dutch background more than native Dutch persons. Therefore, the action amounted to a form of indirect discrimination.¹⁹⁶ Indirect discrimination is prohibited unless it can be objectively justified, meaning that it is fitting and necessary to achieve a legitimate aim.

The CRM judged that the language requirement in this case pursued a legitimate aim: the company was under a legal obligation to ensure that the client understood the information provided to him or her, given the significant financial consequences of the decision made based on the advice provided. The means to reach this goal were also fitting, as by providing the advice in Dutch the company would reasonably satisfy itself that the client understand the information provided.

¹⁸⁹ *Algemene wet gelijke behandeling* art. 7a (1) (the Netherlands, 1994), available in Dutch at <http://wetten.overheid.nl/BWBR0006502/2015-07-01>.

¹⁹⁰ Directive 2000/43/EC of the Council of 29 June 2000 Implementing the Principle of Equal Treatment between Persons Irrespective of Racial or Ethnic Origin, art. 3(e), available at <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32000L0043:en:HTML>.

¹⁹¹ *Kamerstukken II* 2002/03, 28 770, nr. 3, 14, available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-28770-3.html>.

¹⁹² *Algemene wet gelijke behandeling* art. 7a (2) (the Netherlands, 1994), available in Dutch at <http://wetten.overheid.nl/BWBR0006502/2015-07-01>.

¹⁹³ The opinions of the CRM are authoritative but not legally binding.

¹⁹⁴ College voor de Rechten van de Mens, Dossiernummer (Mar. 3, 2016) para. 7, 2015-0314, available in Dutch at <https://www.mensenrechten.nl/publicaties/oordelen/2016-17/detail>.

¹⁹⁵ College voor de Rechten van de Mens, Dossiernummer (Mar. 3, 2016) para. 4.3, 2015-0314, available in Dutch at <https://www.mensenrechten.nl/publicaties/oordelen/2016-17/detail>.

¹⁹⁶ College voor de Rechten van de Mens, Dossiernummer (Mar. 3, 2016) para. 5.2, 2015-0314, available in Dutch at <https://www.mensenrechten.nl/publicaties/oordelen/2016-17/detail>.

The language requirement was, however, not necessary: the company did not offer the alternative of allowing the client to bring a translator to the conversation.¹⁹⁷ Even though this case concerned a complaint against a private actor under Art. 7.1(c) AWGB, the same considerations could be arguably applied to government actions under Art. 7.1(b) AWGB.

In a 2014 case, the CRM also came to the conclusion that a language requirement can be an indirect distinction on the basis of race. The case concerned a provider of psychiatry services whose patients were mostly from Moroccan or Turkish descent. The psychiatry provider had to let a number of employees go and used a language requirement to determine which employees would be eligible for resignation. The CRM came to the conclusion that this requirement constituted indirect distinction on the basis of race because it especially affected people from a state where that language was not spoken. However, the CRM judged that there was an “objective justification” for the distinction.¹⁹⁸

However, the legislator purposely excluded “unilateral government acts” from the scope of the other provisions of the AWGB. The legislator deemed such acts to be sufficiently covered by Art. 1 GW.¹⁹⁹ As such, only Art. 7a AWGB can be used to challenge the government’s policy on the provision of compensation for translation and interpretation services. Such a claim must meet two requirements: (i) the compensation for interpretation and translation services must fall under the term social protection, and (ii) the discontinuation of that compensation must make a distinction on the basis of race. Since the term social protection includes “all aspects of health care,” one could argue that the first requirement is met. The second criterion may be met as well, because the Dutch Institute for Human Rights has consistently confirmed in its opinions (addressed in further detail below) that language is to be considered an attribute of “race.”

One may argue that the justification by the Minister of VWS for the discontinuation of compensation for interpretation introduces a language requirement for the access to health care. The responsibility to master the Dutch language applies to all people equally and as such does not amount to a form of

¹⁹⁷ College voor de Rechten van de Mens, Dossiernummer (Mar. 3, 2016) para. 5.6, 2015-0314, *available in Dutch at* <https://www.mensenrechten.nl/publicaties/oordelen/2016-17/detail>.

¹⁹⁸ College voor de Rechten van de Mens, Oordeelnummer (Sep. 26, 2014) para. 3.8, 2014-118, *available in Dutch at* <https://www.mensenrechten.nl/publicaties/oordelen/2014-118/detail>.

¹⁹⁹ Tweede Kamer, *Handelingen Tweede Kamer* 48-3593 – 48-3595 (Feb. 11, 1993), *available in Dutch at* <http://resolver.kb.nl/resolve?urn=sgd%3Ampg21%3A19921993%3A0000849>.

direct discrimination. Since this responsibility particularly disadvantages individuals of a non-Dutch background compared to individuals of Dutch descent seeking access to health care services, the situation may amount to indirect discrimination. Whether this amounts to a prohibited form of indirect discrimination depends on whether one can construct a convincing argument against the objective justification of the discontinuation. The government would have to argue which legitimate aim is pursued by requiring everybody who seeks health care to master the Dutch language themselves. In addition, the discontinuation must be fitting and necessary to reach that aim. In particular, one can question whether the means are necessary – which includes that they need to also be proportional – to reach the aim. The fact that the discontinuation of compensation can have serious consequences for people's health may not be proportional to an allegedly increased incentive to learn Dutch. Only if the measure satisfies all three criteria of i) pursuing a legitimate aim, ii) fitting measure, and iii) necessary measure, does indirect discrimination not amount to a violation of the AWGB.

International Legal Framework

Non-discrimination is a fundamental human rights principle in international law.²⁰⁰ Art. 2(2) ICESCR obliges States Parties to ensure the exercise of the rights contained in the Covenant without discrimination of any kind as to language as well as race, color, sex, religion, political or other opinion, national or social origin, property, birth or other status.²⁰¹ Although various other human rights treaties do not, the ICESCR specifically refers to language as a discriminatory ground.²⁰² The CESCR attaches immediate effect to the right to non-discrimination.²⁰³ This entails that the States Parties are under an immediate obligation to take deliberate, concrete, and targeted steps towards the full realization of this right.

However, because the Dutch government has not yet ratified the Additional Protocol to the ICESCR which provides for an individual complaints mechanism, individuals cannot make use of the complaints procedure under the ICESCR.

²⁰⁰ Ben Saul, David Kinley & Jacqueline Mowbray, *THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: COMMENTARY, CASES AND MATERIALS* 174 (2014).

²⁰¹ International Covenant on Economic, Social and Cultural Rights, art. 2(2), Dec. 16, 1966, 993 U.N.T.S. 3 (1966), available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

²⁰² International Covenant on Economic, Social and Cultural Rights, art. 2(2), Dec.16, 1966, 993 U.N.T.S. 3 (1966), available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

²⁰³ ESCR Committee, General Comment No. 19, The Right to Social Security, para. 40, UN Doc. E/C.12/2000/4 (Nov. 27, 2007), available at <http://www.refworld.org/docid/47b17b5b39c.html>.

Similarly, individuals cannot invoke their rights under the ICESCR before a Dutch court of law.²⁰⁴ Therefore, any claim of a violation of non-discrimination under the ICESCR directly is likely to be unsuccessful given the lack of judicial forums to hear a complaint against the Netherlands.

Regional Legal Framework

At the regional level, Art. 14 ECHR also prohibits discrimination on the basis of language.²⁰⁵ The European Court of Human Rights (ECtHR) applies the ECHR, and rules on applications from individuals or groups alleging human rights violations of the ECHR by contracting states of the Council of Europe,²⁰⁶ of which the Netherlands is a party.²⁰⁷

The right to non-discrimination, as codified in Art. 14 ECHR, applies in relation to the enjoyment of any other right in the ECHR.²⁰⁸ This means that the applicant must demonstrate the violation of another provision of the ECHR before invoking their right to non-discrimination.²⁰⁹ The ECHR does not include an explicit right to health or health care and thus it would be necessary to submit an application of non-discrimination brought on by the discontinuation of translation services in health care under a violation of another right.²¹⁰ The ECtHR held in the case of *Wasilewski v Poland* (2005) that the ECHR does not guarantee the right to any particular standard of medical service, nor the right to access medical treatment in any particular state.²¹¹ Although the ECtHR took cases that touched upon linguistic barriers in health care settings, for instance in *Vo v. France* (2004)²¹², or *R.K. and A.K. v. U.K* (2008)²¹³, the absence of the language services was not dealt with by the ECtHR in its legal discussion in these cases.

²⁰⁴ Centrale Raad van Beroep (Dec. 14, 2010) ECLI:NL:CRVB:2010:BO6734 available in Dutch at <http://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:CRVB:2010:BO6734>.

²⁰⁵ Convention for the Protection of Human Rights and Fundamental Freedoms, art. 14, Nov. 4, 1950, 213 U.N.T.S. 222 (1953), available at http://www.echr.coe.int/Documents/Convention_ENG.pdf.

²⁰⁶ Convention for the Protection of Human Rights and Fundamental Freedoms, art. 32, Nov. 4, 1950, 213 U.N.T.S. 222 (1953), available at http://www.echr.coe.int/Documents/Convention_ENG.pdf.

²⁰⁷ Council of Europe, *Chart of signatures and ratifications of Treaty 005*, (May. 31, 2016), available at http://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/005/signatures?p_auth=nGggB4Rk.

²⁰⁸ William Schabas, THE EUROPEAN CONVENTION ON HUMAN RIGHTS: A COMMENTARY 562 (2015).

²⁰⁹ William Schabas, THE EUROPEAN CONVENTION ON HUMAN RIGHTS: A COMMENTARY 562 (2015).

²¹⁰ Council of Europe, *Thematic Report – Health-related issues in the case-law of the European Court of Human Rights*, 4 (Jun. 2015), available at http://www.echr.coe.int/Documents/Research_report_health.pdf.

²¹¹ *Wasilewski v Poland*, Application No. 32734/96, Decision of Admissibility of 20 April 1999, para. 2, available at <http://hudoc.echr.coe.int/eng?i=001-4875>.

²¹² *Vo v France*, Application No. 53924/00, Grand Chamber Judgment of 8 July 2004, available at <http://hudoc.echr.coe.int/eng?i=001-61887>.

²¹³ *R.K. and A.K. v. the United Kingdom*, Application No. 38000(1)/05, Judgment of 30 September 2008, available at <http://hudoc.echr.coe.int/eng?i=001-88585>.

To the extent that the right to health or health care is implicit in the other rights under the ECHR, the arguments in health-related cases before the ECtHR have most frequently been based on Arts. 2, 3, and 8 ECHR.²¹⁴ The section on the right to privacy will elaborate on Art. 8 ECHR separately.

Under Art. 2 ECHR, contracting states are under the obligation to protect the right to life of individuals under their jurisdiction and refrain from acts or omissions which threaten the lives of individuals or place the health of individuals at grave risk.²¹⁵ In the case of *Cyprus v. Turkey* (2001), the ECtHR took notice of the fact that under Art. 2 ECHR, a state has obligations to protect the health of individuals in particular circumstances.²¹⁶ The Court noted that issues may arise when authorities of a contracting state place an individual's life at risk by denying health care they have made available to the population in general.²¹⁷ The ECtHR has also noted that in connection to this issue, Art. 2 ECHR provides that a state should not only refrain from the intentional and unlawful taking of life, but must also take necessary steps to safeguard the lives of those within its jurisdiction.²¹⁸ It might be possible to argue that through the discontinuation of compensation for translation and interpretation services in Dutch health care, the Netherlands is placing the health of non-Dutch speakers at risk by denying them adequate access to health care. This claim would be based on Art. 2 ECHR in conjunction with Art. 14 ECHR, arguing that through this discrimination on the basis of language the Netherlands is placing the health of these individuals at risk. However, the threshold for a violation of Art. 2 are very high and the risk to the life of the individual must be of serious gravity. It is questionable whether there is a possibility to argue that the discontinuation of compensation for translation services in Dutch health care reaches the necessary threshold for a violation of the right to life.

²¹⁴ Council of Europe, *Thematic Report – Health-related issues in the case-law of the European Court of Human Rights*, 5 (Jun. 2015), available at http://www.echr.coe.int/Documents/Research_report_health.pdf.

²¹⁵ *Ilhan v Turkey*, Application No. 22277/93, Grand Chamber Judgment of 27 June 2000, para. 75, available at <http://hudoc.echr.coe.int/eng?i=001-58734>.

²¹⁶ *Cyprus v Turkey*, Application No. 25781/94, Grand Chamber Judgment of 10 May 2001, para. 219, available at <http://hudoc.echr.coe.int/eng?i=001-59454>.

²¹⁷ *Cyprus v Turkey*, Application No. 25781/94, Grand Chamber Judgment of 10 May 2001, para. 219, available at <http://hudoc.echr.coe.int/eng?i=001-59454>; *Nitecki v Poland*, Application No. 65653/01, Decision as to Admissibility of 21 March 2002, para. 1, available at <http://hudoc.echr.coe.int/eng?i=001-22339>.

²¹⁸ Council of Europe, *Thematic Report – Health-related issues in the case-law of the European Court of Human Rights*, 4 (Jun. 2015), available at http://www.echr.coe.int/Documents/Research_report_health.pdf.

Art. 3 ECHR guarantees freedom from torture, inhuman, and degrading treatment.²¹⁹ In relation to health, Art. 3 ECHR imposes an obligation on state agents to refrain from treatment, which damages a person's physical health.²²⁰ This relates mainly to detainees and prisoners, for whom the state assumes responsibility.²²¹ In relation to foreigners, issues have primarily arisen under Art. 3 ECHR, where health care needs have been invoked as a shield against expulsion.²²² In relation to the discontinuation of translation services in health care, Art. 3 ECHR does not provide much scope for a claim in this regard.

Returning to the issue of discrimination, Protocol 12 to the ECHR²²³ has a broader scope of application than Art. 14 ECHR, as the right to non-discrimination guaranteed under Protocol 12 does not have to be attached to another right in the ECHR.²²⁴ Until now, the Court has not considered cases regarding discrimination on linguistic grounds. However, since the Netherlands has signed and ratified the Protocol it would be possible to file a complaint regarding the discontinuation of compensation for translation and interpretation services under Article 1(1) of Protocol 12, arguing discrimination on the grounds of language.

The Dutch government has argued that individuals should learn Dutch, can avoid possible barriers to the full enjoyment of the right to health care by learning Dutch or arranging for their own informal translator and there was no need to continue compensation for translation services in health care.²²⁵ In light of this argument, the case of *Andrejeva v. Latvia* (2009)²²⁶ concerning discrimination in the calculation of retirement pensions for non-citizens of Latvia could provide a basis for a claim relating to the discontinuation of compensation for translation and

²¹⁹ Convention for the Protection of Human Rights and Fundamental Freedoms, art. 3, Nov. 4, 1950, 213 U.N.T.S. 222 (1953), available at http://www.echr.coe.int/Documents/Convention_ENG.pdf.

²²⁰ *Kaçiu and Kotorri v Albania*, Application Nos. 33192/07 & 33194/07, Judgment of 25 June 2013, para. 89, available at <http://hudoc.echr.coe.int/eng?i=001-121770>.

²²¹ Council of Europe, *Thematic Report – Health-related issues in the case-law of the European Court of Human Rights*, 4 (Jun. 2015), available at http://www.echr.coe.int/Documents/Research_report_health.pdf.

²²² Council of Europe, *Thematic Report – Health-related issues in the case-law of the European Court of Human Rights*, 20 (Jun. 2015), available at http://www.echr.coe.int/Documents/Research_report_health.pdf.

²²³ Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms, art 1(1), Nov. 4, 2000, ETS 177; 4.XI. 2000 (2005), available at http://www.echr.coe.int/Documents/Library_Collection_P12_ETS177E_ENG.pdf.

