Racism and the Right to Health

02 June 2022

CHOICE for Youth and Sexuality

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CHOICE FOR YOUTH & SEXUALITY

SUBMISSION: INPUT FOR THE SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH: RACISM AND THE RIGHT TO HEALTH

1. Contributing Organisations

CHOICE for Youth and Sexuality is a professional youth-led and youth-serving organization based in the Netherlands. For 25 years, CHOICE has been working with and for young people to fulfil their Sexual and Reproductive Health and Rights (SRHR) and rights to meaningfully participate in decision-making about issues that concern their lives. Through various programs, CHOICE works with young people across several countries in Africa and Asia. Engaging with both New York and Geneva-based UN processes, CHOICE is an advocacy expert on meaningful youth participation, particularly in the context of SRHR for young people in practice and in policy.

2. Introduction

This report sets out to contribute specific youth contributions as youth are often minimally discussed in traditional UN spaces. In 2020, only 49% of Special Procedures reports addressing youth in more than one sentence. While this is a positive increase in comparison to 2019, where only 33% of Special Procedures did so[1], there is still more to be done to recognize age as an intersecting form of discrimination throughout the UN Special Procedures mechanism. This specifically needs to be addressed in regards to youth populations, as the unique challenges that youth face are often overlooked or not adequately addressed in UN processes. Therefore, the objective of this report is to submit information pertaining to your call specifically from a youth perspective, to ensure that no one is left behind.

3. Global Situation of Youth

Racial justice on the global level is intrinsically connected to being able to access and protect available, acceptable and quality sexual and reproductive health and rights (SRHR) and gender equality. Legacies of colonialism, slavery, and racism have infiltrated the structures of health systems all over the world, and continue to cause long-lasting harm throughout people's lives and into the next generations, particularly for people who experience intersecting forms of discrimination.

Accessing sexual and reproductive health services

Adolescents and young people often forgo using sexual and reproductive health services due to stigma and discrimination they may face from providers. This stigma and discrimination often stems from the outdated notion that young people should not be sexually active, and therefore should not be accessing such services (despite the fact that sexual and reproductive services address many health topics, not just practicing safe sex). These interactions can deter youth and adolescents from using such services, as the judgement may lead to distrust and concerns over confidentiality.

Some groups of young people face greater obstacles than others, depending on their intersecting identities. For example, past research has shown that contraceptive mistrust, and negative stereotypes surrounding sexual and reproductive behaviours of black and Latina women deters them from using sexual and reproductive health services[2].

[1] CHOICE For Youth and Sexuality internal monitoring index
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8609799/

Research gap

Not only is there a significant evidence gap in understanding and knowledge of how racism and colonialism impacts SRHR, but if data on sexual and reproductive health and rights is not disaggregated, it leaves a large portion of the population out of medical research. This can then lead to health issues being tackled with a homogenous mind-set. Moreover, the global health landscape generally reflects a lack of intersectionality in reflecting the lived experiences of young people of colour (not to mention that Western institutions control the majority of finances for global health research), without this research, it is not possible to fully understand colonial or racist impacts on SRHR or how structural violence stems from racism and colonialism, nor how we can tackle reproductive injustices[3].

4. Questionnaire on Racism and the Right to Health

a) What are the main ongoing manifestations of racism, and related forms of discrimination enabled by racism that may be prevalent in your country in the area of the right to health broadly including in underlying determinants of health, health outcomes and access to health care?

Racial discrimination is a difficult topic in terms of the lack of systematic evidence of racism. This leads to an assumption that racism doesn't play a role in society. However, recent experiences clearly prove this wrong.

First of all, primary healthcare in the Netherlands is delivered through primary care centers and GP services, with a network of hospitals delivering secondary and emergency services. The Ministry of Health, Welfare, and sport is the government department responsible for public healthcare in the country. "*Tolerence is a source of Dutch pride. The Netherlands was the first European Member State to pass comprehensive anti-discrimination law. The Equal Treatment act has been in force since 1994. However, the recent Social and Cultural Planning Office of the Netherlands report shows that discrimination and negative portrayal of ethnic minorities is a problem and is one of thee reasons for their unfavorable position in the job market. The recent change in political climate makes it imperative to be aware of discrimination in all sectors of society including health care."* [4]

The problem with researching racism in The Netherlands is the lack of systematic evidence in the field. Empirical studies are obviously needed to answer these questions. Krieger, one of the prominent researchers on this topic has described different approaches of studying health consequences of discrimination. "There are measures in place such as anti-discrimination legislation. However,

[3] https://www.icrw.org/wp-content/uploads/2021/12/UAPbrief_v3-SRHR-and-Justice.pdf

[4] *1. European Journal of Public Health*, Volume 17, Issue 3, June 2007, Pages 240–241, https://doi.org/10.1093/eurpub/ckm040

legislation alone is not a sufficient measure to prevent discrimination in health care" Krieger says[5]. It could be that health professional may lack skills in meeting the needs of ethnic minority groups in our society.

