Abstract

Many countries have national health systems that cover all or part of the population. An aging population and advances in medical technology are making health insurance increasingly expensive, and governments are left seeking cost-effective options. The Dutch government is reorganizing its health care system and seeking to combine economic competition with a right to health in order to improve the health of its population. This article addresses privatization in terms of a right to health and asks whether governments can privatize their health care systems while also guaranteeing the availability, accessibility, acceptability, and quality of health care services. It is suggested that a "right to health impact assessment" can be a useful tool applicable also to the privatization processes in other countries.

Beaucoup de pays ont mis en place des programmes nationaux de santé publique couvrant la totalité ou une partie de leur population. L'avancement de l'âge des populations et les progrès de la technologie médicale augmentent progressivement les coûts de l'assurance-maladie et les gouvernements sont forcés de trouver des options dont le rapport coût-efficacité est satisfaisant. Le gouvernement néerlandais est en train de réorganiser sa politique nationale de santé publique et cherche à intégrer les principes de la libre concurrence économique avec ceux du droit à la santé, afin d'améliorer la santé de sa population. Cet article traite de la privatisation en la rapprochant du droit à la santé et interroge les gouvernements sur leur capacité à privatiser la santé publique tout en garantissant la disponibilité, l'accès, l'acceptabilité et la qualité des services de santé. L'étude suggère qu'un "droit à l'estimation de l'impact sur la santé" peut s'avérer utile et susceptible d'être également appliqué aux processus de privatisation d'autres pays.

Muchos países cuentan con sistemas nacionales de salud que cubren completa o parcialmente a la población. Una población que envejece y los avances en la tecnología médica están haciendo que los seguros médicos se vuelvan cada vez más caros, y los gobiernos se queden buscando opciones rentables. El gobierno holandés está reorganizando su sistema de atención médica y está buscando combinar la competencia económica con los derechos a la salud a fin de mejorar la salud de su población. En este artículo se habla de la privatización en términos de un derecho a la salud y se pregunta si los gobiernos pueden privatizar sus sistemas de atención médica mientras garantizan a la vez la disponibilidad, accesibilidad, aceptabilidad y calidad de los servicios de atención médica. Se sugiere que el "derecho a una investigación sobre el impacto en la salud" puede ser una herramienta útil aplicable también al proceso de privatización en otros países.

The Right to Health and the Privatization of National Health Systems: A Case Study of the Netherlands

Brigit Toebes

The right to health is an economic and social right, which is set forth in many human rights conventions at the UN, as well as at the regional level. The most widely recognized provision is Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).[1] The meanings and implications of Article 12 are set forth in an explanatory document, General Comment 14, which was adopted by the UN Committee on Economic, Social and Cultural Rights, the treaty-monitoring body of the ICESCR.[2] As articulated in the General Comment, the right to health is not a right to be healthy as such, but rather a right to a number of freedoms and entitlements relevant to a person's health. Furthermore, it explains that the right to health not only embraces health care services but also the underlying determinants of health, such as access to potable water and adequate sanitation; an adequate supply of safe food, nutrition, and housing; healthy occupational and environmental conditions; and access to health-related education and information, including sexual and reproductive health.[3]

This article describes the reorganization of the Dutch health care system from within this framework and focuses

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primarily on access to health care services even as the underlying determinants of health are as crucial for people's health. Privatization therefore can be understood to concern not only the provision of health care but also services such as clean water and social security.[4]

According to General Comment 14, governments are to guarantee the availability, accessibility, acceptability, and quality of health facilities, goods, and services. Availability means that sufficient health services must be provided. Accessibility implies non-discrimination, physical accessibility, economic accessibility (affordability), and access to information.[5] Acceptability means that health facilities must respect medical ethics and be culturally appropriate, while quality requires that health services are scientifically and medically appropriate and sound.[6] These principles are applied below when discussing the case of the Netherlands.

The Netherlands and the Right to Health

The Netherlands is a party to all relevant international treaties that guarantee a right to health, including the ICESCR, the Convention on the Elimination of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), and the European Social Charter (ESC).[7] In the Netherlands, after ratification international treaties are regarded as part of the national legal order. As a result, the treaties containing a right to health were automatically incorporated into domestic law and can in theory be applied before the Dutch national courts.[8]

The Dutch Constitution formulates the state's responsibility for health by stipulating that "The authorities shall take steps to promote the health of the population."[9] It is a general obligation, leaving public authorities a large margin of discretion. Due to the supremacy of statutes in the Dutch legal system, the courts cannot review the constitutionality of Acts of Parliament. As a result, courts cannot review the constitutionality of health legislation that are acts of Parliament, including the Health Insurance Act discussed below.[10]

The fact that the right to health is part of the Dutch legal order does not necessarily imply that this right can be enforced before the Dutch courts. In fact, given its general

character and the positive obligations it imposes on the government, Dutch courts have been reluctant to grant direct effect to the right to health.[11]

At the legislative and policy levels, however, even as the term "right to health" is almost never used, its implications are strongly embedded in national health laws and policies. The principles of accessibility, availability, and quality are frequently mentioned, and their implications are taken into account with the adoption of new laws and policies.[12]

The Privatization of Health Care Services

Definitions

Privatization means making private what was not private before.[13] It is the sale or transfer of state-owned assets into private hands.[14] A distinction can be made between the transfer of ownership from the public to the private sector, and a situation where services are provided by a private body on the basis of an agreement with the public sector ("contracting out").[15]