²²⁴ William Schabas, *THE EUROPEAN CONVENTION ON HUMAN RIGHTS: A COMMENTARY* 1180 (2015).

²²⁵ Minister of Health, Welfare and Sport, *Inzet tolken*, MINISTRY OF HEALTH, WELFARE AND SPORT, 2-4 (May. 28, 2013), available in Dutch at <https://www.rijksoverheid.nl/binaries/rijksoverheid/documenten/kamerstukken/2013/05/28/kamerbrief-over-inzet-tolken/kamerbrief-over-inzet-tolken.pdf>.

²²⁶ *Andrejeva v Latvia*, Application No. 55707/00, Grand Chamber Judgment of 18 February 2009, available at <http://hudoc.echr.coe.int/eng?i=001-91388>.

interpretation services in health care. In determining the applicant's pension, the Latvian authorities did not take the applicant's years of employment while part of the USSR²²⁷ into consideration when calculating the total amount of the applicant's pension.²²⁸ The Latvian government argued that this outcome could have been avoided if the claimant had applied for Latvian citizenship.²²⁹ The applicant claimed, however, that this outcome violated Art. 14 ECHR in conjunction with Art. 1 Protocol 1 on the right to property.²³⁰ The ECtHR, siding with the applicant, held that it would be unfair "for the applicant to become a naturalized [...] citizen in order to receive" her full pension.²³¹ The ECtHR ruled that the prohibition of discrimination under Art. 14 ECHR is only meaningful if the applicant's personal situation is "taken into account exactly as it stands".²³² In other words, to say that the applicant could have avoided the discrimination by carrying out a specific act renders Art. 14 ECHR mute.²³³

The same could apply to the discontinuation of compensation for translation of health care services. In accordance with said case, the argument that a patient could have avoided being discriminated against on grounds of language flowing from the discontinuation of compensation for translation services by learning Dutch fails, as it would undermine the substance of the prohibition on non-discrimination. Although the case of *Andrejeva* concerned Art. 14 ECHR and thus had to raise the claim in conjunction with Art. 1 Protocol 1, this would not be necessary for a claim in the Netherlands given that it has ratified Protocol 12, which allows for a stand-alone provision prohibiting discrimination.

The Right to Privacy

The use of relatives or friends as informal interpreters inevitably involves the disclosure of confidential medical information to a third person in order to

²²⁷ Latvia was part of the USSR until 1991. The applicant had worked in the USSR and then became a resident but not a citizen in Latvia after the country gained independence.

²²⁸ *Andrejeva v Latvia*, Application No. 55707/00, Grand Chamber Judgment of 18 February 2009, para. 17, available at <http://hudoc.echr.coe.int/eng?i=001-91388>.

²²⁹ *Andrejeva v Latvia*, Application No. 55707/00, Grand Chamber Judgment of 18 February 2009, para. 72, available at <http://hudoc.echr.coe.int/eng?i=001-91388>.

²³⁰ *Andrejeva v Latvia*, Application No. 55707/00, Grand Chamber Judgment of 18 February 2009, para. 58, available at <http://hudoc.echr.coe.int/eng?i=001-91388>.

²³¹ *Andrejeva v Latvia*, Application No. 55707/00, Grand Chamber Judgment of 18 February 2009, para. 91, available at <http://hudoc.echr.coe.int/eng?i=001-91388>.

²³² *Andrejeva v Latvia*, Application No. 55707/00, Grand Chamber Judgment of 18 February 2009, para. 91, available at <http://hudoc.echr.coe.int/eng?i=001-91388>.

²³³ *Andrejeva v Latvia*, Application No. 55707/00, Grand Chamber Judgment of 18 February 2009, para. 91, available at <http://hudoc.echr.coe.int/eng?i=001-91388>.

communicate with the health care provider. The following section therefore outlines the national and international legal framework constituting the right to privacy and the corresponding obligations of the government to protect these rights and explains how the majority of the burden to protect the right to privacy of the patient befalls upon the health care provider and any other person directly involved in the provision of health care services rather than the government under national law. The ICCPR and the ECHR do provide for a number of potential legal obligations that befall upon the state to protect the right to privacy in a health care setting.

National Legal Framework

The right to privacy in the national legal framework is primarily contained in Art. 10 GW. This provision provides for a general right to respect for personal life (Art. 10 (1)), a mandate for the government to regulate the protection of privacy in connection with the collection and the use of personal data (Art. 10 (2)), and an obligation for the government to regulate an individual's access to his or her personal data (Art. 10 (3)). The first two provisions are of interest for the discontinuation of compensation for translation and interpretation services and will be discussed below.

Art. 10(1) GW sets out that everybody has a right to respect for his privacy. Art. 10 (1) GW provides what in Dutch constitutional law is known as a “traditional fundamental right” (*klassiek vrijheidsrecht*), and contains the limitation that restrictions on the fundamental right to privacy are not allowed unless laid down by or pursuant to Act of Parliament.²³⁴ Art. 10(1) GW sets out an obligation to refrain for the government rather than a positive obligation to act.²³⁵ Art. 10(2) and (3) GW task the legislature with positive obligations to regulate certain aspects of the right to privacy, as laid down in Art. 10(1) GW.²³⁶ Art. 10(2) specifically tasks the legislature with regulating the collection and use of personal data.

²³⁴ G. Overkleeft-Verburg, *Het grondrecht op eerbiediging van de persoonlijke levenssfeer*, in DE GRONDWET, EEN SYSTEMATISCH EN ARTIKELSGEWIJS COMMENTAAR 155, 158 (A.K. Koekkoek ed., third edition, 2000), available at <http://www.overkleeft-verborg.nl/PDFs/Het%20grondrecht%20op%20eerbiediging%20van%20de%20persoonlijke%20levenssfeer.pdf> and THE NETHERLANDS CONST. art. 10 (2008), available in Dutch at <https://www.rijksoverheid.nl/documenten/brochures/2008/10/20/the-constitution-of-the-kingdom-of-the-netherlands-2008>.

²³⁵ D.E. Bunschoten, TEKST EN COMMENTAAR GRONDWET art. 10 (2015).

²³⁶ G. Overkleeft-Verburg, *Het grondrecht op eerbiediging van de persoonlijke levenssfeer*, in DE GRONDWET, EEN SYSTEMATISCH EN ARTIKELSGEWIJS COMMENTAAR 155, 158 (A.K. Koekkoek ed., third edition, 2000), available in Dutch at <http://www.overkleeft-verborg.nl/PDFs/Het%20grondrecht%20op%20eerbiediging%20van%20de%20persoonlijke%20levenssfeer.pdf>.

In accordance with its mandate, the legislature adopted the Personal Data Protection Act (*Wet bescherming persoonsgegevens, Wbp*). This act is applicable to “the processing of personal data.” Personal data means all data concerning an identified or identifiable natural person.²³⁷ Processing is defined as, *inter alia*, the collection, recording, providing through redirection, storage, modification, or any other form of bringing together, connecting, protecting, erasing, or destroying personal data.²³⁸ According to the explanatory notes, the term processing also covers obtaining personal data.²³⁹ The act applies to automated as well as non-automated processing of personal data. However, concerning non-automated processing of personal data, the act is only applicable if the data is included in a file or are meant to be included in a file.²⁴⁰ In the health care context this can for instance mean the inclusion of personal data in hospital records.

The processing of certain specific types of personal data, including data concerning someone’s health, is prohibited under the Wbp.²⁴¹ This prohibition does not apply if the processing is done by certain actors appointed by the Wbp or if consent is given by the data subject.²⁴² Among the approved actors are health care providers and (civil) service providers if they process these data with the intention of the proper treatment of the person involved.²⁴³ The legal obligations of health care providers with regard to respecting a patient’s privacy will be discussed in more detail in the section on the legal obligations for health care providers.

In the context of the use of informal interpreters, the processing of data takes place when a patient communicates with a health care provider via an informal interpreter. The informal interpreter will collect the information and redirect it to

²³⁷ Wet bescherming persoonsgegevens, art. 1 (2000), available in Dutch at <http://wetten.overheid.nl/BWBR0011468/2016-01-01>.

²³⁸ Wet bescherming persoonsgegevens, art. 1 (2000), available in Dutch at <http://wetten.overheid.nl/BWBR0011468/2016-01-01>.

²³⁹ Memorie van Toelichting Wbp, p. 51 (1997-1998), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-25892-3.html>.

²⁴⁰ Wet bescherming persoonsgegevens, art. 2 (2000), available in Dutch at <http://wetten.overheid.nl/BWBR0011468/2016-01-01>.

²⁴¹ Wet bescherming persoonsgegevens, art. 16 (2000), available in Dutch at <http://wetten.overheid.nl/BWBR0011468/2016-01-01>.

²⁴² L.B. Sauerwein and J.J. Linnemann, *Handleiding voor Verwerkers van Persoonsgegevens. Wet Bescherming Persoonsgegevens*, MINISTRY OF JUSTICE 49 (Apr. 2002), available in Dutch at <https://autoriteitpersoonsgegevens.nl/sites/default/files/atoms/files/handleiding-wet-bescherming-persoonsgegevens.pdf>.

²⁴³ Wet bescherming persoonsgegevens, art. 21 (2000), available in Dutch at <http://wetten.overheid.nl/BWBR0011468/2016-01-01>.

the doctor, and thus processes personal data concerning someone's health. If the informal translator does not qualify as a person that is appointed by the Wbp to do so, he or she would need the consent of the patient.²⁴⁴ Art. 21(1) Wbp lists a number of responsible parties that can process the data concerning someone's health. Included here are health care institutions, insurance companies, medical professionals, and social services.²⁴⁵ Informal translators do not fall within any of these categories and they are therefore not allowed to process personal data without the consent of the data subject.

Art. 1(i) Wbp stipulates that consent is every free, specific, and informed expression of an individual's will.²⁴⁶ Three criteria must be met for consent to be valid. First, the patient must have been able to express his or her will freely and must have done so in practice.²⁴⁷ The requirement of expression of free will includes that there is no legal consent if the individual who has to provide consent is pressured in to doing so or if he or she feels forced to provide consent due to the nature of the relationship with the "responsible party."²⁴⁸ The term "responsible party" is defined in Wbp as the natural person who determines the aim and means for the processing of personal data.²⁴⁹ Second, the expression of an individual's will must relate to a specific act of data processing or a limited category thereof.²⁵⁰ Third, the individuals must have received information about the processing of personal data in an understandable manner, so as to be able to make an informed choice.²⁵¹ In addition, Art. 8(a) Wbp provides that consent must be unambiguous, which means that no doubt may remain with the processor of personal data as to

²⁴⁴ Wet bescherming persoonsgegevens art. 8 (2000), available in Dutch at <http://wetten.overheid.nl/BWBR0011468/2016-01-01>.

²⁴⁵ Wet bescherming persoonsgegevens art. 21(1) (2000), available in Dutch at <http://wetten.overheid.nl/BWBR0011468/2016-01-01>.

²⁴⁶ Wet bescherming persoonsgegevens art. 1 (2000), available in Dutch at <http://wetten.overheid.nl/BWBR0011468/2016-01-01>.

²⁴⁷ Memorie van Toelichting Wbp, p. 84 (1997-1998), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-25892-3.html>.

²⁴⁸ F.C. Van der Jagt, *Als ja misschien toch nee is: de toestemming van de werknemer voor de verwerking van persoonsgegevens*, TIJDSCHRIFT ARBEIDSRECHT PRAKTIJK 148, 150 (2013), available in Dutch at <https://www.stibbe.com/~media/03%20news/publications/amsterdam/friederike%20van%20der%20jagt/friederike%20van%20der%20jagt%20-%20als%20ja%20misschien%20toch%20nee%20is%20-%20de%20toestemming%20van%20de%20werknemer%20voor%20de%20verwerking%20van%20persoonsgegevens.pdf>.

²⁴⁹ Wet bescherming persoonsgegevens, art. 1(d) (2000), available in Dutch at <http://wetten.overheid.nl/BWBR0011468/2016-01-01>.

²⁵⁰ Memorie van Toelichting Wbp, p. 51 (1997-1998), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-25892-3.html>.

²⁵¹ Memorie van Toelichting Wbp, p. 51 (1997-1998), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-25892-3.html>.

whether and to what the patient consented.²⁵²

Since the patient needs the informal translator to communicate with the doctor, the nature of the relationship between the translator and the patient therefore is one of dependency. Patients may feel forced to provide consent in order to access health care because without the interpreter the individual cannot communicate with his or her medical practitioner. The individuals thus depend on the informal translator in order to access medical services and therefore might feel pressured into giving their consent. Therefore, the nature of this consent might constitute a violation of Arts. 1(i) and 8(a) Wbp. However, it must be noted that this would constitute a violation of the informal translator of the right to privacy, as he or she would process personal data without the necessary consent. The question that rises is whether the government is also in violation of its obligations.

Art. 10(1) GW contains a duty to refrain from interfering with someone's privacy unless provided for in an Act of Parliament, rather than a positive obligation to act.²⁵³ It will be hard to attribute a violation of privacy to the government by discontinuing translation and interpretation services, as the discontinuation does not necessarily impose an obligation upon patients to use informal translation services. Besides the use of an informal translator, doctors have also suggested the use of translation apps and using the medical translation card (*Medische Vertaalkaart*).²⁵⁴ Although these solutions might have their own limitations, they do show that there are other options than the use of an informal translator.

Therefore, it will be difficult to establish a direct causal link between the discontinuation of translation and interpretation services by the government, and the possible restriction of a patient's privacy in using an informal translator. Further, courts have only in exceptional cases held that the lack of granting certain facilities by the government constituted a restriction of a fundamental right.²⁵⁵ One example of this is the case in which a prison director refused the use of meeting facilities by an association of detainees.²⁵⁶ The Supreme Court held that this constituted a violation of Art. 9 GW, which contains a fundamental right to meet

²⁵² Memorie van Toelichting Wbp, p. 67 (1997-1998), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-25892-3.html>.

²⁵³ D.E. Bunschoten, TEKST EN COMMENTAAR GRONDWET art. 10 (2015).

²⁵⁴ KPMG, *Einde tolkenvergoeding: geef hier uw knelpunten en tips door*, (Jan. 4, 2012) available in Dutch at <http://www.knmg.nl/Nieuws/Overzicht-nieuws/Nieuwsbericht/108393/Einde-tolkenvergoeding-geef-hier-uw-knelpunten-en-tips-door.htm>.

²⁵⁵ A.J. Nieuwenhuis and A.W. Hins, HOOFDSTUKKEN GRONDRECHTEN 157 (2011).

²⁵⁶ A.J. Nieuwenhuis and A.W. Hins, HOOFDSTUKKEN GRONDRECHTEN 157 (2011).

and protest.²⁵⁷ Notable in this situation is that the detainees would not be able to meet with each other without the facilities offered by the director.²⁵⁸ However, if this is applied to the situation of translation and interpretation services, it will be difficult to argue that patients that don't speak Dutch aren't able to use health care facilities at all without the use of a professional translator.

International Legal Framework

Art. 12 UDHR²⁵⁹ and Art. 17 ICCPR stipulate that “no one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honor and reputation” and that “everyone has the right to protection of the law against such interference or attacks.”²⁶⁰

The UN Human Rights Committee (Human Rights Committee) clarifies the concept of the right to privacy, in General Comment No. 16.²⁶¹ According to this General Comment the correct interpretation of the right to privacy under Art. 17 ICCPR is as follows:

Article 17 provides for the right of every person to be protected against arbitrary or unlawful interference with his privacy, family, home or correspondence as well as against unlawful attacks on his honor and reputation. In the view of the Committee this right is required to be guaranteed against all such interferences and attacks whether they emanate from State authorities or from natural or legal persons. The obligations imposed by this article require the State to adopt legislative and other measures to give effect to the prohibition against such interferences and attacks as well as to the protection of this right.²⁶²

The ICCPR utilizes the expression “arbitrary or unlawful interference,” which implies that there are some interferences that are permissible under the

²⁵⁷ A.J. Nieuwenhuis and A.W. Hins, HOOFDSTUKKEN GRONDRECHTEN 157 (2011).