To conclude, it is highly necessary to take discrimination in health care more seriously. This requires investments in countries with limited information, such as the Netherlands. This kind of information will allow researchers to determine whether racism exists in the health services, and if yes, its role in ethnic inequalities. In addition to this, we do see there are health inequalities between different groups within The Netherlands. "*However, we should critically look at what is the real cause of these health differences, and not take these social categories to signify biological or genetic differences. The underlying cause is often not the fact that you belong to a specific group, but another variable, like muscle mass as we saw before. More often, it can also be a societal factor. In many societies, for example, 'blackness' is associated with high blood pressure. Some might conclude from this that there is a genetic predisposition among 'black' people. That it is 'a black thing'. I would argue, however, that this is an incorrect and simplistic conclusion; namely that 'black' is a significant biological or genetic characteristic."* Says Alana Helberg-Proctor[6], assistant professor in the Department of Health, Ethics and Society of Maastricht University. She is an expert on the use of ethnicity in Dutch health research.

b) Who are the most affected people and why? Please describe existing disparities in the provision of and access to health services that affect people of different racial and ethnic origin, descent as well as other groups, such as migrants. The lack of data, analysis or health indicators in this regard may also be reflected.

People most affected in the Netherlands are people who don't speak the Dutch language so well. It is harder for them to reach out to health care and therefore they are not included in the dutch health care system.

Over the years, more and more health care workers meet migrants who are "illegal" in The Netherlands[7]. This includes ex-asylum seekers, who have not returned to their country of origin, and are in The Netherlands still. Since 1998 we have the Koppelingswet (Linkage Act[8]) in the Netherlands. As a result of this Linkage Act, undocumented people are not entitled to social security services such as financial support, health insurance or

[5] 3. Krieger, N. (1999). Embodying Inequality: A Review of Concepts, Measures, and Methods for Studying Health Consequences of Discrimination. https://doi.org/10.2190/M11W-VWXE-KQM9-G97Q

[6] 2. Helberg-Proctor, A., M'charek, A., & Meesters, E. (2019). 'Ras' speelt ten onrechte rol in klinische besluitvorming: Factor 'ras' In richtlijnen is niet zonder risico. Medisch Contact. Retrieved from https://www.medischcontact.nl/nieuws/laatste-nieuws/artikel/ras-speelt-ten-onrechte-rol-in-klinischebesluitvorming.htm

[7] http://www.lampion.info/information-in-english/healthcare-for-undocumented-migrants-the-situation-in-the-netherlands

[8] http://www.lampion.info/documents/doc/linkage_act.pdf

housing. Undocumented people can only get healthcare services if they pay for it, which they often cannot afford.

According to Pharos, a Dutch knowledge centre that is specialised in the field of refugees, migrants and health care, there are 125 to 225 thousand undocumented migrants in the Netherlands. In general they are in a worse state of health than people with a residence peremit. Actually it is regulated by law that undocumented migrants should receive medical care, even if they can't afford it themselves. However, in practice this turns out differently. Number one reason for this is the inadequatee financing of this care and the lack of knowledge about the regulations on the part of the care providers and the groups themselves.

c) Under the right to health, States have a special obligation to refrain from denying or limiting equal access for all persons, comprising minorities, asylum seekers and migrants including undocumented migrants, to preventive, curative and palliative health services; abstain from enforcing discriminatory practices as a State policy as well as to ensure equal access to health care and health-related services provided by third parties. Please explain how the above point is implemented in your country, what works well and not so well and illustrate with disaggregated data if possible.

n/a

d) What has been the impact of colonialism and the imposition of allopathic medicine on the availability of indigenous and traditional health knowledge systems, medicine and practices, and on the right to health more broadly in your country?]. Are health services available in your country that give due consideration and acknowledgment of, or respectfully incorporate indigenous/traditional health knowledge systems and practices, preventative care, healing practices and medicines? Please share examples of good practices.

n/a

e) Please share examples of good legal and policy frameworks that address past or ongoing racism and racial and related forms of discrimination, specifically in relation to access to underlying determinants as well as quality health care, goods, services and facilities, including sexual and reproductive health.