According to Graham, privatization must be distinguished from liberalization and deregulation because liberalization is a process of introducing competition into an industry, but deregulation implies relaxing the rules under which a sector conducts its activities. Yet the transfer of ownership from public to private is generally accompanied to some degree by liberalization and/or deregulation.[16] Other authors choose to use the broader term "commercialization," a concept that embraces both privatization and liberalization, but also denotes commercial behavior by publicly owned bodies.[17]

Current Trends

Many countries are currently undergoing health care privatization processes. Public health systems are increasingly coming under pressure because of the rising costs of health care. These cost increases are due to a variety of factors, including improvements in medical techniques, the changing age profiles of populations, and rising expectations about the quality of care.[18]

A side-effect of the pressure on public health systems is the emergence of long waiting lists for many treatments. In

Canada, for example, where privately financed purchases of core medical services are banned by law, long waiting lists have led to an intervention by the Canadian Supreme Court. In a landmark decision, the Court ruled that "the prohibition on obtaining private health insurance . . . is not constitutional where the public system fails to deliver reasonable services." The Court stipulated that waiting lists had become so long that they violated patients' "life and personal security, inviolability and freedom" under the Quebec Charter of Human Rights and Freedoms.[19] Because the decision is expected to lead to sweeping changes in the Canadian health care system, it is considered a blow to the publicly financed national health care system.[20]

The patterns of reform differ from country to country. For example, in the Netherlands privatization largely concerns health insurance as such, but in the United Kingdom it concerns health care provision, as the government gradually seeks to contract out health care services to the private sector.[21]

In the Netherlands, privatization is linked to liberalization: while power is transferred to the insurance companies, competition is introduced in the insurance market.

Impact on Health and Welfare

Some public health experts claim that privatization of health care services can have a negative effect on health outcomes and on the accessibility of health care services for poor and disadvantaged people, in particular in poorer countries. [22] For example, a recent study by Mackintosh and Koivusalo suggests that countries with better health outcomes have significantly lower commercial health expenditures. [23] With regard to children's health, in particular, this study suggests that better post-natal care is associated with either a higher percentage of gross domestic product (GDP) spent by government or social insurance funds spent on health care, but not with more private health spending.[24]

Public health experts, therefore, suggest that ethical principles, including equity, should be embedded in the privatization processes.[25] This is similar to suggesting, as this article does, that principles like availability, accessibility, acceptability, and quality should be applied when introducing privatization.

Governmental Obligations and the Privatization of Health Care Services

The right to health does not prohibit the privatization of health care services per se. There is no explicit or specific prohibition to privatize health care services in the international human rights treaties or in the existing explanatory documents. As such, the right to health may be satisfied through whatever mix of public and private services are appropriate in the national context.

Nevertheless, according to General Comment 14, governments are to ensure that the privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability, and quality of health facilities, goods, and services. It also claims that affordability of health services requires that these services, whether privately or publicly provided, are affordable for all, including disadvantaged groups.[26] In particular, it stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.[27] The CEDAW Committee uses similar language in its General Recommendation on Health, claiming that "States parties cannot absolve themselves of responsibility in these areas [women's ill-health] by delegating or transferring these powers to private sector agencies." The CEDAW Committee expressed its concern "at the growing evidence that States are relinquishing these obligations as they transfer State health functions to private agencies."[28]

In conclusion, the international documents contain a clear governmental obligation to ensure that, in the case of privatization, the availability, accessibility, acceptability, and quality of health care services are guaranteed to everyone. It can be seen from this that governments bear strong responsibility for the provision of health care services and cannot relinquish this responsibility by claiming that private actors have become the primary providers of these services. How governments are to ensure the availability, accessibility, and quality of services is not made clear, nor are there directives in the international documents as to how governments are to exercise control over private entities in the health care system.

Human Rights Obligations of Other Actors in the Health Sector

The human rights responsibilities of other actors in the health sector, including insurance and pharmaceutical companies, hospitals, and health workers, raise additional areas of concern. Since they often play a key role in providing health care services, the question arises whether they have responsibilities regarding the right to health.

From a moral point of view, it is arguable that powerful actors in the health sector are obliged to comply with the right to health, regardless of whether or not they are government entities. This would imply that insurance companies should not refuse to provide coverage to patients, and that they should not make medical services more expensive for patients with health problems. Along the same lines, hospitals should not refuse patients on the basis of their legal, economic, or insurance status.

From a legal point of view, however, the argument is harder to make. The right to health is primarily a right of the individual vis-à-vis their government and therefore does not directly bind other actors in the field. To suggest that the right to health applies to private actors is to say that it has a "horizontal effect" or *drittwirkung*, terms over which there is much confusion.[29] Yet, international human rights law provides several means of recognizing third-party applicability, and at a practical level there is clearly a trend towards doing so.[30]

The recognition of human rights responsibilities by actors other than states is clearly developing and could make an important contribution ensuring the rights of individuals. It is important to note, however, that pointing to the responsibilities of other actors in the health sector does not lessen the primary responsibility of governments to guarantee the right to health.

The Reorganization of the Dutch Health Care System

Problems in the Dutch Health Care System

Prior to 2006, there was a distinction in the Netherlands between the National Health Service, which covered more than 60% of the population, and private insurance that covered the remainder of the population. Employees, people en-

titled to a social benefit, and self-employed individuals with a specified income level were insured under the compulsory Social Health Insurance Act (*Ziekenfondswet*). People with a higher income could choose either to take out private health insurance or to be uninsured.[31]

Like many other governments, the Dutch government is struggling with the rising costs of its health care system. This is caused in part by the increasing demand for health care, which in turn is caused by the aging of the population and medical-technical advancement.[32] Together with a shortage of medical personnel, the lack of financial resources has, among other things, resulted in long waiting lists for many treatments.[33] These lists reached a peak at the beginning of the new century. Since then, more funding has been made available, and measures have been started to make the system more efficient.