²⁵⁸ A.J. Nieuwenhuis and A.W. Hins, HOOFDSTUKKEN GRONDRECHTEN 157 (2011).

²⁵⁹ Universal Declaration of Human Rights, art. 12, Dec. 10, 1948, U.N. Doc A/810 (1948), *available at* <http://www.un.org/en/universal-declaration-human-rights/index.html>.

²⁶⁰ International Covenant on Civil and Political Rights, art. 17, Dec. 16, 1966, 1057 U.N.T.S. 407 (1966), *available at* <http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx>.

²⁶¹ Human Rights Committee, General Comment No. 16, The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation, U.N. Doc. HRI/GEN/1/Rev.1 (Apr. 8, 1988), *available at* <http://www.refworld.org/docid/453883f922.htm>.

²⁶² Human Rights Committee, General Comment No. 16, The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation, para. 1, U.N. Doc. HRI/GEN/1/Rev.1 (Apr. 8, 1988), *available at* <http://www.refworld.org/docid/453883f922.htm>.

ICCPR.²⁶³ Indeed in General Comment No.16 the Human Rights Committee highlights that some interferences can indeed “conform to the covenant.”²⁶⁴ The term “interference” has a very broad meaning in relation to privacy and mainly deals with the situations when the state undertakes a positive act, which does not impede the individual’s right to privacy.²⁶⁵ The ICCPR utilizes the term “unlawful” when describing an interference, indicating that domestic law must detail the precise circumstances in which such interferences are permissible.²⁶⁶ This in turn means that no interference can take place unless the law, which in itself must comply with the ICCPR, explicitly allows for one.²⁶⁷ However, the prohibition of “unlawful” interferences with privacy offers only limited protection, as states could potentially authorize highly oppressive invasions of privacy as long as they were laid down in domestic law.²⁶⁸ That is why the word “arbitrary” supplements the prohibition. The concept of an “arbitrary interference” intends to guarantee that even an interference provided by law should be in accordance with the provisions of the ICCPR.²⁶⁹ Hence the prohibition on “arbitrary” interference incorporates notions of reasonableness into Art. 17 ICCPR.²⁷⁰

To interpret whether an interference with privacy is reasonable, General Comment No. 16 indicates that the state should only be able to call for information relating to an individual’s private life when it is essential to the interests of society.²⁷¹ Similarly, in the case of *Toonen v Australia* (1992) the Human Rights Committee interpreted reasonableness to imply that “any interference with privacy

²⁶³ Sarah Joseph & Melissa Castan, *THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS: CASES, MATERIALS AND COMMENTARY* 535 (2014).

²⁶⁴ Human Rights Committee, General Comment No. 16, The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation, para. 8, U.N. Doc. HRI/GEN/1/Rev.1 (Apr. 8, 1988), available at <http://www.refworld.org/docid/453883f922.htm>.

²⁶⁵ Sarah Joseph & Melissa Castan, *THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS: CASES, MATERIALS AND COMMENTARY* 533-4 (2014).

²⁶⁶ Human Rights Committee, General Comment No. 16, The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation, para. 3, U.N. Doc. HRI/GEN/1/Rev.1 (Apr. 8, 1988), available at <http://www.refworld.org/docid/453883f922.htm>.

²⁶⁷ UN Human Rights Committee, General Comment No. 16, The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation, para. 3, U.N. Doc. HRI/GEN/1/Rev.1 (Apr. 8, 1988), available at <http://www.refworld.org/docid/453883f922.htm>.

²⁶⁸ Sarah Joseph & Melissa Castan, *THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS: CASES, MATERIALS AND COMMENTARY* 537 (2014).

²⁶⁹ Human Rights Committee, General Comment No. 16, The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation, para. 4, U.N. Doc. HRI/GEN/1/Rev.1 (Apr. 8, 1988), available at <http://www.refworld.org/docid/453883f922.htm>.

²⁷⁰ Sarah Joseph & Melissa Castan, *THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS: CASES, MATERIALS AND COMMENTARY* 537 (2014).

²⁷¹ Human Rights Committee, General Comment No. 16, The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation, para. 7, U.N. Doc. HRI/GEN/1/Rev.1 (Apr. 8, 1988), available at <http://www.refworld.org/docid/453883f922.htm>.

must be proportional to the end sought and be necessary in the circumstances”.²⁷² The ICCPR does not list permissible limitations, instead leaving it open to interpretation on a case-by-case basis. It is domestic law that enabled the discontinuation of compensation for translation in health care and therefore it does not comprise an “unlawful interference.” Whether it constitutes an “arbitrary interference” with the right to privacy is open to interpretation. It is possible to argue that discontinuing compensation for translation in health care undermines the patient’s right to privacy, as they may have to rely on informal translators in order to communicate with their medical practitioner on their personal/intimate health issues.

General Comment No. 16 further expresses that under Art. 17 ICCPR there is an obligation on the state to “adopt legislative and other measures to give effect to the prohibition against arbitrary interferences.”²⁷³ This obligation entails that a state is under an obligation to provide a remedy for arbitrary invasions of privacy in the private sector.²⁷⁴ This is important as many gross invasions of privacy occur in the private sector.²⁷⁵ However, the scope of this obligation is unclear and no cases have explicitly dealt with this positive obligation.²⁷⁶

Regional Legal Framework

At the Regional level the ECHR provides for the right to privacy in Art. 8 ECHR:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of

²⁷² *Toonen v Australia*, Communication No. 488/1992, CCPR/C/50/D/488/1992, para. 8.3, (Mar. 31, 1994), available at <http://www1.umn.edu/humanrts/undocs/html/vws488.htm>.

²⁷³ Human Rights Committee, General Comment No. 16, The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation, para. 1, U.N. Doc. HRI/GEN/1/Rev.1 (Apr. 8, 1988), available at <http://www.refworld.org/docid/453883f922.htm>.

²⁷⁴ Sarah Joseph & Melissa Castan, *THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS: CASES, MATERIALS AND COMMENTARY* 541 (2014).

²⁷⁵ Sarah Joseph & Melissa Castan, *THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS: CASES, MATERIALS AND COMMENTARY* 541 (2014).

²⁷⁶ Sarah Joseph & Melissa Castan, *THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS: CASES, MATERIALS AND COMMENTARY* 541 (2014).

disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others”²⁷⁷

The jurisprudence of the ECtHR elaborates on the definition of the term “interference by public authority.” “Interference” can include an inappropriate strip search or medical examination against the will of the patient.²⁷⁸ Discontinuing compensation for translation and interpretation services increases the risk of interference with Art. 8 ECHR due to the fact that individuals of low Dutch language proficiency may not be able to provide free consent for sharing their personal data with a third party or full consent to a specific medical procedure. However, Art. 8(2) ECHR provides that there are limitations to the right to privacy, and that in certain circumstances, other public interests may prevail.²⁷⁹

Art. 8 ECHR has been invoked in a number of cases at the ECtHR in relation to health issues. The ECtHR has interpreted the notion of privacy as covering the right to protect one’s physical and moral integrity as well as the right to refuse or request a particular form of medical treatment.²⁸⁰ The ECtHR has found that states are under a positive obligation to secure the right to ensure effective respect for physical integrity.²⁸¹ The issue of free and informed consent to medical treatment has also been a recurring feature in the case law of Art. 8 ECHR.²⁸²

The case of *Z v Finland* (1996) established that medical records fall within the rights of privacy as defined under Art. 8 ECHR.²⁸³ According to the ECtHR, it is vital that the confidentiality of health data is maintained: “[a]ny state measures

²⁷⁷ Convention for the Protection of Human Rights and Fundamental Freedoms, art. 8, Nov. 4, 1950, 213 U.N.T.S. 222 (1953), available at http://www.echr.coe.int/Documents/Convention_ENG.pdf.

²⁷⁸ *YF v. Turkey*, Application No. 24209/94, Judgment of 22 July 2003, para. 33, available at <http://hudoc.echr.coe.int/eng?i=001-61247>.

²⁷⁹ William Schabas, *THE EUROPEAN CONVENTION ON HUMAN RIGHTS: A COMMENTARY* 367 (2015).

²⁸⁰ Council of Europe, *Thematic Report – Health-related issues in the case-law of the European Court of Human Rights*, 5 (Jun. 2015), available at http://www.echr.coe.int/Documents/Research_report_health.pdf.

²⁸¹ Council of Europe, *Thematic Report – Health-related issues in the case-law of the European Court of Human Rights*, 5 (Jun. 2015), available at http://www.echr.coe.int/Documents/Research_report_health.pdf.

²⁸² Council of Europe, *Thematic Report – Health-related issues in the case-law of the European Court of Human Rights*, 5 (Jun. 2015), available at http://www.echr.coe.int/Documents/Research_report_health.pdf.

²⁸³ *Z v Finland*, Application No. 22009/93, Judgment of 25 February 1997, paras. 70-71, available at <http://hudoc.echr.coe.int/eng?i=001-58033>.

compelling communication or disclosure of such information without the consent of the patient calls for the most careful scrutiny.”²⁸⁴

As set out above, it is possible that having to use the help of a friend, neighbor, or minor to get health care forces a patient to consent to disclosing sensitive personal information to a third party, thus violating the requirement of free consent. “Informal” translators are also not bound by professional duties of confidentiality and thus such information may be further disseminated against the will of the patient.²⁸⁵ Therefore, it is possible to argue that the new regulations force patients that do not speak Dutch to forsake their right to privacy, for example, if they lack financial means to hire a professional translator. Similarly, the lack of translation and interpretation services undermines the ability to provide full and informed consent to the medical procedures, which in turn may constitute a violation of Art. 8 ECHR.

The ECtHR has held that consent is an important concept under Art. 8 ECHR.²⁸⁶ In the case of *V.C. v Slovakia* (2011) the ECtHR held that the failure of a state owned hospital to ensure that a Roma woman had fully consented to a medical procedure violated Art. 8 ECHR.²⁸⁷ The ECtHR referred to several international legal instruments elaborating what consent specifically means.²⁸⁸ For example, under the Convention on Human Rights and Biomedicine (CHRB), which the Netherlands has signed but not ratified, Art. 5 CHRB provides that carrying out an intervention in a person’s health is only possible upon his or her free and informed consent.²⁸⁹ Similarly, the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has defined informed consent as:

²⁸⁴ *Z v Finland*, Application No. 22009/93, Judgment of 25 February 1997, para. 96, available at <http://hudoc.echr.coe.int/eng?i=001-58033>.

²⁸⁵ Sarah Joseph & Melissa Castan, *THE INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS: CASES, MATERIALS AND COMMENTARY* 548 (2014).

²⁸⁶ Council of Europe, *Thematic Report – Health-related issues in the case-law of the European Court of Human Rights*, 11 (Jun. 2015), available at http://www.echr.coe.int/Documents/Research_report_health.pdf.

²⁸⁷ *V.C v Slovakia*, Application No. 18968/07, Judgment of 8 November 2011, para. 154, available at <http://hudoc.echr.coe.int/eng?i=001-107364>.

²⁸⁸ *V.C v Slovakia*, Application No. 18968/07, Judgment of 8 November 2011, para. 76, available at <http://hudoc.echr.coe.int/eng?i=001-107364>.

²⁸⁹ Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, art. 5, Apr. 4, 1997, ETS No. 164; 4.IV.1997 (1999), available at <https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168007cf98>.

Informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to health care providers. Its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being.²⁹⁰

The ECtHR has thus held that a lack of informed consent to a medical procedure would violate Art. 8 ECHR.²⁹¹ In light of this it is possible to argue that the discontinuation of compensation for translation and interpretation services in Dutch health care undermines the ability of a patient to provide full and informed consent. A lack of professional translation and interpretation services could lead to the patient being unable to fully understand the medical procedure, its consequences and thus render them unable to provide full and voluntary informed consent to medical procedures. It can be argued that the discontinuation of compensation for translation services in health care undermines the duty of the state, as held by the ECtHR, to ensure in state-run medical institutions that an individual is capable of providing full and informed consent.

The Municipalities

This section analyzes to what extent Dutch municipalities have an obligation under Dutch law to ensure access to health care. These obligations complement or apply in addition to the obligations of the Dutch central government. The municipality has health care responsibilities over three types of care: public health care, societal care, and youth care. Public health mostly covers the spread of infectious diseases, societal care concerns the elderly and disabled, and youth care concerns those under 18 years old.

Public health complements curative care. The needs of individuals determine curative care, whereas the needs of the population as a whole determines

²⁹⁰ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, para. 9, delivered to the General Assembly, U.N. Doc A/64/272 (Aug. 10, 2009), available at <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N09/450/87/PDF/N0945087.pdf?OpenElement>.

²⁹¹ Bernadette Rainey, Elizabeth Wicks & Claire Ovey, THE EUROPEAN CONVENTION ON HUMAN RIGHTS 394-5 (2014); *V.C v Slovakia*, Application No. 18968/07, Judgment of 8 November 2011, para. 144, available at <http://hudoc.echr.coe.int/eng?i=001-107364>.

public health care.²⁹² However, the execution of public health care may nevertheless be directed at individuals. Under the Public Health Act (*Wet publieke gezondheid, Wpg*), municipalities are responsible for various aspects of disease prevention, health promotion, and health protection.²⁹³ For example, under the Wpg municipalities are generally responsible for youth care, elderly care, and the control of infectious diseases. Furthermore, municipalities are obliged to regularly analyze the health situation of the population and to estimate the demand for care under youth and elderly.²⁹⁴ The laws that govern youth care and societal care are the Societal Support Act (*Wet maatschappelijke ondersteuning, Wmo*) and the Youth Act (*Jeugdwet, Jw*).

Access to Health Care

Public Health Care

The Wpg is based on the 2005 International Health Regulations (IHR) and contains the division of responsibilities regarding public health between the central government and municipalities.²⁹⁵ The central government has a coordinating role, whereas the role of municipalities is more executive in nature.²⁹⁶ Under the Wpg, the municipalities carry the ultimate responsibility to control infectious diseases.²⁹⁷ This recalls the municipality's responsibilities under the Community Act (*Gemeentewet, Gw*).²⁹⁸ According to this Act, the mayor may give orders necessary to maintain public order or restrict danger in the case of a disturbance or serious threat to public order.²⁹⁹ In the explanatory notes to the Gw, the mayor is specifically given authority to prevent and combat epidemic outbreaks of infectious diseases.³⁰⁰

²⁹² Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 31 316 nr. 3*, 32 (Jan. 14, 2008), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-31316-3.html>.

²⁹³ For an overview of these obligations, see: *Wet publieke gezondheid* (the Netherlands, 2008), available in Dutch at <http://wetten.overheid.nl/BWBR0024705/2016-01-01>.

²⁹⁴ *Wet publieke gezondheid*, arts. 2.2(a), 5.2(b) & 5a.2(b) (the Netherlands, 2008), available in Dutch at <http://wetten.overheid.nl/BWBR0024705/2016-01-01>.

²⁹⁵ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 31 316 nr. 3*, 8 (Jan. 14, 2008), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-31316-3.html>.

²⁹⁶ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 31 316 nr. 3*, 8-9 (Jan. 14, 2008), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-31316-3.html>.

²⁹⁷ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 31 316 nr. 3*, 7 (Jan. 14, 2008), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-31316-3.html>.