The Netherlands states in Article 1 of the Constitution that everyone in the Netherlands must be treated equally in equal cases[9]. Discrimination on the grounds of religion, belief, political affiliation, race, sex or on any ground whatsoever shall not be permitted. Furthermore, on the first of October in 2012 the 'Wet College voor de Rechten van de Mens', which roughly translates to Law College for Human Rights, was established. In this law the tasks, composition and working methods of the College are explained. The law also contains provisions that

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Article title:	De Nederlandse wet over discriminatie | College voor de Rechten van de Mens
Website title:	College voor de Rechten van de Mens
URL:	https://mensenrechten.nl/nl/de-nederlandse-wet-over-discriminatie

relate to the transition from the Equal Treatment Commission to the College for Human Rights. The College makes observations about discrimination and supervises human rights in the Netherlands.

Another law which aims to protect citizens from discrimination is the 'Algemene Wet Gelijke Behandeling[10]', which roughly translates to the General Equal Treatment Act has been in place since 1994. This law provides protection to people who are the victim of discrimination on the grounds of for instance religion, political beliefs, gender, nationality or race. This law only provides protection in specific cases;

- processes concerning work/ labour for instance in recruitment processes
- goods and services, for instance shopping, partaking in sports, education and financial services
- the liberal profession such as freelancers
- Membership of trade unions or associations of professional colleagues
- Social protection such as in the case of student loans or other benefits

In the past, some initiatives have been started to integrate cultural competency training into the medical curriculum (for instance the book 'Een arts van de wereld' concerning ethnic diversity in the medical practice) and 'interculturalisation' of mental health services[11].

Most recently, on the 15th of October 2021, the Dutch government has installed a National Coordinator against Discrimination and Racism in the wake of the Black Lives Matter demonstrations in 2020. The National Program, which will detail the future measures against discrimination is expected to be published in the summer of 2022. The program will consist of annual actionable goals and multiannual strategies.[12] As this project has just been set up, we will need to sharply monitor and evaluate its proceedings.

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Article title:	wetten.nl - Regeling - Algemene wet gelijke behandeling - BWBR0006502
Website title:	Wetten.overheid.nl
URL:	https://wetten.overheid.nl/BWBR0006502/2008-09-01

11 Agyemang, Charles, Conny Seeleman, Jeanine Suurmond, and Karien Stronks. "Racism in health and health care in Europe: where does the Netherlands stand?." *The European Journal of Public Health* 17, no. 3 (2007): 240-241.

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Article title:	Aanpak discriminatie
Website title:	Rijksoverheid.nl
URL:	https://www.rijksoverheid.nl/onderwerpen/discriminatie/aanpak-discriminatie

f) Please share examples of public health financing, non-governmental sector funding practices, inter-agency finance solutions, medical insurance products that show manifestations of ongoing or past racism and related discrimination, at the local and global levels that impact racialized people, as well as other factors such as poverty, or discrimination based on age, sex, gender identity, expression, sexual orientation, disability, migration status, health status e.g. HIV, Albinism etc. and the rural and urban divide."

Within Europe, The Netherlands is one of the countries which spends the most of its gross domestic product (GDP) on healthcare coming in at place 10 within Europe. In 2018 and 2019, 10% of its GDP was spent on healthcare, a large part on long-term healthcare and relatively little on (para)medical care.[13]

The Netherlands applies a system of universal coverage of medical care expenses as well as long-term healthcare which are financed through compulsory income-related contributions.[14] A study carried out in 2016 showed that health spending in any given year is skewed toward poorer individuals, meaning that individuals in the bottom part of the income distribution spend two to three times what those at the top spend, at all stages of the life cycle. Unfortunately this study does not account for, or show results relating to either race, ethnicity or background.

As the Dutch healthcare system comprises of public and private insurance, not all individuals can access or purchase all options available in the private healthcare.[15] Emergency visits or visits to the general practitioner (GP) are covered for all individuals*, however for instance not all dental care is included in the basic coverage. This automatically will lead to exclusion of certain groups of people to necessary healthcare, and more research needs to be done in order to analyze which people are not getting the necessary treatments.