Yet, the waiting lists in the Netherlands are sometimes still unacceptably long. For example, there are huge shortfalls in appropriate care for children with mental and behavioral disorders.[34] Moreover, many elderly people spend a long time waiting for a place in a nursing home.[35] There are often long waiting lists for fertility treatment and even for necessary or non-elective surgery.[36] On occasion, the length of the waiting list has led to situations where people have died because they could not get the treatment they needed in time.[37]

As a result of the unavailability of health care services, people living in the Netherlands are increasingly seeking medical care across the border, especially in Germany and Belgium. Although this relieves some of the pressure, the government has expressed fear that this practice will endanger the return on its investments in the national health care sector.[38] The Netherlands, however, adheres to the principle of the free movement of services within the Europe Union (EU) and is only allowed to protect its own health care sector to a limited extent.[39] There is an extensive body of case law of the European Court of Justice that prohibits the Netherlands and other member states from taking too many protectionist measures.[40]

As mentioned earlier, waiting lists are partly caused by shortfalls in medical personnel. There is a particular shortage of general practitioners (GPs). Although everyone is supposed

to have access to a GP, many people are still without recourse to general medical care.[41] The shortage is most visible in areas where it is less attractive for GPs to set up their practices, a factor that may give rise to the added problem of insufficient physical accessibility.

In terms of information accessibility and acceptability, particular problems arise in the Netherlands concerning the availability of medical treatment for immigrant populations. Immigrants are not always able to express themselves in Dutch and sometimes have health concerns arising in part from their often weaker socio-economic position. Hereditary and cultural aspects may also play a role.[42] For example, female immigrants from certain countries may have more difficulty speaking openly about reproductive health problems. At the same time, teenage pregnancies have risen in the Netherlands, in particular among ethnic minorities, resulting in increased needs for services.[43] In this regard, it is regrettable that governmental cutbacks have led to the closure of a number of reproductive health centers where free and anonymous reproductive health services were provided. Similarly, the goal of providing free contraceptives for all has been abandoned, reducing the access of poor populations to contraceptives.[44]

With regard to the accessibility of secondary care facilities, it is important to mention the tendency to centralize hospitals. Many large specialized hospitals have already been built, to the detriment of smaller general and, more importantly, local hospitals.[45] This trend may eventually obstruct people's access to medical care, particularly for those who are less mobile.

The New Dutch Health Care System

In order to ensure that the health care system remains accessible to the entire population, the Dutch government is taking a number of steps, of which the following are the most important.[46]

First, the government is gradually introducing competition between insurance companies. This implies that those insurance companies that had been public entities will gradually become private. This is intended to broaden the range of consumer choice and in the long run reduce costs.[47] In addition, the government has introduced the "Health Insur-

ance Act," a basic insurance scheme governing both the national sickness fund and private insurance.[48]

Under the new system, each person, regardless of income, is supposed to receive the same basic insurance coverage provided by the private insurance company of his or her choice. The insurance companies, having all become private entities, will be allowed to compete with each other and make a profit. Consumers will have access to basic health care coverage that is comparable to the former Social Health Insurance package. Anyone wanting additional insurance can purchase supplementary coverage.[49]

Fifty percent of the basic health insurance will be financed by a fund consisting of governmental and employment-based contributions (contributions by both the employer and the employee).[50] The other half will be financed by the insurance contributions of all insured persons 18 years and older. The insurance companies can determine the level of this contribution but are not allowed to differentiate between health status, age, or other factors related to the insured. Additional government contributions will also be put in place for those who fall below a certain income level.

In order to ensure the accessibility and affordability of health care services, the government has imposed obligations on the insurance companies, including the obligation to accept all applicants, and the aforementioned prohibition against differentiating between consumers on the basis of their health status, age, and other factors.[51] In order to equalize the financial risks that the insurance companies carry, the government makes a contribution to those companies that carry the greatest financial burden. [52]

A "Right to Health Impact Assessment" of the New System

At this stage, it is difficult to assess how effective the new system will be and what effects it will have on the Dutch population. It is possible that, due to the larger role of insurance companies, the system will become more efficient in terms of cost. This, in turn, may enhance the availability and affordability of medical services for patients. However, from a human rights perspective, the choice of

such a system also contains risks, a number of which are pointed out below. The purpose of this exercise is not to denigrate the new health care system, or to suggest that the problems in the health sector should or could be solved through this or another reorganization. Rather, the aim is to determine which checks and balances, from a human rights perspective, governments should build in when they privatize their health systems.

The idea to do a human rights impact assessment for public health policies is not new. As early as 1994, Gostin and Mann suggested undertaking a human rights impact assessment for the formulation and evaluation of public health policies.[53] More recently, some authors have suggested that governments should undertake this sort of assessment before introducing competition and privatization into their health sector.[54]

The focus here is on a right to health impact assessment, even as this has its limitations, since other human rights, including the rights to participation and privacy, can also be important when privatization is introduced.[55] A right to health impact assessment, in this case would apply the concepts from General Comment on the Right to Health (availability, accessibility, etc.), the state obligations to "respect," "protect," and "fulfill," and the so-called core content of the right. In addition, any tensions between the right to health and European competition law would need to be addressed. Each of these is considered below, and areas of concern are highlighted.