²⁹⁸ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 31 316 nr. 3*, 23 (Jan. 14, 2008), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-31316-3.html>.

²⁹⁹ *Gemeentewet* arts. 172 & 175 (the Netherlands, 1992), available in Dutch at <http://wetten.overheid.nl/BWBR0005416/2016-02-01>.

³⁰⁰ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 31 316 nr. 3*, 23 (Jan. 14, 2008), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-31316-3.html>.

Municipalities have a duty of care under the Wpg and Gw to take appropriate actions to prevent and combat epidemic outbreaks and infectious diseases. Maintaining a municipal health care system sufficiently accessible to all could be seen as a prerequisite for fulfilling this duty of care. Discontinuing compensation for translation and interpretation services in health care at the municipal level hinders those with low Dutch proficiency seeking to procure health care services. Such discontinuation threatens the accessibility of the municipal health care system and as such public health care as a whole.

A parallel argument emerges between the duty of care of the central government for curative care and the duty of care of the municipalities for public health care and infectious disease prevention. In assessing whether municipalities have violated their duty of care and thus commit an unlawful act as defined under in Art. 6:162 BW by reintroducing a barrier for the access to public health care, two factors must be considered: (i) the existence of an unlawful endangerment;³⁰¹ and (ii) the level of policy discretion awarded to the state organ.³⁰² The former requires empirical evidence that the compromised accessibility of public health services following the discontinuation of compensation for translation services results in fewer individuals of low Dutch proficiency seeking such services. In addition, the specific public health risks that resulting from these individuals not seeking health care services need to be addressed. The court will then assess this illegal endangerment in light of the policy discretion awarded to the municipalities under the relevant provisions of the Wpg and Gw as well as any other relevant piece of legislation.

Societal Care

The Wmo 2015, which replaced the Wmo 2007, widened municipalities' responsibilities to provide societal support. It aims to support individuals with disabilities to live independently and participate in society to the fullest of their abilities.³⁰³ The responsibility of the individual in need of support is an important pillar of the Wmo, as the government/municipalities no longer provide support by

³⁰¹ For further details on the structure of an unlawful act, please refer to section on the national legal framework on the right to health care under the Dutch Government.

³⁰² For further details on the structure of an unlawful act, please refer to section on the national legal framework on the right to health care under the Dutch Government

³⁰³ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 841 nr. 3*, 1 (Jan. 15, 2014), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33841-3.html>.

default.³⁰⁴ Instead, the municipalities now rely primarily on an individual's ability to provide a solution to the fullest of his or her own abilities and offers support where needed on a case by case basis.

Art. 2.1.1. Wmo contains the general obligation for the municipalities to ensure societal care.³⁰⁵ In addition to general support services, municipalities must provide individual services to those who cannot partake in everyday life, either alone, or despite having formal or informal care.³⁰⁶ The municipalities do not provide care directly, but have a facilitating role that is similar to the government's role in curative care. In both areas, private institutions or health care professionals provide the actual care in a system of regulated competition. As such, the municipality's duty of care under Art. 2.1.1 Wmo is similar to the government's duty of care under Art. 22 of the Dutch Constitution. Similarly, a failure to provide compensation for translation and interpretation services could amount to an unlawful act according to Art. 6:162 BW.

In assessing the policy discretion awarded to the municipalities in particular, the responsibility of the individual as an important pillar of the Wmo stands out. In the government's view, the municipalities have an obligation to promote individuals to utilize and strengthen their problem-solving capacities and should rely on societal support as little as possible.³⁰⁷ In this respect, the municipalities may expect and request "an active contribution" from the client and may ask them to take steps that may not be of his or her first choice.³⁰⁸

However, the explanatory notes emphasize that despite this policy discretion, any person should be able to ask for support from the municipality if they are unable to rely on their own abilities.³⁰⁹ No client should be excluded from access to support from his or her municipality based on, for example, their

³⁰⁴ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 841 nr. 3*, 20 (Jan. 15, 2014), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33841-3.html>.

³⁰⁵ *Wet maatschappelijke ondersteuning* art. 2.1.1 (the Netherlands, 2015), available in Dutch at <http://wetten.overheid.nl/BWBR0035362/2015-01-01>

³⁰⁶ *Wet maatschappelijke ondersteuning* art. 2.1.2(2)(f) (the Netherlands, 2015), available in Dutch at <http://wetten.overheid.nl/BWBR0035362/2015-01-01>.

³⁰⁷ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 841 nr. 3*, 23 (Jan. 15, 2014), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33841-3.html>.

³⁰⁸ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 841 nr. 3*, 22-23 (Jan. 15, 2014), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33841-3.html>.

³⁰⁹ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 841 nr. 3*, 20 (Jan. 15, 2014), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33841-3.html>.

income.³¹⁰ This means that societal support services, which may include translation and interpretation services for individuals who cannot live self-reliantly without them, should in principle be accessible to all in need.

Moreover, the municipality cannot reject requests for societal health care for lack of budgetary reasons only. In May 2016, the Administrative High Court (*Centrale Raad van Beroep, CRvB*) heard a case against the municipality of Utrecht. The municipality had limited the number of hours of household support for certain citizens under the Wmo. Even though the municipality pointed at the fact that the central government had diminished the municipal budget for societal care, the court ruled that the municipality could not base such a decision to change the provision of societal care for reasons of lack of financial means only.³¹¹ Instead, it found that the municipality must base such a decision on objective and independent research into the client's situation.

The municipal council (*gemeenteraad*) must periodically issue a policy plan on societal support, which the municipal authority (*gemeentebestuur*) executes.³¹² The council furthermore establishes criteria for eligibility for custom fit care, criteria for determining the height of the individual budget (*persoonsgebonden budget*), and criteria for the quality of services.³¹³ A provided service must be safe, effective, and client oriented. It must be fitted to the client's needs, and it must respect and take into account his or her rights.³¹⁴ Residents of the Netherlands and foreigners may be eligible for custom fit care facilities.³¹⁵ A foreigner is eligible for custom fit care if he or she lawfully resides in the Netherlands, in correspondence with Arts. 1 and 8(a-e) of the Foreigners Act (*Vreemdelingenwet, Vw*) of 2008.³¹⁶

³¹⁰ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 841 nr. 3*, 20 (Jan. 15, 2014), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33841-3.html>.

³¹¹ Centrale Raad van Beroep (May 18, 2016) para. 5.7.2 [ECLI:NL:CRVB:2016:1402] available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:CRVB:2016:1402>.

³¹² *Wet maatschappelijke ondersteuning* art. 2.1.2 (the Netherlands, 2015), available in Dutch at <http://wetten.overheid.nl/BWBR0035362/2015-01-01>.

³¹³ *Wet maatschappelijke ondersteuning* art. 2.1.3 (the Netherlands, 2015), available in Dutch at <http://wetten.overheid.nl/BWBR0035362/2015-01-01>.

³¹⁴ *Wet maatschappelijke ondersteuning* art. 3.1.2 (the Netherlands, 2015), available in Dutch at <http://wetten.overheid.nl/BWBR0035362/2015-01-01>.

³¹⁵ *Wet maatschappelijke ondersteuning* art. 1.2.1 (the Netherlands, 2015), available in Dutch at <http://wetten.overheid.nl/BWBR0035362/2015-01-01>.

³¹⁶ *Wet maatschappelijke ondersteuning* art. 1.2.2(1) (the Netherlands, 2015), available in Dutch at <http://wetten.overheid.nl/BWBR0035362/2015-01-01>.

Art. 2.1.2 Wmo specifies the requirements of the policy plan.³¹⁷ Among other aspects, the plan must pay particular attention to the opportunity for those who receive individual care to personally choose their care providers, thereby taking into account their religion, beliefs, and cultural background.³¹⁸ The explanatory notes to the Wmo emphasize that this requirement relates less to the provided services, and more to how the municipality's policy plan pays attention to religion, belief, and culture when this is essential for the quality of care.³¹⁹ The law aims to prevent municipalities from neglecting minority groups.³²⁰ Moreover, Art. 2.3.5 Wmo reads that custom fit care facilities, which by definition are fitted to a client's needs and characteristics,³²¹ may need to be adjusted to this person's religion, belief, and cultural background.³²²

If language is considered part of one of these elements and essential for the quality of care, this could be an aspect that the municipality is obliged to pay particular attention to in its policy plan for societal care and in facilitating individual societal care services. In order to link this to translation and interpretation services in health care, it would thus need to be argued that (i) language is connected to cultural background; and that (ii) proper communication based on language is essential for the quality of care.

First, an argument that language is part of culture can be found in the 2010 proposal of the Ministry of Education, Culture, and Science, and the Ministry of General Affairs to include a Dutch language clause in the Dutch Constitution, stipulating that Dutch is the official language in the Netherlands and that the government has a duty of care to promote the use of the Dutch language.³²³ They argued that language is one of the essential characteristics of a community. Through language, individuals feel connected with each other. As such, language

³¹⁷ *Wet maatschappelijke ondersteuning* art. 2.1.2 (the Netherlands, 2015), available in Dutch at <http://wetten.overheid.nl/BWBR0035362/2015-01-01>.

³¹⁸ *Wet maatschappelijke ondersteuning* art. 2.1.2(4)(c) (the Netherlands, 2015), available in Dutch at <http://wetten.overheid.nl/BWBR0035362/2015-01-01>.

³¹⁹ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 841 nr. 3*, 109 (Jan. 15, 2014), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33841-3.html>.

³²⁰ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 841 nr. 3*, 109 (Jan. 15, 2014), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33841-3.html>.

³²¹ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 841 nr. 3*, 124 (Jan. 15, 2014), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33841-3.html>.

³²² *Wet maatschappelijke ondersteuning* art. 2.3.5(5)(h) (the Netherlands, 2015), available in Dutch at <http://wetten.overheid.nl/BWBR0035362/2015-01-01>.

³²³ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 32 522 nr. 3* (Sep. 29, 2010), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-32522-3.html>.

is an important element of culture.³²⁴ Although the Council of State (*Raad van State*) advised against the specifics of the draft, it saw no pressing arguments against a general language clause.³²⁵ The Council argued that since there is no discussion on whether the Dutch language is the language of the Netherlands, and since this could be established through a formal law, a change to the Constitution would be unnecessary.³²⁶ However, the Council of State saw no pressing arguments against a general language clause in the Constitution either.³²⁷ It moreover recognized the importance of a governmental policy on the use and knowledge of the Dutch language as a way of protecting culture and promoting integration.³²⁸ As such, a legal argument can be made that language is an important element of culture. In the context of translation and interpretation services in health care, this means that language, as part of cultural background, may be an aspect that the municipality take into account when facilitating individual services to a client under the Wmo.

Second, the quality norm for using translators in health care (*Kwaliteitsnorm tolkgebruik bij anderstaligen in de zorg*), produced by the Royal Dutch Medical Association (*Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst, KNMG*), the Dutch General Practitioners Association (*Landelijke Huisartsen Vereniging, LHV*), and other related organizations make the connection between communication and quality of care.³²⁹ Health care providers may use this document to determine whether the use of an informal or formal translator is necessary in a specific case. The document emphasizes that the obligation to provide good quality care implies that doctor and patient need to be able to communicate well, in a language that both understand.³³⁰ As such, it may be argued that proper communication based on language is essential for the quality of

³²⁴ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 32 522 nr. 3, 2* (Sep. 29, 2010), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-32522-3.html>.

³²⁵ Raad van State (Aug. 5, 2010) paras. II-1 & II-2(a) [W01.10.0071/I] available in Dutch at <https://www.raadvanstate.nl/adviezen/zoeken-in-adviezen/tekst-advies.html?id=9297>.

³²⁶ Raad van State (Aug. 5, 2010) paras. II-1 & II-2(a) [W01.10.0071/I] available in Dutch at <https://www.raadvanstate.nl/adviezen/zoeken-in-adviezen/tekst-advies.html?id=9297>.

³²⁷ Raad van State (Aug. 5, 2010) paras. II-1 & II-2(a) [W01.10.0071/I] available in Dutch at <https://www.raadvanstate.nl/adviezen/zoeken-in-adviezen/tekst-advies.html?id=9297>.

³²⁸ Raad van State (Aug. 5, 2010) paras. II-3 [W01.10.0071/I] available in Dutch at <https://www.raadvanstate.nl/adviezen/zoeken-in-adviezen/tekst-advies.html?id=9297>.

³²⁹ *Kwaliteitsnorm tolkgebruik bij anderstaligen in de zorg*, KNMG, KNOW, LHV, NHG, NIP, NPCF, NVvP, initiated by Pharos (Mar. 2014), available in Dutch at http://www.pharos.nl/documents/doc/kwaliteitsnorm_tolkgebruik-.pdf.

³³⁰ *Kwaliteitsnorm tolkgebruik bij anderstaligen in de zorg*, KNMG, KNOW, LHV, NHG, NIP, NPCF, NVvP, initiated by Pharos, 5 (Mar. 2014), available in Dutch at http://www.pharos.nl/documents/doc/kwaliteitsnorm_tolkgebruik-.pdf.

care. Therefore, the municipality may have an obligation to pay particular attention to this aspect when formulating its policy plan on societal care.

In sum, if clients who are eligible for individual societal care experience communication problems due to their non-Dutch cultural background, and these communication problems are deemed essential for the quality of care, the municipality may have an obligation under Art. 2.1.2 Wmo to pay particular attention to their cultural background in its policy plan on societal care. Furthermore, it may have an obligation under Art. 2.3.5 Wmo to ensure that individual care facilities are adjusted to such clients' cultural background. The explanatory notes do not specify what this means exactly, but it may be argued that services that are adjusted to a client's needs in terms of language, may include care providers or translators who speak the same language as the client. If the municipality fails to do so, it may be in violation of its obligations under the Wmo.

Youth Care

As of January 2015, municipalities are primarily responsible for the support, help, and care of children below 18 years of age with educational or psychiatric problems or disorders. Before 2015, youth care was regulated by three separate laws: the Youth Care Act (*Wet op de jeugdzorg, Wjz*) the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten, Awbz*), and the Health Care Insurance Act (*Zorgverzekeringswet, Zw*). The new Youth Act (*Jeugdwet, Jw*) harmonizes youth care under one legal act and one financing system, for which the municipality now bears primary responsibility. One reason for the reorganization of youth care was the unequal accessibility of youth care.³³¹ Especially migrants' problems were identified late, which may mean that the threshold for asking for help was too high.³³² Accordingly, the new Jw contains an obligation for the municipality to provide an infrastructure for youth care that includes a focus on local and personal circumstances.³³³

The Jw contains an obligation for the municipality to ensure access to youth care, comparable to the municipality's obligation to provide societal support under

³³¹ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3*, 10 (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

³³² Ministerie van Justitie, *Evaluatieonderzoek Wet op de Jeugdzorg: Eindrapport*, 28 (Oct. 2009), available in Dutch at http://www.nji.nl/nl/Download-NJi/Jeugdzorg_Evaluatieonderzoek_Wet_091103.pdf.

³³³ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3*, 7 (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

the Wmo.³³⁴ If a child or his or her parents experience problems with growing up, self-reliance, or participation in society, the municipality has an obligation to compensate for youth care. The starting point of the Jw is, similar to the Wmo, that the municipality has an obligation to facilitate care only insofar the child and his or her parents are unable to provide a solution on their own.³³⁵

Offered youth care must be “recognizable” and “easily accessible.”³³⁶ “Easily accessible” means that youth care must be reachable and available in urgent situations.³³⁷ “Recognizable” means that children and their parents know whom to reach with questions or concerns, which may be the municipality or an appointed organization. An example of recognizable youth care is a Youth and Family Center (*Centrum voor jeugd en gezin, Cjg*), which gathers different youth care facilities in one place.³³⁸ The appointed organization could also be a local center or team at school. It is left to the policy discretion of the municipality how to arrange this in accordance with local circumstances.³³⁹ It is important that an organization communicates its availability and contact details in a clear manner to ensure that it is reachable for questions or concerns.³⁴⁰ Support should be provided within the family environment as much as possible.³⁴¹

Under Art. 7.3.2 Jw, the youth care provider must inform the person concerned in a clear manner, and, if requested, in written form.³⁴² In case a child or parent is of low Dutch proficiency, clear communication could imply that the care provider and the child or parent are able to speak the same language. Although this obligation befalls on the health care provider rather than the

³³⁴ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3, 7* (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

³³⁵ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3, 7* (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

³³⁶ *Jeugdwet* art. 2.6.1(b) (the Netherlands, 2014), available in Dutch at <http://wetten.overheid.nl/BWBR0034925/2015-01-01>.