**all individuals with healthcare insurance, all individuals under the age of 18 and in some cases undocumented individuals.*

g) Please share good practices and examples of public health interventions resulting in adequate access (inside and outside the health sector), support knowledge production or implementation of programs that successfully address inequalities in particular the impact of racism and related racial discrimination, as well as other factors such as poverty, or discrimination based on sex, gender identity, expression, sexual orientation, disability and migration status.

[13] CBS. 2020. *Dutch health expenditure 10th highest in Europe*. [online] Available at: <https://www.cbs.nl/en-gb/news/2020/47/dutch-health-expenditure-10th-highest-in-europe> [Accessed 30 May 2022].

[14] Bakx, Pieter, Owen O'Donnell, and Eddy Van Doorslaer. "Spending on health care in the Netherlands: not going so Dutch." *Fiscal Studies* 37, no. 3-4 (2016): 593-625.

[15]

Author	Xenia Gonikberg
Article title:	Healthcare in the Netherlands - The Borgen Project
Website title:	The Borgen Project
URL:	https://borgenproject.org/healthcare-in-the-netherlands/

- An example of successful inclusion of people with an immigrant background in a health initiative was the spread of information during the COVID-19 pandemic. Press conferences were translated in 8 different languages and always included a sign language interpreter. Posters, flyers and signs were also translated in various languages, often Arabic, to provide easier access to information for people who did not speak the Dutch Language[16].
- The *Vilans* organisation for elderly care published a study into 'culturally aware care' in which they explored the ways in which the caretaking needs of black and brown people differs from white patients. The research also paid attention to the influence of diversity within teams of care providers, on the one hand noting the positive potentialities this provides while considering on the other the possible friction and misunderstandings within teams. Through conversations with various culturally aware elderly homes, *Vilans* created a guide for other care providers to implement[17].
- The KIT Royal Tropical Institute provides trainings for medical professionals to become more attentive of cultural differences. These trainings are open to all health professionals from dentists and first aid workers to physiotherapists and youth nurses. The comprehensive training discusses interculturally appropriate conversation styles, varieties in understanding and describing health issues and awareness of the caregiver's own cultural background and bias[18].

h) Please share good examples and practices that enable accountability in public and private sector that enable access to justice and redress to victims of racism and discrimination on the grounds such as colour, descent, national or ethnic origin or migrant or refugee status in the provision of health care and as it intersects with factors such as poverty, or discrimination based on age, sex, gender identity, expression, sexual orientation, disability, migration status, health status e.g. HIV, Albinism etc. and the rural and urban divide."

The Dutch organization *Dokters van de wereld* supports the right to healthcare for those with less access to the regular healthcare system, such as people living in poverty or refugees

[16] Rijksoverheid. 'Anderstalige communicatiemiddelen over het coronavirus.' Rijksoverheid, https://www.rijksoverheid.nl/onderwerpen/coronavirus-covid-19/coronavirus-beeld-en-video/communicatiemiddelen-anderstalig

[17] Sterenborg, Marike. "Kleurrijke zorgverleners." Vilans, Februari 2020. https://www.vilans.nl/kennis/kleurrijke-zorgverleners

[18] KIT Acedemy. "Cultuursensitieve Gezondheidszorg." KIT Royal Tropical Institute, https://academy.kit.nl/groups/cultuursensitieve-gezondheidszorg-group/

without a residency permit[19]. Although every person in the Netherlands has a legal right to healthcare, many people are unaware of their rights or are scared of detention or deportation if they approach a hospital without the appropriate documents. This fear is often confirmed when undocumented migrants who do visit the doctor are sent away without the appropriate care and their medical issues are ignored due to their status.

Dokters van de wereld provides necessary healthcare in lower income neighborhoods through a mobile 'healthcare bus' and a 'dental bus' which is free and open to everyone. Inside the bus are voluntary medical professionals who take the time to explain the Dutch healthcare system, and to guide patients to the right health outlets. The organisation has built a large network of medical practices who are aware of the rights of undocumented migrants in The Netherlands and are willing to provide the necessary care without papers. Besides this, the organization also arranges supportive meetings in which they inform undocumented refugees about their rights to healthcare[20].

i) Please share information about the sources of health financing for your country, the quantity and quality of said financing, as well as any aid or funding conditionalities, global economic policies, and austerity or other measures requested or encouraged by international financial institutions, multilateral agencies or donors, that negatively affect health systems and people's access to health in your country.