The Right to Health and European Competition Law

A first observation using a right to health impact assessment is the tension between guaranteeing a right to health and European competition law. This has several legal implications, one of which is discussed here.[56] Since insurance companies are private entities, they fall under three European non-life insurance directives.[57] The purpose of these directives is to enhance the European insurance market by lifting trade barriers. The most important, among other things, prohibits EU member states from regulating the insurance companies' conditions for accepting clients and determining the level of premiums. However, the directive also provides that member

states may take the above-mentioned measures if it is deemed necessary for the "general good."[58] Whether the measures to regulate health insurance companies are for the "general good" is a matter that has been heavily debated in the Netherlands.[59] A letter from a Dutch European Commission member suggests that the new health care system is not in violation of the above-mentioned directive.[60] Nevertheless, the Dutch measures remain somewhat risky.

Availability, Accessibility, Acceptability, and Quality

Paragraph 12 of the ICESCR General Comment lays out the principles of availability, accessibility, acceptability, and quality.

Availability. Paragraph 12 describes availability as follows:

> Functioning public health and health-care facilities, goods, and services, as well as programmes, have to be available in sufficient quantity within the State party.

It is possible that the Dutch system will become more efficient due to the larger role of the private sector. Privatization may reduce waiting lists and enhance the availability of health care services.

The introduction of government-imposed budget restrictions placed on hospitals is, however, of concern. The system is designed to facilitate the choice of suitable hospitals by insurance companies, but critics believe that it creates artificial maximum treatment capacity, which in turn may affect the general availability of health care services.[61] By comparison, related concerns have arisen in the newly introduced system of payment-by-result in the United Kingdom. Under this system, hospitals are paid a fixed fee for every procedure they perform. There are concerns, however, that this plan risks creating a lack of available emergency treatment, since it also applies to emergency medical services.[62]

Accessibility. Paragraph 12 describes accessibility as follows:

> Health facilities, goods, and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party.

Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, affordability, and information accessibility.

Non-discrimination is defined as follows:

> Health facilities, goods, and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

Under the new Dutch system, insurance companies can ban persons who refuse or are unable to pay their insurance premiums. Several critics have expressed the fear that, as a result, many people will remain uninsured.[63]

Physical accessibility is defined as follows:

> Health facilities, goods, and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities, and persons with HIV/AIDS.

Since Dutch insurance companies are under no obligation to contract health care services in a client's neighborhood, there is concern that the new system may hamper the physical/geographic accessibility of these services. Consequently, the new system may hamper the physical accessibility of health services, especially in worse-off areas where there is already a lack of sufficient services.

Affordability is defined as follows:

> Health facilities, goods, and services must be affordable for all. Payment for health-care services, as well as 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.

It is possible that this system will make health care services cheaper for consumers. Much will depend on the composition of the health care package and, related to that, on any additional insurance consumers will be required to purchase.

Another critical concern is that even as the new system prohibits insurance companies from refusing clients, this does not apply to additional insurance, so that patients with more expensive medical needs may in principle be refused added coverage. This can be particularly detrimental to people with chronic illnesses, who often need supplementary coverage. As a result, the new system may affect the affordability of health care services for persons who need expensive supplementary coverage.

Information accessibility is defined as:

> the right to seek, receive, and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

One of the ostensible purposes of the new system is to broaden the consumer's range of choice. This requires that there are a sufficient number of insurance companies to choose from. It is, however, uncertain whether there will actually be competition, since at present there are only a few insurance companies in the Netherlands. In principle, European competition law allows foreign health insurance companies to have access to the Dutch insurance market. However, given the character of the health market, it is unlikely that this will happen in the near future.[64]

From a right to health perspective, if the system works and there is a sufficiently wide range of choice, the question arises whether everyone is able to make an adequate choice between the various options. With insurance policies often being quite complex, consumers may not be able to make well-informed choices. In effect, there is concern that the new system may hamper the accessibility of information related to medical services.[65] Therefore, on the basis of the information accessibility requirement in the General Comment, the Dutch government should take measures to ensure that insurance policies are written to be transparent and easy to understand.

Acceptability. Paragraph 12 describes acceptability as follows:

> All health facilities, goods, and services must be respectful of medical ethics and culturally appropriate, i.e., respectful of the culture of individuals, minorities,

> peoples, and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

An aspect of the new system is that in most cases the insurance companies will contract medical services for the consumer. As a result, the insured cannot always choose the medical service they prefer. This may hamper a person's freedom to choose a health care provider and affect the acceptability of the health care service.[66] Also, it may hamper the freedom of health care providers to refer patients to those providers that they consider most suitable. This in turn may threaten the medical professionalism of health care providers.[67]

Quality. Paragraph 12 describes quality as follows:

> As well as being culturally acceptable, health facilities, goods, and services must also be scientifically and medically appropriate and of good quality.

There is a risk that in their search for the least expensive option, health insurance companies will not contract health care services that are best for their clients. It should be noted that the quality requirement becomes even more critical in systems where public health services are contracted out to private health care providers. It is unclear how the government will succeed in supervising the quality of these privately provided health care services. A related problem will be safeguarding the quality of medical personnel. In the UK, for example, it is not clear whether profit-making companies running treatment centers will provide training that is up to the same standards as the National Health Service (NHS).[68]

Core Health Services

Paragraphs 43-44 of the General Comment stipulate that there must be the provision of core health services. In terms of the accessibility and affordability of health care services, much will depend on the range of services included in the basic health care package. A possible danger is that

during times of economic recession, the basic health care package will be reduced to the extent that it only covers the most basic needs—such as access to a general practioner and hospital care—while additional insurance will be too expensive for most people to buy.