³³⁷ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3, 122* (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

³³⁸ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3, 24* (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

³³⁹ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3, 122* (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

³⁴⁰ Ministerie van Veiligheid en Justitie, Ministerie van Volksgezondheid, Welzijn en Sport, Nederlands Jeugdinstituut, Vereniging van Nederlandse Gemeenten, *Factsheet Toetsingskader essentiële vereisten: Toegang Jeugdhulp*, 5 (Nov. 2014), available in Dutch at <https://voordejeugd.nl/ondersteuning/ondersteuning/toolkit-toegang>.

³⁴¹ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3, 24* (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

³⁴² *Jeugdwet* art. 7.3.2 (the Netherlands, 2014), available in Dutch at <http://wetten.overheid.nl/BWBR0034925/2015-01-01>.

municipality, under Art. 2.6 Jw the municipality is responsible for a qualitatively and quantitatively adequate supply of services.³⁴³ A lack of translators may mean that the supply is inadequate in terms of quality, since this leads to unclear communication between the care provider and the child. Therefore, municipalities may have a separate obligation to ensure that youth care organizations have translators or interpreters available.

When a child needs youth care, the municipality has the responsibility to provide services that ensure the child is able to grow up healthy and safe; can grow towards independence; can be self-reliant; and participate in society.³⁴⁴ As was discussed above, municipalities are responsible for providing a qualitative and quantitative adequate supply of youth help and certified institutions.³⁴⁵ The services that they facilitate constitute general, freely accessible services, as well as individual measures that concern specialized care. For freely accessible services, no official decision to grant the service to the child (*beschikking*) is necessary. The municipality itself decides which services are freely accessible and which are not.³⁴⁶ For those that are not, the municipality looks at the needs and personal situation of each applicant for youth care.³⁴⁷ It must ask for advice by experts, but can decide independently which services will be provided to the child.³⁴⁸

In providing support, the municipality must take into account the needs and characteristics of the child and its parents, as well as their religion, belief, and cultural background.³⁴⁹ According to the explanatory notes to the Jw, this does not mean a child must receive care from someone with the same religion, belief, or cultural background.³⁵⁰ However, it does mean that the municipality cannot take any decision incompatible with the child's religion, belief, or cultural background. In facilitating the supply of care providers, the municipality must therefore include

³⁴³ *Jeugdwet* art. 2.6.1(a) (the Netherlands, 2014), available in Dutch at <http://wetten.overheid.nl/BWBR0034925/2015-01-01>

³⁴⁴ *Jeugdwet* art. 2.3.1 (the Netherlands, 2014), available in Dutch at <http://wetten.overheid.nl/BWBR0034925/2015-01-01>.

³⁴⁵ *Jeugdwet* art. 2.6.1(a) (the Netherlands, 2014), available in Dutch at <http://wetten.overheid.nl/BWBR0034925/2015-01-01>.

³⁴⁶ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3, 7* (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

³⁴⁷ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3, 7* (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

³⁴⁸ *Jeugdwet* art. 2.3.1 (the Netherlands, 2014), available in Dutch at <http://wetten.overheid.nl/BWBR0034925/2015-01-01>.

³⁴⁹ *Jeugdwet* art. 2.3.4 (the Netherlands, 2014), available in Dutch at <http://wetten.overheid.nl/BWBR0034925/2015-01-01>.

³⁵⁰ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3, 120* (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

providers that have knowledge, experience, or expertise regarding a specific religion, belief, or cultural background.³⁵¹ As was shown above, language could be seen as an important element of culture. If a child experiences communicative problems with his or her doctor in terms of language, this might therefore be considered incompatible with his or her non-Dutch cultural background. As such, the municipality could have an obligation to facilitate access to health care providers that can speak the child's language. Art 2.6 Jw therefore offers a possibility to challenge the decision to discontinue compensation for translation and interpretation services in health care provided by the municipalities.

The Health Care Insurance Companies

Under the current health care system, the health insurance companies have a duty of care to ensure, *inter alia*, the quality of care provided. This duty is primarily contained in the Zvw and has been elaborated upon in its explanatory notes and by the NZa.

Art. 11 of the Zvw imposes a duty of care on health insurance companies towards those they insure.³⁵² The legislator emphasized, however, that the primary duty to ensure the quality of the offered health care lies with the care providers.³⁵³ The insurance company's duty of care is primarily an obligation of result, which means that the insurance company has a contractual duty to "realize" the offered product or service.³⁵⁴ The duty of care extends to the care that individuals are legally entitled to, meaning the care in the basic package.³⁵⁵ The duty of care does not only entail a duty to compensate the costs of the care but also to ensure that clients can actually obtain that care. The content of this duty varies according to whether the insurance policy concerns contracted or non-contracted care.

Non-contracted care is obtained from care providers who do not have an agreement with the insurance company. The insured can still obtain care from these providers but will only be able to have 80 per cent of the costs of such

³⁵¹ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting 33 684 nr. 3*, 120 (Jul. 4, 2013), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-33684-3.html>.

³⁵² *Zorgverzekeringswet art. 11* (The Netherlands, 2005), available in Dutch at <http://wetten.overheid.nl/BWBR0018450/2016-01-01>.

³⁵³ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting, 29 763 nr. 3*, 42 (Sept. 24, 2004), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-29763-3.html>.

³⁵⁴ NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 9 (Dec., 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

³⁵⁵ NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 26 (Dec., 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

treatment compensated by his health care insurance company. In such situations, the insurance companies and the care providers do not have a formal relationship with each other. The insurance company therefore has an obligation to check whether the declared care fits within the coverage of the insurance policy.³⁵⁶ In addition, the insurance company is responsible for a timely and correct compensation of the costs made by the insured.³⁵⁷

Contracted care is provided on the basis of a contract between the health care insurance company and the health care provider. The insurance companies annually conclude agreements with certain care providers and fully compensate their customers for care obtained. The insurance companies are thus able to exercise influence over the quality of the care by setting quality conditions upon the procured care. This quality may concern the safety, attainability, timeliness, and the necessity for constant innovation in care.³⁵⁸ The NZa has concurred with this interpretation of the duty of care.³⁵⁹ The insurance company however is not allowed to enter into the doctor-patient relationship. The insurance company must indicate in the insurance policy how it will meet its duty of care.³⁶⁰

The insurance company must ensure that the provided care is of a “good quality.”³⁶¹ The insurance company must further ensure that the provided care is “appropriate” in light of the needs of the insured. Appropriate care is care that is necessary, effective, and expedient from the perspective of the patient.³⁶²

The insurance company’s duty of care further entails that care must be sufficiently accessible. The NZa defines accessible care to mean that persons who need care have access to health care in time and without unwanted hurdles.³⁶³ The question of accessibility has numerous aspects, of which equality and affordability

³⁵⁶ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting*, 29 763 nr. 3, 43 (Sept. 24, 2004), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-29763-3.html>.

³⁵⁷ NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 14 (Dec., 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

³⁵⁸ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting*, 29 763 nr. 3, 43 (Sept. 24, 2004), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-29763-3.html>.

³⁵⁹ NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 5 (Dec. 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

³⁶⁰ Tweede Kamer der Staten-Generaal, *Memorie van Toelichting*, 29 763 nr. 3, 44 (Sept. 24, 2004), available in Dutch at <https://zoek.officielebekendmakingen.nl/kst-29763-3.html>.

³⁶¹ NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 36 (Dec., 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

³⁶² NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 15 (Dec., 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

³⁶³ NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 19 (Dec., 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

are the most relevant. Equality is defined as the fact that everybody should have access to (necessary) care of good quality, regardless of age, gender, health situation, and social background.³⁶⁴ Another relevant aspect of accessibility is the affordability of the care, which requires the absence of (large) financial hurdles for the access to care provision and insurance. The NZa does not provide any further details on what circumstances may constitute unwanted hurdles. In absence of any additional specificity, an argument could be made that the reliance on an informal interpret such as a friend or a family constitutes an unwanted burden to the care required. Without any case law or precedent on the matter, it remains to be seen whether such an argument would stand in court.

If the insurance company cannot procure the delivery of the care agreed upon, it violates its duty of care. In such a case, the insurance company may be held liable for the damage suffered by the insured and may be ordered to repair the damage. It is not allowed for the insurance company to simply pay a monetary compensation, as this does not reverse the violation in all circumstances.³⁶⁵

Although the duty of care is primarily owed to the insured, the care providers can, under certain circumstances, also rely on the insurance company's duty of care. This was most prominently decided in a 2015 case at the Trade and Industry Appeals Tribunal (*College voor Beroep voor het Bedrijfsleven, CBB*). The case concerned the question whether the NZa had correctly determined that maximum rate for a visit to the general practitioner or family doctor by deciding that certain types of treatment could only be performed if the GP had an agreement with the patient's insurance company. The CBB decided that this impeded GPs and family doctors from providing all the necessary care, as they would not be compensated for certain services or products that had not been included in the determination of the maximum tariff for a visit. An association of GPs filed a case against the NZa and the CBB judged that all three actors in the market should be able to rely on the duty of care because it aims to ensure a proper functioning of the health care market.³⁶⁶

In sum, insurance companies do not have a direct obligation to compensate for interpretation services, since their customers are not legally entitled to such

³⁶⁴ NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 20 (Dec., 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

³⁶⁵ NZa, *Beleidsregel TH/BR-08 Toezichtkader Zorgplicht zorgverzekeraar Zvw*, 11 (Dec., 2014), available in Dutch at https://www.nza.nl/1048076/1048090/TH_BR_018__Toezichtkader_zorgplicht_zorgverzekeraar_Zvw.pdf.

³⁶⁶ College van Beroep voor het bedrijfsleven (Dec. 1, 2015), ECLI:NL:CBB:2015:370, available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:CBB:2015:370>.

service under the basic package agreed upon by the government. However, insurance companies do have a (broad) obligation to ensure the quality and accessibility of the care procured from the health care providers. Accessibility includes equality and affordability. Given the open nature of the duty of care, leaving room for insurance companies and health care providers to fill in the details in mutual cooperation, health care insurance companies could compensate for professional translation services procured in the course of receiving health care. The open nature of the norm suggests it is unlikely that the insurance companies should, as a matter of legal obligation, compensate for such translation services under the Zvw. It remains to be tested in court whether the fact that those in need of care with insufficient command of the Dutch language may need to rely on informal translators constitutes an unwanted burden to the access of care in violation of the health care insurance company's duty of care under Art. 11 Zvw.

The Health Care Providers

The Dutch government has delegated the majority of the responsibility to provide health care of a sufficient quality to the health care providers. In a market of regulated competition, the health care providers therefore bear most of the legal obligations to provide good and accessible health care.

This section first analyzes the legal obligations of health care providers to provide access to health care. This question relates to providers' obligation to provide good care, and patients' rights such as the right to informed consent and information. Relevant laws in this context are the Professions in Individual Health Care Act (*Wet op de beroepen in de individuele gezondheidszorg, BIG*) and the Act on Quality, Complaints, and Disputes in Health Care (*Wet kwaliteit, klachten en geschillen zorg, Wkkgz*).

The second part of this section considers the legal question of the right to privacy of the patient. The Act on Medical Treatment Agreement (*Wet op de geneeskundige behandelovereenkomst, WGBO*) and the Act on the Protection of Personal Data (*Wet bescherming persoonsgegevens, Wbp*) are of particular importance in this regard.

The Right to Health Care

On 1 January 2016, the Wkkgz entered into force.³⁶⁷ Similar to its predecessor, the Wkkgz obliges care providers, which include health care institutions and individual health care practitioners, to guarantee and improve quality of health care services provided. The law ensures that patients are provided with good health care, as well as a fast and easy accessible complaints procedure in case it fails these standards.

Art. 2.2 Wkkgz defines good care as care that is of sufficient quality and of a high level.³⁶⁸ Art. 2.2a Wkkgz reads that in any case, care must be safe, timely, efficient, effective, and patient-oriented.³⁶⁹ Art. 2.2b Wkkgz obliges the care provider to act in accordance with the responsibilities following from the current professional standard. “Professional standard” is understood to include guidelines, norms, and care standards that prescribe what is necessary in order to deliver good care from the client’s perspective.³⁷⁰ Art. 2.2c requires health care providers to ensure that clients’ rights are complied with and that clients are treated with respect.³⁷¹ The Wet BIG similarly aims to improve the quality of health care provided by individual practitioners.

Patients’ rights in health care are laid down in the WGBO, which constitutes part of Book 7 BW. Similar to Art. 2.2b Wkkgz, Art. 7:453 BW requires health care providers to act in accordance with the responsibilities that arise from the current professional standard, prescribing what is necessary in order to deliver good care.³⁷² The obligation to deliver good care implies that health care providers and their patients should be able to communicate effectively, in a language that is mutually comprehended.³⁷³

³⁶⁷ *Wet kwaliteit, klachten en geschillen zorg* (the Netherlands, 2016), available in Dutch at <http://wetten.overheid.nl/BWBR0037173/2016-01-01>.

³⁶⁸ *Wet kwaliteit, klachten en geschillen zorg* art. 2.2 (the Netherlands, 2016), available in Dutch at <http://wetten.overheid.nl/BWBR0037173/2016-01-01>.

³⁶⁹ *Wet kwaliteit, klachten en geschillen zorg* art. 2.2(a) (the Netherlands, 2016), available in Dutch at <http://wetten.overheid.nl/BWBR0037173/2016-01-01>.

³⁷⁰ *Wet kwaliteit, klachten en geschillen zorg* art. 1.1 (the Netherlands, 2016), available in Dutch at <http://wetten.overheid.nl/BWBR0037173/2016-01-01>.

³⁷¹ *Wet kwaliteit, klachten en geschillen zorg* art. 2.2(c) (the Netherlands, 2016), available in Dutch at <http://wetten.overheid.nl/BWBR0037173/2016-01-01>.

³⁷² *Dutch Civil Code Book 7* art. 453 (The Netherlands, 1992) available in Dutch at <http://wetten.overheid.nl/BWBR0005290/2016-01-01#Boek7>.

³⁷³ KNMG, KNOW, LHV, NHG, NIP, NPCF, NVvP (initiated by Pharos), *Kwaliteitsnorm tolkgebruik bij anderstaligen in de zorg*, 5 (Mar. 2014), available in Dutch at http://www.pharos.nl/documents/doc/kwaliteitsnorm_tolkgebruik-.pdf.