Healthcare insurance is mandatory in the Netherlands for every legal inhabitant over the age of 18. Children are automatically insured under their parents' insurance. Insurance costs approximately €115 per month for basic coverage, which includes visits to the GP, some medicine, specialist and hospital costs. However, this coverage only starts after the mandatory 'own risk' of €385 each year. In this way, smaller specialist visits or regular medicine will always have to be paid out-of-pocket by the patient, until their total medical spending that year amasses to €385.

For low-income citizens, The Netherlands has an elaborate healthcare benefit system in place which supports all incomes below €31.998 per year with up to €111 euro benefit each month[21]. This way, lower income citizens with large healthcare costs are always supported for their medical needs once the total medical spending that year passes €385. However, there is no extra safety net available for this 'own risk', which places an in increasing number of lower income citizens in a precarious position when they unexpectedly have to pay these

[19] Dokters van de wereld. "Wat doen wij." *Dokters van de wereld*, https://doktersvandewereld.org/wat-doen-wij/de-zorgbus/

[20] Ibid

[21] Belastingdienst. "I Want to Apply for a Benefit." Startpagina van de Belastingdienst, December 27, 2021. https://www.belastingdienst.nl/wps/wcm/connect/bldcontenten/belastingdienst/individuals/benefits/how_do_benefits_work/i_want_to_apply_for_a_benefit/i_want_to_apply_for_a_benefit.

costs. Debt-prevention organisations also note that due to increasing bureaucracy many people in The Netherlands are unaware which benefits are applicable to them, and which types of care are insured, which can lead to large unexpected costs[22].

It is important to note that although healthcare insurance is mandatory in The Netherlands, the healthcare benefit is only accessible to Dutch citizens or people with a residence permit who also have Dutch health insurance. Immigrant inhabitants are often not eligible for Dutch health insurance.

Additionally, many types of care that are excluded from the basic insurance have to be paid out of pocket as well. This includes dental care, physiotherapy, and 'alternative healing methods'. The latter proves especially problematic with regards to healthcare practices connected to a culture or region outside of western Europe, such as acupuncture and herbal rituals, which are generally never covered[23].

j) What are the historical and ongoing legacies and impacts of colonialism and slavery on the right to health in your country? And how has the lack of reparations for slavery, colonialism, apartheid and racial discrimination impacted the right to health in your country?

The Netherlands has a long and painful history colonialism and slavery throughout the world, resulting in the diaspora and mass migration to The Netherlands of many formerly colonised communities. This is visible in the nearly 1 million people from Indonesian, Surinamese and Antillean decent currently living in The Netherlands. Additionally, another 1 million Dutch citizens are from Moroccan or Turkish descent in the aftermath of extensive contracting of labour immigrants from Morocco and Turkey between 1960 and 1970[24].

Recent research from CBS states that people from an Antillean, Moroccan, Surinamese or Turkish background in The Netherlands structurally face higher costs for healthcare than any other group in The Netherlands[25], Dutch people, or people from the global North.

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[22] Kuijper, Koen. "Nederlanders in Extreme Geldproblemen Door Hoge Zorgkosten." Zorgwijzer. August 16, 2021. https://www.zorgwijzer.nl/zorgverzekering-2020/nederlanders-in-extreme-geldproblemen-door-hoge-zorgkosten.

[23] Zorgwijzer. "Vergoeding Chinese Geneeswijzen."2022. https://www.zorgwijzer.nl/vergoeding/chinese-geneeswijzen#:~:text=De%20CZ%2Dgroep%20van%20zorgverzekeraars,Zorgdirect%20vergoeden%20alleen%20nog%20acupunctuur.

[24] CBS. "CBS introduceert nieuwe indeling bevolking naar herkomst. Centraal Bureau voor Statistiek, Februari 16, 2022. https://www.cbs.nl/nl-nl/nieuws/2022/07/cbs-introduceert-nieuwe-indeling-bevolking-naar-herkomst#:~:text=Van%20de%20890%20duizend%20in,(164%20duizend)%20een%20Turkse.

[25]

k) Please also share good practices and examples of reparations for racial discrimination related to the right to health violations and abuses.

n/a

CBS. "Jaarraport Integratie 2020." Centraal Bureau voor Statistiek, November 11, 2020. https://www.cbs.nl/nl-nl/publicatie/2020/46/jaarrapport-integratie-2020