A critical question in the context of privatization is whether a reduction of the health care package is more likely to occur once insurance is privatized than it would be under the current system. In the new Dutch system, insurance companies have a certain amount of freedom to shape the basic health care package, but there is a danger that this will result in insufficient amounts of the more expensive types of care and exclusion of certain high-risk patients (for example, diabetics and people with other chronic diseases).[69] The implication being that despite the prohibition against refusing patients, insurance companies may nonetheless bar inclusion through the health care packages that they offer.

As mentioned above, the starting point is that the basic health care package largely corresponds to the current sickness fund package, including, among other things, provision of a general practitioner, hospital care, medicines, and medical appliances. However, a number of medical services have recently been taken out of this package, including dental care for people over 18, physiotherapy, the contraceptive pill for women over 21, the first in vitro fertilization treatment, and travel in an ambulance in situations where a patient is able to sit.

The definition of clearly defined core health services could be an important starting point for the Netherlands or any other state to determine what is included in a basic health care package. General Comment 14 defines a number of core obligations of the right to health, minimum obligations which should apply under all circumstances.[70] A connection is made, *inter alia*, with the Primary Health Care Strategy of the World Health Organization (WHO).[71] However, these core obligations are far too general for a government to rely on when making decisions about the content of its basic health package.[72] Even as the Committee on Economic, Social and Cultural Rights may be able to define country-specific core obligations or benchmarks, the collection of information for this purpose, and

the supervision of such a system would require enormous financial resources.[73]

In addition to the ICESCR framework, the conventions of the International Labour Organisation (ILO) may also be useful in defining the basic health care package. The ILO treaties oblige governments to guarantee access to specified medical services. Some conventions apply to a particular population, such as employed women.[74] Of particular importance for the Dutch situation are ILO Conventions 102 (Social Security Convention), 103 (Maternity Protection Convention), and 121 (Employment Injury Benefits Convention), to which the Netherlands is a party.[75] The ILO conventions are taken fairly seriously by the Dutch government, and they have been successfully invoked before the Dutch courts. By implication, the basic health insurance package should at minimum include the services mentioned in these conventions. For example, on the basis of Conventions 102 and 103, reproductive health care should at least cover pre-natal care, confinement, post-natal care, and hospitalization where necessary.[76] These conventions prohibit governments from requiring payment for reproductive health services. This was upheld in a Dutch court decision, which, based on these conventions, recognized a right to a delivery in a hospital.[77]

Nonetheless, the Dutch government is struggling with its responsibilities under these treaties. Recently, for example, the Dutch government denounced an ILO treaty to circumvent its implications.[78]

The Obligation to Protect

The insurance companies gained freedom and power in the new system. It is therefore of the utmost importance that there is an adequate system to supervise their functioning and behavior.

Paragraph 35 of the General Comment makes a distinction between obligations to respect, to protect, and to fulfill the right to health. The obligation to respect requires states to refrain from interfering directly or indirectly with the right to health. The obligation to protect requires states to take measures that prevent third parties from interfering with Article 12 guarantees. Finally, the obligation to fulfill requires states to "adopt appropriate legislative, administra-

tive, budgetary, judicial, promotional, and other measures towards the full realization of the right to health."[79]

When a state privatizes a particular service, there is a shift from fulfilling a right to the state's obligation to offer protection against possible abuses by the private actor who becomes the provider of the service. This shift requires a different approach on the part of the state. As de Feyter and Gómez Isa point out, governments can only offer adequate protection if they develop tools to supervise the human rights impact of privately delivered social services and provide legal assistance and recourse when human rights are abused.[80] Along similar lines, the Committee on the Rights of the Child recommends that "States parties take appropriate legislative measures and establish a permanent monitoring mechanism aimed at ensuring that non-state service providers respect the relevant principles and provisions of the Convention on the Rights of the Child."[81]

The Dutch health care system provides for a complex supervisory arrangement—exercised by a number of different authorities—over finance, competition, compliance with the draft Health Insurance Act, and the quality of the provided care. At this time, it is difficult to foresee the extent to which this regulatory system will take into account the perspective of clients and ensure that health care services provided by third parties are accessible and of good quality.

Another important aspect of the obligation to protect concerns the government's obligation to create possibilities for individuals to complain about failure or malpractice by the actors in the health care sector. Given the private character of the new basic health insurance, Dutch clients can lodge a complaint against an insurance company with a court competent to deal with disputes under private law. Another option is to lodge a complaint with an independent conciliation board, which can hear the case but takes nonbinding decisions.[82] Again, at this time, it is difficult to predict to what extent the interests of the insured will be adequately protected by these mechanisms.

General Conclusions

The Netherlands case illustrates tensions between privatization of health care services and the obligation of a gov-

ernment to guarantee a right to health. A "right to health impact assessment" implies attention to a range of issues.

For the Netherlands, an important aspect of a right to health impact assessment is assessing the tension between European competition law and the governmental measures imposed on the insurance companies designed to guarantee the accessibility of health care services.