The patient's right to good care interlinks with the right to receive clear and understandable information. Art. 7:450 BW reads that a patient's consent must be obtained prior to commencing medical treatment.³⁷⁴ Health care providers must inform patients in a 'clear manner' and if requested in written form.³⁷⁵ The term "clear" means that care providers express themselves in a manner understood by the patient.³⁷⁶

Health care providers would act in violation of their duties under the various provisions of the WGBO, Wkkgz and BIG set out above if they are unable to communicate in an effective manner comprehended by the patient. In order to do so, health care providers may need to rely on professional translation services. In order to assist health care providers in the determination if and when to rely on professional translation services, the Ministry of VWS, in cooperation with various stakeholders, published a field guide.³⁷⁷ The field guide consists of a Q&A and contains various principles for the use of professional translation services. Health care providers are to rely on their own professional estimation whether the patient understands what he or she is being told.³⁷⁸ Furthermore, the field guide suggests that professional translators are to be preferred over informal translators such as relatives or friends. Only when relying on the services of professional translators can health care providers satisfy themselves that the interests of both the patient and the health care provider are being served.³⁷⁹ Taboos and emotional ties with the patient may prevent relatives and family members from effectively serving as a vehicle between the patient and the health care provider, even if their command of

³⁷⁴ *Dutch Civil Code Book 7 art. 450* (The Netherlands, 1992) available in Dutch at <http://wetten.overheid.nl/BWBR0005290/2016-01-01#Boek7>.

³⁷⁵ *Dutch Civil Code Book 7 art. 448* (The Netherlands, 1992) available in Dutch at <http://wetten.overheid.nl/BWBR0005290/2016-01-01#Boek7>.

³⁷⁶ KNMG, KNOW, LHV, NHG, NIP, NPCF, NVvP (initiated by Pharos), *Kwaliteitsnorm tolkgebruik bij anderstaligen in de zorg*, 5 (Mar. 2014), available in Dutch at http://www.pharos.nl/documents/doc/kwaliteitsnorm_tolkgebruik-.pdf.

³⁷⁷ Pharos, *Wanneer laten tolken? Veldnormen voor de inzet van tolken in de gezondheidszorg*, 2 (Aug. 13, 2008), available in Dutch at <https://www.rijksoverheid.nl/documenten/brochures/2008/08/13/wanneer-laten-tolken-veldnormen-voor-de-inzet-van-tolken-in-de-gezondheidszorg>.

³⁷⁸ Pharos, *Wanneer laten tolken? Veldnormen voor de inzet van tolken in de gezondheidszorg*, 2 (Aug. 13, 2008), available in Dutch at <https://www.rijksoverheid.nl/documenten/brochures/2008/08/13/wanneer-laten-tolken-veldnormen-voor-de-inzet-van-tolken-in-de-gezondheidszorg>.

³⁷⁹ Pharos, *Wanneer laten tolken? Veldnormen voor de inzet van tolken in de gezondheidszorg*, 2 (Aug. 13, 2008), available in Dutch at <https://www.rijksoverheid.nl/documenten/brochures/2008/08/13/wanneer-laten-tolken-veldnormen-voor-de-inzet-van-tolken-in-de-gezondheidszorg>.

both languages is beyond doubt.³⁸⁰ Also, the field guide states that financial considerations should never weight heavier than the best interest of the patient.

The principles set out in the field guide can be considered part of current professional standard which health care providers are obliged to observe under Art. 2.2b Wkkgz and Art. 7:453 BW. With the discontinuation of compensation for translation services, stating that patients of low Dutch proficiency bear responsibility to sufficiently master the Dutch language, puts health care providers in a legal predicament. They may be required to rely on the services of professional health care providers, but receive no financial support when needing to do so. This points towards an inherent inconsistency between the principles in the field guide and the factual arrangement sustained by the Minister of VWS.

Anecdotal evidence supports the assertion that this legal predicament may come at the expense of the patient. One patient interviewed on the consequences of the discontinuation of compensation for translation and interpretation services states:

“For example when I go to the doctor or the verloskundige [mid-wife], they tell me to bring someone to translate. I don’t have anyone to do this for me all the time and to come with me to appointments. They are kind people, but this is really a problem. Where can I find a translator? One time the huisarts [GP] sent me back because he didn’t accept Google Translate. Very bad. I felt sad, I don’t know what I can do about this problem.”³⁸¹

This example shows that access to care may be limited by health care providers when they are simultaneously obliged under various pieces of legislation to provide health care but only upon satisfying themselves that the patient has adequately understood what he or she is being told and cannot rely on the support of professional translators.

The Right to Privacy

³⁸⁰ Pharos, *Wanneer laten tolken? Veldnormen voor de inzet van tolken in de gezondheidszorg*, 2 (Aug. 13, 2008), available in Dutch at <https://www.rijksoverheid.nl/documenten/brochures/2008/08/13/wanneer-laten-tolken-veldnormen-voor-de-inzet-van-tolken-in-de-gezondheidszorg>.

³⁸¹ Jacqueline Mulders & Bram Tuk, *Syrische nieuwkomers in de gemeente: Ervaringen van gezinnen met opvang, zorg en opvoeding*, PHAROS 40 (June 2016), available in Dutch at <http://www.pharos.nl/documents/doc/syrische-nieuwkomers-in-de-gemeente.pdf>.

In health care, privacy constitutes the right of individuals not to have personal (medical) information disclosed to any third parties without their consent. Individuals may decide with whom and in what context they share their own medical information. At the foundation of the trust shared in the patient-doctor relationship is the requirement that information related to health remains private and that sensitive information shared by the patient does not leave the doctor's office or brings prejudice to the patient in any way.³⁸² For more than two thousand years, health care professionals have taken the Hippocratic Oath, which still defines ethics of health practice. On the issue of privacy, the Oath says:

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account must be spread abroad, I will keep to myself, holding such things shameful to be spoken about.³⁸³

This passage has been subjected to different interpretations, but the majority of scholars and health care providers view that it is the duty of the doctor to respect the privacy of his patient above all else and that this is the foundation of an ethical health practice. The Oath has taken the shape of various declarations and treaties.

In the Netherlands, the obligation of health care providers to protect patient's personal data is laid down in the Wbp. Art. 2.1.1.a Wbp reads that the prohibition on the use of personal data does not apply when this is necessary for a health care provider or institution to deliver good treatment or caretaking to the patient.³⁸⁴ However, this applies only to those who are subject to an oath of secrecy on the basis of their profession or on the basis of an agreement. In case the responsible person is not subject to an oath of secrecy, Art. 2.1.2 Wbp obliges health care providers to keep personal data confidential.³⁸⁵

The right to privacy is also included in the WGBO. The WGBO and the Wbp supplement each other. More specifically, under the WGBO a health care provider must ensure that no information about a patient will be disclosed to

³⁸² World Health Watch, *Legal frameworks for eHealth: based on the findings of the second global survey on eHealth, Global Observatory for eHealth series*, 5 GLOBAL OBSERVATORY FOR EHEALTH SERIES 5, 18 (2012), available at http://apps.who.int/iris/bitstream/10665/44807/1/9789241503143_eng.pdf.

³⁸³ ENCYCLOPAEDIA BRITANNICA, *Hippocratic Oath* (Sept. 11, 2014), available at <http://www.britannica.com/topic/Hippocratic-oath>.

³⁸⁴ *Wet bescherming persoonsgegevens* art. 21(1)(a) (the Netherlands, 2000), available in Dutch at <http://wetten.overheid.nl/BWBR0011468/2016-01-01>.

³⁸⁵ *Wet bescherming persoonsgegevens* art. 21(1)(a) (the Netherlands, 2000), available in Dutch at <http://wetten.overheid.nl/BWBR0011468/2016-01-01>.

anyone other than the patient, unless a patient gives his or her consent hereto.³⁸⁶ “Anyone other” does not include those who are directly involved in the execution of a treatment agreement or who replace the care provider.³⁸⁷ However, since an informal translator does not actually execute a treatment, such persons would not fall into the category of those for whom consent from the patient is not needed.

In the context of translation services, these obligations raise the question whether health care providers, in not being able to provide a professional translator to their patient, are sufficiently able to ensure the patient’s right to privacy. Patients are left no choice but to rely on their own informal network of friends or relatives as an informal translator if they are financially unable to procure the services of professional translators themselves. The question arises whether under such financial circumstances a person can freely consent to disclosing confidential medical information to third parties (in this case informal translators), if the necessity of medical treatment is imminent.

Comparative State Practice on Translation and Interpretation Services in Health Care

This section addresses international state practice regarding interpretation and translation in health care services. For the purpose of this memorandum, interpretation and translation relates only to the non-official languages of the state. Practices of bi- or trilingual states in guaranteeing equal provision of public services in all official languages are beyond the scope of this memorandum.

On the issue of translation and interpretation in health care, states can be categorized as follows: (1) states that guarantees the right to interpretation and translation in health care by law; (2) states that provide for such right as a matter of public policy; and (3) states that have no legal or policy provisions on the matter. This section addresses notable examples of each category in turn.

The first group consists of the United States of America (U.S.) and the United Kingdom (U.K.). Belgium belongs to the second group because its municipalities guarantee access to interpretation and translation services in health

³⁸⁶ *Dutch Civil Code Book 7* art. 457 (The Netherlands, 1992) available in Dutch at <http://wetten.overheid.nl/BWBR0005290/2016-01-01#Boek7>.

³⁸⁷ *Dutch Civil Code Book 7* art. 457 (The Netherlands, 1992) available in Dutch at <http://wetten.overheid.nl/BWBR0005290/2016-01-01#Boek7>.

care as a matter of policy rather than law. The majority of the European Union states and beyond (Germany, France, Spain, Italy, Greece, Austria, Switzerland, Finland, Sweden, Turkey) belong to the third group, as they have no legislation or policies regarding the right to translation and interpretation in health care.

Interpretation and Translation Provided by Law

The right to interpretation and translation in health care is a particular aspect of the general health care system. None of the jurisdictions analyzed included the right in their health care legislation as such. States that recognize the right to interpretation and translation do so as part of non-discrimination legislation. However, the number of states that recognize that non-discrimination and equality legislation includes the right to interpretation and translation in health care is limited.

The United States

In the U.S. Title VI of The Civil Rights Act, a landmark document in U.S. non-discrimination legislation, codifies the right to interpretation and translation services in health care provision. Title VI “prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.”³⁸⁸ The goal of Title VI is to ensure that state funded programs and activities under no circumstance contribute to any prohibited form of discrimination. The interpretation of national origin includes linguistic diversity, since the latter flows from national origin diversity of the population.³⁸⁹ In 2000, President Clinton signed Executive Order 13166 “Improving Access to Services for People with Low English Proficiency” (EO). The EO does not create any new rights, but ensures that the rights under Title VI are duly respected and given full consideration. The EO obliges all federal and federally funded agencies to provide persons of LEP meaningful access to their services.³⁹⁰

Pursuant to the EO, the Department of Health and Human Services issued their Guidance to Federal Financial Assistance Recipients Regarding Title VI

³⁸⁸ *Title VI, The Civil Rights Act Of 1964* 42 U.S.C. § 2000d Et Seq. (United States, 1964) available at <https://www.justice.gov/crt/title-vi-1964-civil-rights-act>.

³⁸⁹ Lynda Flowers, *Improving Access to Care Among Medicare Beneficiaries with Limited English Proficiency: Can Medicare Do More?* AARP PUBLIC POLICY INSTITUTE, 7 (Aug. 6, 2008), available at http://assets.aarp.org/rgcenter/health/i6_medicare.pdf; *Lau v. Nichols*, 414 U.S. 653 (1974), available at <https://supreme.justia.com/cases/federal/us/414/653/case.html>.

³⁹⁰ *Executive Order 13166 Improving Access to Services for Persons With Limited English Proficiency* (United States, 2000), available at <https://www.justice.gov/crt/federal-coordination-and-compliance-section-180>.

Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (HHS LEP Guidance). The HHS Guidance reaffirms the institution's commitment to the quality of services available to LEP persons.³⁹¹ The Guidance introduces a four-factor analysis for the recipients of federal funding to determine which language assistance measures health care providers should undertake to fulfill their obligations under Title VI:

- (1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee;
- (2) the frequency with which LEP individuals come in contact with the program;
- (3) the nature and importance of the program, activity, or service provided by the program to people's lives;
- (4) the resources available to the grantee/recipient and costs.³⁹²

To date, all 50 states have enacted laws concerning language access in health care.³⁹³ For instance, California's Dymally-Alatorre Bilingual Services Act (BSA) obliges all public institutions to provide interpreters and written translations necessary for persons of LEP to access their services. Moreover, such institutions are under an obligation to conduct a biannual review of their compliance with the BSA as well as federal law and update their language access plan if the circumstances change.³⁹⁴

However, since the outcome of the four-factor analysis varies per recipient institution and language diversity of the population in its immediate vicinity, the implementation practices and the types of oral interpretation and written translation vary accordingly. If the four-factor analyses showed that among the LEP

³⁹¹ The Department of Health and Human Services, *Fact Sheet on Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient (LEP) Persons*, (Aug. 4, 2003), available at <http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html>. The full text of the HHS Guidance is available at <http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html>.

³⁹² The Department of Health and Human Services, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, Art. V (Aug. 4, 2003), available at <http://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html>.

³⁹³ Marguerite Ro, Jinny Jihyun Park, & Deena Jang, *Language Access, in ASIAN AMERICAN COMMUNITIES AND HEALTH: CONTEXT RESEARCH, AND ACTION 323, 333* (Chau Trinh-Shevrin, Nadia S. Islam, and Mariano J. Rey, eds., 1st ed., 2009).

³⁹⁴ *The Dymally-Alatorre Bilingual Services Act* para.7299.6 (State of California (United States), 1973), available at <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=gov&group=07001-08000&file=7290-7299.8>.

population of a certain region exists a large Spanish-speaking community, some hospitals may be required to train and hire in-house face-to-face Spanish interpreters, or provide special training to bilingual staff to receive funding. Such determination is to be made on a case-by-case basis.

In 1991 Washington State Department of Social and Health Services together with the Office for Civil Rights established a Language Interpreter Services and Translations Office. Its main task is to develop and implement the language testing and certification program for the bilingual staff and medical interpreters.³⁹⁵ Other states have since developed similar health care interpreter certification standards.³⁹⁶ While in oral translation the institutions have a certain degree of flexibility, when it comes to the written translation, the HHS obliges all its institutions to provide all vital information in languages other than English (based on the outcome of the first step of the four-factor analyses) in plain language and accurate professional translation.³⁹⁷

The HHS Office for Civil Rights (OCR) ensures compliance with Title VI and the EO 13166. Its mandate allows the OCR to receive complaints from private persons and initiate investigations into the alleged violations. If it confirms the breach of title VI rights it can either allow the recipient time to correct the violation themselves or enter in agreement with the recipient for the OCR to assist in that process. The sanctions for non-compliance may amount to terminating the federal funding to the recipient.³⁹⁸ However, institutions typically agree to some corrective measures or enter into Voluntary Resolution Agreements with the OCR.

For example, in 2012, a patient of the Mee Memorial Hospital in California filed a complaint regarding difficulties in communicating with the medical staff of the hospital due to the absence of the translator for Triqui Bajo, an indigenous Mexican language, which prevented him from gaining meaningful access to the

³⁹⁵ Washington State Department of Social and Health Services, *Language Access Program Overview*, (Sept. 3, 2011), available at www.wascla.org/library/attachment.202624.

³⁹⁶ See Alice Hm Chen, Mara K. Youdelman, & Jamie Brooks, *The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond*, 22 JOURNAL OF GENERAL INTERNAL MEDICINE 362 (2007), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150609/>.

³⁹⁷ The Department of Health and Human Services, *Language Access Plan*, 11 (2013), available at <http://www.hhs.gov/sites/default/files/open/pres-actions/2013-hhs-language-access-plan.pdf>.

³⁹⁸ U.S. Department of Education, *The OCR Case Resolution and Investigation Manual*, art. IV (Jan., 2010), available at <http://www2.ed.gov/about/offices/list/ocr/docs/ocrcpm-2010.html#IV>.

service of the hospital.³⁹⁹ The OCR investigated the matter and the hospital agreed to enter into a Resolution Agreement. By entering into that agreement the Mee Memorial Hospital assumed the responsibility to establish a Central Coordinating Office that would ensure the availability of interpreters in all necessary languages; to provide additional training to the staff in how to guarantee the LEP patients' rights; and amend its LEP policy so as to include notifications of the fact that all services for LEP persons are free of charge, to increase assessments of the needs of patients, and the comprehensiveness of the contact with the patients, who need interpreters.⁴⁰⁰

Lep.gov website serves as an information hub for all parties involved in the implementation of Title VI and EO 13166 rights.