Furthermore, a right to health impact assessment implies surveying the extent to which the principles of availability, accessibility, quality, and acceptability of health care services can be guaranteed. In the Netherlands, even as these principles are firmly embedded in law, it appears particularly important to take into account the accessibility of information for clients who must now choose between various private insurance companies. Also, the principles of financial accessibility and non-discrimination may be under threat because there is a risk that the new system will create more uninsured persons. In addition, since insurance companies are enabled to contract the health care providers of their choice, a client's freedom to choose a health care provider, and the physical accessibility of health care services, are of concern.

Furthermore, a right to health impact assessment assumes an acceptable core of health care services that remain affordable to all. If a country is a party to the ILO Conventions, the implications of these conventions must also be taken into account. If the basic health care package becomes too narrow, and supplementary coverage is too expensive for people to buy, the economic accessibility or affordability of health care services may come under threat.

Once the decision to privatize has been made, a crucial question becomes how a government succeeds in regulating and governing these now powerful actors in the health sector. A system needs to be set up that ensures that the government meets its obligation to "protect" individuals in relation to the actors to which the service provision has been delegated. This implies the adoption of legislation protecting individuals against possible malpractice by actors in the health sector (such as the Dutch legislation which prohibits insurance companies to refuse patients).[83] Furthermore, it implies setting up supervisory mechanisms and providing access to legal recourse and remedies.

For the international human rights community, it is important to formulate an adequate response to the current trend in privatization of national health systems. The existing human rights framework does not yet contain much in this area. Privatization of health services is not prohibited, but a delegation of state obligations in relation to human rights relating to health is also not acceptable. It is therefore of crucial importance to define state responsibilities and establish how governments are to oversee the engagement of these actors in the health sector.

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2. Committee on Economic, Social and Cultural Rights, General Comment No. 14 on The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000). Available at http://www.unhchr.ch.

3. Ibid.: paras. 8 and 11.

4. On the privatization of water services, see D. M. Chirwa, "Privatisation of Water in Southern Africa: A Human Rights Perspective," *African Human Rights Law Journal* 4/2 (2004): pp. 218–41. See also S. Flynn and D. M. Chirwa, "The Constitutional Implications of Commercialising Water in South Africa," in D. A. McDonald and G. Ruiters (eds), *The Age of Commodity: Water Privatisation in Southern Africa* (London: Earthscan, 2005): pp. 59–76. More generally, see K. de Feyter and F. Gómez Isa (eds), *Privatisation and Human Rights* (Antwerp/Oxford: Intersentia, 2005); L. Lamarche, "Social Protection is a Matter of Human Rights: Exploring the ICESCR Right to Social Security in the Context of Globalisation," in *Privatisation and Human Rights* (see above in this note): pp. 129–75; and A. Kok, "Privatisation and the Right to Access to Water," in *Privatisation and Human Rights*: pp. 259–89.

5. Non-discrimination: health services must be accessible to all, especially to the most vulnerable and marginalized groups in society; physical accessibility requires that health services must be within safe physical reach for all sections of the population; economic accessibility requires that health services be affordable to all. General Comment 14 (see note 2): para. 12.
6. See note 2: paras. 11 and 12.
7. See note 2.
8. Constitution of the Netherlands, Article 93. Available at http://en.wikipedia.org/wiki/Constitution_of_the_Netherlands#Provisions. As to the modalities of implementation of international law, see A. Cassese, *International Law,* 2nd Edition (Oxford: Oxford University Press, 2004): pp. 220–1.
9. Constitution of the Netherlands (see note 8); Article 22, para. 1. See also B. C. A. Toebes, *The Right to Health As a Human Right in International Law* (Antwerp/Oxford: Intersentia/HART, 1999): p. 103.
10. Constitution of the Netherlands (see note 8), Article 120; Toebes (see note 9): p. 201.
11. Toebes (see note 9): p. 198.
12. See, for example, explanatory document to the Health Insurance Act (see note 38): pp. 2, 7, and 8.
13. de Feyter and Gómez Isa (see note 4): p. 1.
14. M. Mackintosh and M. Koivusalo, "Health Systems and Commercialization: In Search of Good Sense," in M. Mackintosh and M. Koivusalo, *Commercialisation of Health Care: Global and Local Dynamics and Policy Responses* (Hampshire, UK: Palgrave, 2005): p. 4.
15. C. Graham, "Human Rights and the Privatisation of Public Utilities and Essential Services," in de Feyter and Gómez Isa, *Privatisation and Human Rights* (see note 4): p. 35. "Contracting out" is a practice that is currently being introduced in the UK. For a critical assessment of this development, see "Plans to Hand Over NHS Staff and Buildings to Private Sector," *The Guardian* (September 22, 2005). Available at http://www.guardian.co.uk.
16. de Feyter and Gómez Isa (see note 4): pp. 1–7; and Graham (see note 15): pp. 33–56.
17. Ibid.
18. Albert Weale, "Ethical Issues in Social Insurance for Health," in T. Sorell, *Health Care: Ethics and Insurance* (London/New York: Routledge, 1998): p. 138.
19. *Chaoulli v. Quebec* (2005) 1 S.C.R. 791, paras. 124 and 158. Available at http://www.lexum.unmontreal.ca.
20. C. Kraus, "In Blow to Canada's Health System, Quebec Law Is Voided," *New York Times* (June 10, 2005).
21. For a critical account of the privatization of the British NHS, see A. M. Pollock, *NHS plc, The Privatisation of Our Health* Care (London/New York: Verso, 2004). Other examples: Australia and New Zealand have differing degrees of decentralization and privatization of provision. In Sweden, there is a move toward the privatization of public providers. See European Observatory on Health Care Systems, *Health Care Systems in Eight Countries: Trends and Challenges (*London: London School of Economics and Political Science, April 2002): pp. 12 and 107.

22. Mackintosh and Koivusalo (see note 14): p. 8.
23. Ibid.: p. 14. See also N. Johnson, "Introduction," in *Private Markets in Health and Welfare* (Oxford: Berg Publishers Limited, 1995): p. 11. Johnson suggests that markets in health and welfare may create greater inequality.
24. Mackintosh and Koivusalo (see note 14): p. 15.
25. Ibid.: p. 5. See also N. Daniels et al., *Benchmarks of Fairness for Health Care Reform* (New York/Oxford: Oxford University Press, 1996). For example, see Chapter 3, where a number of "benchmarks of fairness" are suggested for the introduction of health care reform, including universal access, equitable financing, value for money, and accountability.
26. General Comment 14 (see note 2): paras. 12 and 35.
27. General Comment 14 (see note 2): para. 24.
28. Committee on the Elimination of all Forms of Discrimination Against Women, General Recommendation No. 24, Women and Health (Article 12), 20th Sess. (1999). Available at http:// www.unhchr.ch.
29. M. Nowak, *Introduction to the Human Rights Regime* (Leiden/Boston: Brill Academic Publishers, 2003): pp. 51–3.
30. For example, there is a basis for this responsibility in the Universal Declaration of Human Rights, which in Article 29 recognizes that the Declaration is a common standard for "every organ in society." However, it is not clear whether this provision is part of customary international law. See, for example, W. J. M. van Genugten, "The Status of Transnational Corporations in International Public Law," in *Human Rights and the Oil Industry* (Antwerpen/Groningen/Oxford: Intersentia, 2000): p. 78.
31. See the website of the Dutch Ministry of Health, Welfare, and Sport at http://www.minvws.nl/en/themes/health-insurance-system/default.asp. The *Ziekenfonds* is an insurance system that is not-for-profit, mutual, income-level-related, and compulsory in character. It is financed by a general fund that generates half its revenues from employees and the other half from employers, retirement funds, and unemployment funds, thereby assisting with health insurance for retirees and the unemployed. All sickness fund applicants must be accepted. For more information about the Dutch health system, see the World Health Organization website at http://www.who.org, and the Dutch Ministry of Health, Welfare, and Sport at http://www.minvws.nl.
32. See, for example, the explanatory report to the draft Health Insurance Act (see note 38): p. 2.
33. An additional factor that is thought to cause long waiting lists is the government-imposed budget limitations on hospitals, which create artificial maximum treatment capacities.
34. RIVM (Dutch Institute for Health and Environment). Available at http:// www.rivm.nl/vtv/object_map/o661n21999.html.
35. RIVM. Available at http://www.rivm.nl/vtv/object_map/ o1054n22026. html.
36. RIVM. Available at www.rivm.nl/vtv/object_class/atl_wchtziekenhuiszorg. html.
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www.wachtlijsthulp.nl/nieuws/nieuws27.htm.
38. Netherlands Government, explanatory document to the Draft Health Insurance Act, Tweede Kamer, 2003–2004, 29763, No. 3. Available at http://www.overheid.nl. The Health Insurance Act has been accepted by the Dutch Parliament (Second Chamber) as well as by the Dutch Senate (First Chamber) and became law on January 1, 2006.
39. European Court of Justices cases *Kohll: C-158/96, Decker: C-120/95, Müller-Fauré and Van Riet: C-385/99*. Available at http://curia.europa.eu/en/content/juris/index.htm.
40. Ibid.
41. "Maak het vak van huisarts snel aantrekkelijker" [Make Being a GP More Attractive], *NRC Handelsblad* (Dutch newspaper) (January 29, 2004). Available at http://www.nrc.nl.
42. RIVM, "*Preventie Gericht op Allochtonen*" [Prevention Focused on Immigrants] (undated). Available at www.rivm.nl. For example, this study shows that the prevalence of diabetes is higher among Turks, Moroccans, and the Suriname population than among the indigenous population.
43. For women aged 15–19 in Holland, the number of teenage pregnancies has increased from 10 per 1,000 in 1992 to 16.2 in 2001 and 2002. Women from Suriname, Turkey, Morocco, and especially the Dutch Caribbean, including those born in Holland, have far more abortions than "ethnic" Dutch women—some 60% of the total. BBC News, "Dutch Abandon Free Contraceptives for All" (January 15, 2004). Available at http://news.bbc.co.uk/2/hi/health/3398769.stm.
44. Ibid.
45. "Kamer eist actie tegen fusiegolf in de zorg" [Parliament Demands Action Against Increased Merging of Hospitals], *NRC Handelsblad* (Dutch newspaper) (October 3, 2002). Available at http://www.nrc.nl.
46. See also the website of the Dutch Ministry of Health, Welfare, and Sport. Available at http://www.minvws.nl/en/themes/health-insurance-system/default.asp.
47. Partly, this is implemented by the Wet herziening overeenkomstenstelsel zorg [Act Revising the Contractual System in the Dutch Health Care System], Kamerstukken II 2002/2003, 28 994. Available at http://www.st-ab.nl/1-05027ks03.htm. For some general information, see the website of the Dutch Ministry of Health, Welfare, and Sport (see note 46).
48. Health Insurance Act (`Zorgverzekeringswet'), Tweede Kamer, 2004/2005, 30 124, A. The Health Insurance Act has been accepted by the Dutch Parliament (Second Chamber) as well as by the Dutch Senate (First Chamber) and became law on January 1, 2006. Available at the general government website at http://www.overheid.nl, and at the website of the Ministry of Health, Welfare, and Sport at http://www.minvws.nl/dossiers/zorgverzekering/wetsteksten/. The explanatory document to this Act can be accessed through the website of the Dutch Ministry of Health, Welfare, and Sport at http://www.minvws.nl/images/zorgverzekeringswet%20toelichting%20plus%artikelsgewijze%toelichting.
49. Health Insurance Act (see note 48): Article 10.
50. About financing health care systems, the following can be noted. In the developed world, there are three main models of health-care finance. In