The United Kingdom

The right to interpretation and translation in health care in the U.K. follows from the 2010 Equality Act (EA). The EA combines and harmonizes all pieces of non-discrimination legislation adopted in The U.K. over the past 50 years. The EA provides protection from all types of discrimination in the public and private sphere on the basis of race, sex, sexual orientation, age, religion, disability, or marital status. According to Chapter I of the EA the concept of race includes color, nationality, and ethnic or national origin.⁴⁰¹ Ethnicity in turn includes language,⁴⁰² which means that discrimination on the basis of language constitutes a violation of the EA. The governments of Wales and Scotland adapted the Equality Act in the Welsh Statutory Instruments 2011 and the Scottish Statutory Instruments 2011 respectively. In Northern Ireland the Race Relations Order 1997 and the Northern Ireland Statutory Instruments 1997 guarantee the EA standards of non-discrimination.

This general legislation however, does not give any specific implementation directives, and every institution is responsible for developing their own strategy regarding language services that would ensure compliance with the equality

³⁹⁹ HHS Office for Civil Rights, *Mee Memorial Hospital Bulletin*, (Aug. 21, 2014), available at <http://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/mee-memorial-hospital/mee-bulletin/index.html>.

⁴⁰⁰ *Resolution Agreement Between the U.S. Department of Health and Human Services Office for Civil Rights and the Mee Memorial Hospital* Sections IV B (1) and IV B (3), (Aug. 8, 2014), available at <http://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/mee-memorial-hospital/index.html>.

⁴⁰¹ *The Equality Act 2010* art. 9 (United Kingdom, 2010) available at <http://www.legislation.gov.uk/ukpga/2010/15/section/9>.

⁴⁰² Institute of Race Relations, *Definitions*, (2016), available at <http://www.irr.org.uk/research/statistics/definitions/>.

legislation.⁴⁰³ Northern Ireland is an exception, as the Northern Ireland Health and Social Care Interpreting Service provides and administers the interpretation and translation services for all Health and Social Care Trusts (HSCT). The Belfast HSCT bears the primary responsibility for the language services in the whole of Northern Ireland. It employs interpreters in 36 languages, provides special training, and allocates them to the hospitals to meet the needs of the particular locations.⁴⁰⁴ Its services are free of charge for the patients and the doctors.

Throughout the rest of the U.K. language services provision normally takes one of the following two forms: hiring professional interpreters for the most common foreign languages and contracting out the translation of less frequently used languages to telephone interpreting agencies; or contracting out all interpretation and translation services to private agencies. The institutions that choose the first option can combine their contracts with the police and other public institutions to reduce the costs. This is especially effective in the urban areas where the need for interpretation services is high. Where the language diversity is low, the second approach is the most cost-effective option.⁴⁰⁵ All of these services are free of charge for the patients, including the home-visits if needed.⁴⁰⁶

Whatever option health care institutions choose to employ, they must “remove or minimize disadvantages suffered by persons who share a relevant protected characteristic”, and “take steps to meet the needs of persons who share a relevant protected characteristic.”⁴⁰⁷ To that end many hospitals developed Equality and Diversity teams to evaluate compliance with the EA. For instance, the Equality team of the University Hospitals of Leicester NHS Trust publishes annual reports detailing the names of the translating agencies that the hospitals work with, the number of interpretation and translation requests, and other equality-related facts and figures.⁴⁰⁸ In England, the Equality and Diversity

⁴⁰³ Claudia V. Angelelli, *Study on Public Service Translation in Cross-border Healthcare: Final Report for the European Commission Directorate-General for Translation DGT/2014/TPS*, 63 (Sept. 2015), available at http://ec.europa.eu/dgs/translation/publications/studies/public_service_translation_healthcare_eu_en.pdf.

⁴⁰⁴ Belfast Health and Social Care Trust, *Interpreting Services*, available at <http://www.belfasttrust.hscni.net/hospitals/InterpretingServices.htm>.

⁴⁰⁵ Claudia V. Angelelli, *Study on Public Service Translation in Cross-border Healthcare: Final Report for the European Commission Directorate-General for Translation DGT/2014/TPS*, 64 (Sept. 2015), available at http://ec.europa.eu/dgs/translation/publications/studies/public_service_translation_healthcare_eu_en.pdf

⁴⁰⁶ Helen J. Graham, *General Practice Skills*, in *A TEXTBOOK OF GENERAL PRACTICE*, 83 (Anne Stephenson, ed., 3rd ed., 2011).

⁴⁰⁷ *The Equality Act 2010* art. 149 (United Kingdom, 2010) available at <http://www.legislation.gov.uk/ukpga/2010/15/section/149>.

⁴⁰⁸ University Hospitals of Leicester NHS Trust, *Equality: Annual Report 2014-2015*, 10 (2015), available at <http://www.leicestershospitals.nhs.uk/aboutus/equality-and-diversity/reports-and-data/>.

Council brings together the representatives of various institutions in health and social care, their partner organizations (including language services providers), patient collectives, and staff groups to share best practices and introduce new strategies and guidance to improve the system.⁴⁰⁹

Translation and Interpretation Provided Through Policy

In the absence of national legislation similar to that in the U.S. or the U.K., municipal governments, where applicable, can assume the responsibility to provide equal access to health care for linguistic minorities and persons with low proficiency in the official languages of the state. Belgium's experience in intercultural mediation and interpretation and translation services provision is unique and represents a fruitful source of good practice.

In Belgium there is no legislation on the federal level that guarantees access to health care through the use of interpretation and translation services.⁴¹⁰ The Community governments assume this responsibility instead. The federal structure of Belgium allows the Communities high levels of independence. Therefore, regional variations exist to the right to interpretation and translation in health care. However, the Communities' initiative to provide interpretation and translation services in health care is not rooted in a legal obligation, but is a matter of public policy. In Flanders, for instance, Integration and Naturalization Agency (Agentschap Integratie en Inburgering) provides social interpreting and translation services in health care and other social services in support of the Flemish integration policy. The government also subsidizes 8 decentralized interpretation and translation offices on the territory of the region.⁴¹¹ And in Wallonia the SeTIS Walloon association united the social interpretation and translation agencies from Liège, Namur, Verviers, and La Louvière to provide common tools for social cohesion and equal opportunities. SeTIS Walloon provides oral face-to-face interpretation, written translation, and telephone services in the hospitals.⁴¹²

⁴⁰⁹ NHS England, *The NHS Equality and Diversity Council*, available at <https://www.england.nhs.uk/about/gov/equality-hub/edc/>.

⁴¹⁰ Vincent Lorant, Raj Bhopal, *Comparing policies to tackle ethnic inequalities in health: Belgium 1 Scotland 4*, 21 EUROPEAN JOURNAL OF PUBLIC HEALTH 235 (2010), available at <http://eurpub.oxfordjournals.org/content/21/2/235>.

⁴¹¹ Ninke Mussche, Vincent Corluy & Ive Marx, *Migrant Access to Social Security – Policy and Practice in Belgium*, BELGIAN NATIONAL CONTACT POINT OF THE EUROPEAN MIGRATION NETWORK, 58 (2013), available at http://ec.europa.eu/dgs/home-affairs/what-we-do/networks/european_migration_network/reports/docs/emn-studies/illegally-resident/migrant_access_to_social_security_in_belgium_emn-study_2013.pdf.

⁴¹² SeTIS Walloon, *Présentation du SeTIS Wallon*, available at http://www.setisw.be/pages/1_1-Presentation.html.

Additionally, all Belgian hospitals can apply for the funding of intercultural mediators, who along with interpretation and translation services provide cultural brokerage on the culture-sensitive issues, and can help the patient file discrimination complaints to the authorities.⁴¹³ They are full-time employees of the hospitals, whose main goal is to mediate the problems and misunderstandings between the doctors and the patients flowing from the differences in socio-cultural backgrounds, ethnic tensions, and language barriers.⁴¹⁴ The scope of their tasks draws upon the Standards of Practice of the International Medical Interpreters Association (IMEA).⁴¹⁵ However, studies show that the standards for the conduct of intercultural mediators vary across Belgium. The French-speaking Communities perceive the IMEA standards rather as a general guidance and give “more discretion to the interpreter, to act in accordance with his/her own situational judgment,” while the Dutch-speaking ones insist on strict adherence to the IMEA framework.⁴¹⁶

Overall, the roots of the right to interpretation and translation in health care in Belgium do not lie in clear legal obligations like in the U.S. and the U.K. Rather, it is a policy-based mechanism that allows institutions more space to decide on the scope of the services they provide based on the specifics of the region and the diversity of the population. Health care institutions and Communities’ governments acknowledge the need to provide the interpretation and translation services in health care, and perceive it largely as a pathway to successful integration of foreign nationals into the Belgian society. The cultural mediation approach enables patients and health care professionals to bridge both linguistic and cultural gaps in order to avoid conflicts and misunderstanding in the culture-specific aspects of health care.

Absence of Law or Policy on Translation and Interpretation in Health Care

⁴¹³ Fabrizia Petrei, Lucia Morariu, *Two Successful Examples of Reasonable Accommodation and Intercultural Mediation In the Health-care Sector*, 21 TRENDS IN SOCIAL COHESION, 268 (2009).

⁴¹⁴ Hans Verrept, *Interculturele Bemiddeling in de Ziekenhuizen*, 4 HOSPITALIA 170 (2002), available in Dutch at http://health.belgium.be/internet2Prd/groups/public/@public/@dg1/@mentalcare/documents/ie2divers/875843_fr.pdf.

⁴¹⁵ See International Medical Interpreters Association, *Standards from IMIA*, available at <http://www.imiaweb.org/standards/standards.asp>.

⁴¹⁶ Antoon Cox, *Do You Get the Message? Defining the Interpreter’s Role in Medical Interpreting in Belgium*, MONTI 161, 171 (2015), available at http://repositori.uji.es/xmlui/bitstream/handle/10234/149435/MonTI_2015_Special_Issue_07.pdf.

In states where neither national nor regional legislation contain any guidance, standards, or policies regarding the right to interpretation and translation, health care providers develop their own methods of working with patients with low proficiency in the local language. Hiring bilingual staff, volunteers, or professional interpreters and translators, as well as using the so-called ad hoc interpreters, i.e. family members, friends, or neighbors, or NGOs – are some of the means that hospitals resort to in the absence of a standardized system. For some states, financial constraints do not allow for the federal or regional governments to provide subsidies for interpretation and translation, others do not consider it as a pressing issue on the political agendas.

A study by Angelelli on cross-border health care showed that the governments of Italy, Spain, Germany, and Greece consider English a *lingua franca* for communication. As long as health care providers are fluent in English and able to operate with medical terms in English, no additional interpretation or translation services are needed.⁴¹⁷

Lack of government funding places significant financial burden on the hospitals when having to rely on professional interpreters. For many, especially in the rural areas or towns with small population, professional interpretation services are not affordable. In Spain, the costs of translation vary per language. An hour of translation from Russian into Spanish costs around €50, whereas translation from Chinese into Spanish can cost as much as €85, and a full day of face-to-face translation on site can cost up to €580.⁴¹⁸ Private hospitals charge the costs to the patients, while the public hospitals more often try to manage with the help of bilingual staff or the patient's relatives and friends. The use of hospital staff burdens bilingual nurses to have to balance between providing both interpretation and health care services. A study of 12 hospitals in Vienna showed that in 61 percent of the cases when the need for translation during medical consultation arose, Serbocroat-speaking cleaners with no expertise neither in medicine nor interpretation performed that function.⁴¹⁹

⁴¹⁷ Claudia V. Angelelli, *Study on Public Service Translation in Cross-border Healthcare: Final Report for the European Commission Directorate-General for Translation DGT/2014/TPS*, 81 (Sept. 2015), available at http://ec.europa.eu/dgs/translation/publications/studies/public_service_translation_healthcare_eu_en.pdf.

⁴¹⁸ Claudia V. Angelelli, *Study on Public Service Translation in Cross-border Healthcare: Final Report for the European Commission Directorate-General for Translation DGT/2014/TPS*, 74 (Sept. 2015), available at http://ec.europa.eu/dgs/translation/publications/studies/public_service_translation_healthcare_eu_en.pdf.

⁴¹⁹ Franz Pochhacker, Mira Kadric, *The Hospital Cleaner as Healthcare Interpreter, A Case Study*, 5 THE TRANSLATOR 161, (1999).

In the Scandinavian states, the costs of interpretation and translation also lie with the patients. However, under Article 5 of the Nordic Convention on Social Assistance and Social Services, citizens of the Nordic states have the right to use the social services, including health care, in their own languages when visiting or residing in another Nordic State. This provision applies to Finnish, Swedish, Norwegian, Danish, and Icelandic languages.⁴²⁰ In addition, Sweden has a government-funded system in place to ensure full and equal access to health care for people with hearing, visual, and mental disabilities. The doctors use face-to-face, video conference, and telephone interpretation that the various federal and regional governmental institutions provide.⁴²¹ Even though accommodating linguistic diversity beyond Nordic languages would require these same technologies, their use does not go beyond the patients with disabilities. In Finland national legislation does not oblige to provide treatment in other languages than Finnish or Swedish, which is why patients need to arrange and pay for their own interpreter if they need one.

The efforts to provide wider access to health care in Europe are mostly project-based. For instance, the Migrant Friendly Hospitals project ran in 12 hospitals across Europe from 2002 to 2004. The goal of the project was to improve communication between patients and their doctors, introduce culturally-sensitive services, and make patients aware of their rights.⁴²² A “Migrant Friendly Hospital” initiative in Geneva University Hospitals ran from 2010 to 2013. The aim of this project was to familiarize the hospital staff with the available tools for improving doctor-patient relations, like a community interpreter Geneva Red Cross Service, and creating shared knowledge and practices around migrant care.⁴²³ Another pilot project called “Quality assurance in health care provision for non-German speaking patients - Video Remote Interpreting in health care” ran in Vienna hospitals from October 2013 to March 2014. It provided video conferencing interpretation in Turkish, Serbian, Croatian, Bosnian, and Austrian

⁴²⁰ *Nordic Convention on Social Assistance and Social Services* Title II art.5 (1994), available at <http://www.norden.org/en/om-samarbejdet-1/nordic-agreements/treaties-and-agreements/social-and-health-care/nordic-convention-on-social-assistance-and-social-services>.

⁴²¹ Swedish Agency for Disability Policy Coordination, *Break the Barriers: Guidelines for Accessibility According to the Disability Policy Ordinance*, 526 (2001), available at euroquality.se/pdf/Break_the_barriers_Handisam.pdf.

⁴²² Sonja Novak-Zezula et al., *Improving interpreting in clinical communication: models of feasible practice from the European project 'Migrant-friendly Hospitals'*, 2 *DIVERSITY IN HEALTH AND SOCIAL CARE* 223 (2005), available at <http://diversityhealthcare.imedpub.com/improving-interpreting-in-clinical-communication-models-of-feasible-practice-from-the-european-project-migrantfriendly-hospitals.pdf>.

⁴²³ Patricia Hudelson et al., *A 'Migrant Friendly Hospital' Initiative in Geneva, Switzerland: Evaluation of the Effects on Staff Knowledge and Practices*, 9 *PLOS ONE* 1 (2014), available at <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0106758>.

Sign language.⁴²⁴ Despite the short-term success of these and other similar projects, they failed to produce any long-term policy solutions.

Conclusion

This memorandum analyzes the national and international legal implications of the Dutch government's decision to discontinue compensation for translation and interpretation services in Dutch health care. It addresses in turn the role and obligations of the following actors on the health care sub-markets, as well as their legal obligations: the Dutch central government, the municipalities, the health care insurance companies, and the health care providers.

The Dutch government

The Right to Health Care

Discontinuation of compensation for interpretation and translation services in Dutch health care re-introduced an obstacle for individuals of low Dutch proficiency to gain access to required health care and may have decrease the quality of health care provided, thereby constituting a cause for ill-health or a barrier for attaining the highest possible standard of health. A collective complaint for a violation of the ESC can be made, since the Netherlands has signed and ratified the ESC and the Additional Protocol providing for the system of collective complaints. None of the other national or international legal provisions on the right to health care allow individuals to invoke that right before a court directly.

The *Urgenda* case provides a framework to assess the government's duty of care to ensure health care is sufficiently accessible under Dutch civil law. On the basis of the *Urgenda* judgment, the Dutch courts could interpret the state's policy freedom on how to fulfill its duty of care, as laid down in Art. 22 GW, as being limited by an obligation to take progressive measures to ensure access to health care in light of its national and international legal obligations. The question whether the state violated its duty of care by discontinuing compensation for translation services will depend on whether the discontinuation creates a situation of illegal endangerment as well as the level of the state's policy discretion awarded.

⁴²⁴ Videodolmetschen, *Project Healthcare 2013/2014*, available at <http://www.videodolmetschen.com/en/forschung/projekt-gesundheit.html>.

The Right to Non-Discrimination

The CRM delivered an opinion (March 2016) in a case of a financial company refusing to offer to the plaintiff services because his insufficient command of the Dutch language. Even though this case concerned a complaint against a private actor under Art. 7.1(c) AWGB, the same considerations could be arguably applied to government actions under Art. 7.1(b) AWGB. Since this discontinuation particularly disadvantages individuals of a non-Dutch background compared to individuals of Dutch descent seeking access to health care services, the situation may amount to a prohibited form indirect discrimination.

Although to date the ECtHR has not heard any cases on language discrimination, since the Netherlands has signed and ratified Protocol 12, which guarantees the right to non-discrimination without having to link it to any of the other rights under the ECHR, it may be possible to file a complaint regarding the discontinuation of compensation for translation and interpretation services under Article 1(1) of Protocol 12, arguing discrimination on the grounds of language.

The case of *Andrejeva v. Latvia* (ECtHR, 2009) concerning discrimination in the calculation of retirement pensions for non-citizens of Latvia could provide a basis for a claim relating to the discontinuation of compensation for translation and interpretation services in health care. According to this case, there is no merit to the defense that the patient could have avoided being discriminated against by learning Dutch, as it would undermine the substance of the prohibition on non-discrimination.

The Right to Privacy

Use of a translator during the provision of health care amounts to the processing of personal regulated by the provisions of the Wbg. Only specific categories of individuals are allowed to process medical data, always with the consent of the patient. Informal translators do not belong to the category of medical professionals allowed to process medical data. Thus, the use of informal translators may constitute a violation of the right to privacy in a medical setting.

However, it will be hard to attribute a violation of privacy to the government by discontinuing translation and interpretation services, as the discontinuation does not necessarily impose an obligation upon patients to use informal translation services. It will therefore be difficult to establish a direct causal link between the discontinuation of translation and interpretation services by the government, and the possible restriction of a patient's privacy in using an informal translator.

Further, Dutch courts have only in exceptional cases held that the lack of granting certain facilities by the government constituted a restriction of a fundamental right.

Having to use the help of a friend, neighbor, or minor to get health care forces a patient to consent to disclosing sensitive personal information to a third party, thus violating the requirement of free consent. “Informal” translators are also not bound by professional duties of confidentiality and thus such information may be further disseminated against the will of the patient. Therefore, it is possible to argue that the new regulations force patients that do not speak Dutch to forego their right to privacy, for example, if they lack financial means to hire a professional translator. Similarly, the lack of translation and interpretation services undermines the ability to provide full and informed consent to medical procedures, which in turn may constitute a violation of Art. 8 ECHR.

The ECtHR (*V.C. v Slovakia*) held that a lack of informed consent to a medical procedure would violate Art. 8 ECHR. In light of this it is possible to argue that the discontinuation of compensation for translation and interpretation services in Dutch health care undermines the ability of a patient to provide full and informed consent. A lack of professional translation and interpretation services could lead to the patient being unable to fully understand the medical procedure, its consequences and thus render them unable to provide full and voluntary informed consent to medical procedures. Given that the ECtHR has held that it is the duty of the state, in the state-run medical institutions, to ensure that the individual is capable of providing full and informed consent, the discontinuation of compensation for translation services in health care arguably undermines this duty.

The Municipalities

The Municipalities have health care responsibilities over three types of care: public health care, societal care, and youth care. In relation to public health care, while the central government has a coordinating role, the role of municipalities is more executive in nature. Municipalities have a duty of care under the Public Health Act (*Wet publieke gezondheid, Wpg*) and the Community Act (*Gemeentewet, Gw*) to take appropriate action to prevent and combat epidemic outbreaks and infectious diseases. Maintaining a municipal health care system sufficiently accessible to all could be seen as a prerequisite for fulfilling this duty of care. Discontinuation of translation services arguably threatens the accessibility of the municipal health care system and as such public health care as a whole.

In terms of societal and youth care, the Societal Support Act (*Wet maatschappelijke ondersteuning, Wmo*) and the Youth Act (*Jeudgwet, Jw*) contain an obligation for the municipality to provide an infrastructure for societal care and youth care that includes a focus on local and personal circumstances. Persons in need of societal support or youth care can apply for individual care facilities. In case they cannot live self-reliantly or participate in society without such support, the municipality has an obligation to provide these services. The municipality must take into account the client's individual needs and characteristics, such as his or her cultural background. Translation and interpretation services may be an example of individual services that the municipality is obliged to provide to the client.

Specifically, in relation to societal care, Art. 2.1.1. Wmo contains the general obligation for the municipalities to ensure societal care. The municipalities do not provide care directly, but have a facilitating role that is similar to the government's role in curative care. As such, the municipality's duty of care under Art. 2.1.1 Wmo may be similar to the government's duty of care under Art. 22 of the Dutch Constitution, as described above in the Urgenda case. A failure to provide compensation for translation and interpretation services may therefore amount to an unlawful act under Dutch civil law.

In relation specifically to youth care, under Art. 2.6 Jw the municipality is responsible for a qualitatively and quantitatively adequate supply of health services. A lack of translators may mean that the supply is inadequate in terms of quality, since this leads to unclear communication between the care provider and the child. Therefore, municipalities may have a separate obligation to ensure that youth care organizations have translators or interpreters available.

Health Care Insurance Companies

Although the duty of care is primarily owed to the insured, the health care providers can, under certain circumstances, also rely on and invoke the insurance company's duty of care. This was most prominently decided in a 2015 case at the Trade and Industry Appeals Tribunal (*College voor Beroep voor het Bedrijfsleven, CBB*).⁴²⁵

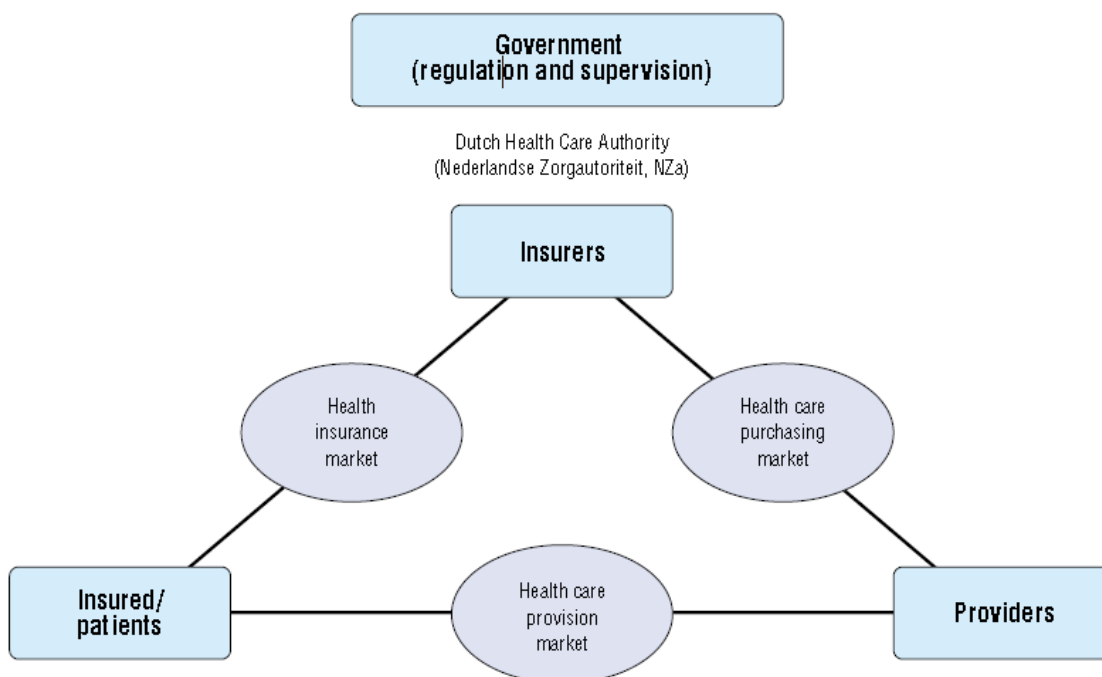
⁴²⁵ College van Beroep voor het bedrijfsleven (Dec. 1, 2015), ECLI:NL:CBB:2015:370, available in Dutch at <http://deeplink.rechtspraak.nl/uitspraak?id=ECLI:NL:CBB:2015:370>.

Insurance companies do not have a direct obligation to compensate for interpretation services, since its customers are not legally entitled to such service under the basic package. However, insurance companies do have a broadly defined obligation to ensure the quality and accessibility of care. Accessibility includes equality and affordability. Given the open nature of the duty of care, leaving room for insurance companies and health care providers to fill in the details in mutual cooperation, health care insurance companies could compensate for professional translation services procured in the course of receiving health care. However, the open nature of the norm suggests it is unlikely that the insurance companies should, as a matter of legal obligation, compensate for such translation services under the Health Care Insurance Act (*Zorgverzekeringswet, Zvw*).

Health care providers

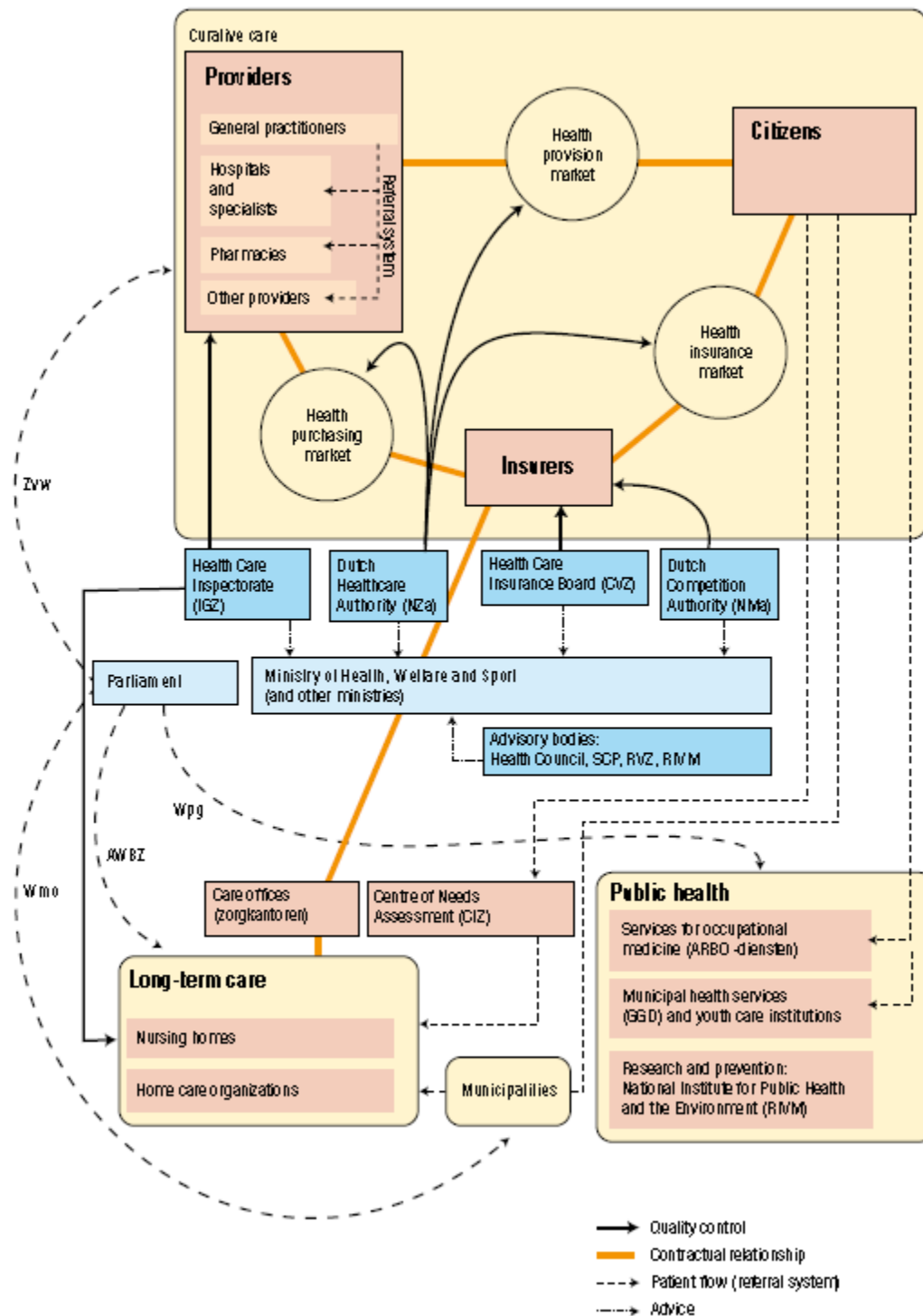
Dutch health care providers carry the majority of the legal responsibility to ensure the quality and accessibility of care provided of all actors on the Dutch health care system. Under the Wet BIG and Art. 2.2 Wkkgz, health care providers must provide care of sufficient quality and under the WGBO and Wbp they are to protect the patient's right to privacy. The discontinuation of compensation for translation and interpretation services puts health care providers at the largest risk of violating their legal obligations towards the patients, notwithstanding the fact that other actors in the health care system may also have a duty of care towards patients with low Dutch proficiency.

Annexes

Annex 1

Willemijn Schäfer et. al., *The Netherlands Health System Review*, 12 Health Systems in Review 1, 22 (2012) available at http://www.euro.who.int/__data/assets/pdf_file/0008/85391/E93667.pdf

Annex 2



Willemijn Schäfer et. al., *The Netherlands Health System Review*, 12 Health Systems in Review 1, 14 (2012) available at http://www.euro.who.int/__data/assets/pdf_file/0008/85391/E93667.pdf

Note: this illustration still refers to the AWBZ which has since been replaced by the Long-term Care Act

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Through its work, PILPG promotes the use of international law as an alternative to violent conflict for resolving international disputes. PILPG provides legal counsel to *pro bono* clients during peace negotiations, advises on the creation and operation of transitional justice mechanisms, provides expertise during the drafting of post-conflict constitutions, and advises on ways to strengthen the rule of law and effective institutions. To facilitate the utilization of this legal assistance, PILPG also provides policy formulation advice and training on matters related to conflict resolution.

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