many countries, like the Netherlands, funding comes mainly from compulsory social-insurance contributions paid by workers and their employers (the Bismarkian system). In several countries, general taxation is the principal source of revenue, as in Britain, Canada, and Sweden (the Beveridgean system). Finally, the US is unusual in that private funding accounts for a much bigger share of health-care spending because most workers and their families are insured privately through their employers. "Searching for a Miracle Solution," *The Economist* (August 20, 2005): p. 21.

51. See Article 3 of the Health Insurance Act (see note 48), regarding the so-called *acceptatieplicht*—the duty to accept every applicant.

52. Health Insurance Act (see note 48): Article 32.

53. L. Gostin and J. Mann, "Towards the Development of Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies," *Health and Human Rights* 1/1 (1994): pp. 59–80. For Health Impact Assessment more generally, see the WHO guidelines available at http://www.who.int/hia/en/.

54. According to Hunt, privatization "should be preceded by an independent, objective and publicly available assessment of the impact on the respective right." P. Hunt, "The International Human Rights Treaty Obligations of State Parties in the Context of Service Provision," in *Day of General Discussion: The Private Sector as Service Provider and Its Role in Implementing Child Rights,* UN Doc. No. CRC/C/121, 31st Session (September 20, 2002): pp. 4–5. See also F. Gómez Isa, "Globalisation, Privatisation and Human Rights," in de Feyter and Gómez Isa (see note 4): p. 18.

55. See note 38. A great number of public bodies were consulted regarding the right to participation before the introduction of the new Dutch Health Insurance Act. Explanatory document to the Health Insurance Act, pp. 17–9.

56. Another issue at stake was whether contributions by the government to equalize the risk constitute unjustified "state aid" under European law. Recently, the European Commission declared that these measures are justified.

57. First Council Directive 73/239/EEC (July 24, 1973) on the coordination of laws, regulations, and administrative provisions relating to the taking up and pursuit of the business of direct insurance other than life assurance, *Official Journal,* L 228 (August 16, 1973): pp. 3–19**;** Second Council Directive 88/357/EEC (June 22, 1988) on the coordination of laws, regulations, and administrative provisions relating to direct insurance other than life assurance and laying down provisions to facilitate the effective exercise of freedom to provide services and amending Directive 73/239/EEC, *Official Journal,* L 172 (April 7, 1988): pp. 1–14; Council Directive 92/49/EEC (June 18, 1992) on the coordination of laws, regulations, and administrative provisions relating to direct insurance other than life assurance and amending Directives 73/239/EEC and 88/357/EEC (third non-life insurance Directive), *Official Journal,* L 228, (November 8, 1992): pp. 0001–23. Available at http://www.europa.eu.int/eur-lex.

58. Third non-life insurance directive (see note 57): Article 54, para. 1.

59. For example, Interdepartementale Commissie Europees Recht, *Advies*

Inzake Europeesrechtelijke Aspecten van een Stelsel van Ziektekostenverzekeringen [Advice Concerning European Legal Aspects of a Health Insurance System] (April 3, 2001) and de Landsadvocaat, *Een Nieuw Stelsel van Zorgverzekering* [A New Health Insurance System] (December 4, 2002).

60. Letter from European Commission Member Frits Bolkestein, November 25, 2003, CAB/PvB/D(03)0848 (not available online; a reference can be found in the explanatory document to the Dutch Health Insurance Act, see note 38).

61. "DBCs" (diagnosebehandelcombinaties) [Combinations of Diagnosis and Treatment]. On this issue, see H. F. Aarts, "Ambtenaar bedenkt DFC" [Civil Servant Invents DBC], in *NRC Handelsblad* (Dutch newspaper) (September 26, 2005). Available at http://www.nrc.nl.

62. "A and E Services at Risk from NHS Changes," *The Guardian* (October 11, 2005). Available at http://www.guardian.co.uk.

63. "Oppositie Blijft Bezorgd over Onverzekerden [Opposition Remains Concerned about the Situation of the Uninsured], *NRC Handelsblad* (Dutch newspaper) (December 14, 2005). Available at http://www.nrc.nl.

64. See also note 47. The Netherlands Council of State advice to the draft Health Insurance Act, Tweede Kamer, 2003–2004, 29763, No. 4: p. 14. Available at http://www.overheid.nl.

65. The Netherlands Council of State (see note 64): p. 13. On information accessibility see General Comment 14 (see note 2): para. 12.

66. Ibid. Also, see Article 4, para. 3 of Convention 102 of the International Labour Organisation (ILO) to which the Netherlands is a party. Available at http://www.ilo.org. This convention, which is applicable to female employees and/or a part of the female population, stipulates that women should have the freedom to choose a reproductive health care provider of their choice.

67. The Netherlands Council of State (see note 64): p.15. General Comment 14 (see note 2): para. 12, on acceptability.

68. "As doctors, we see the cancer that eats away the NHS," *The Guardian* (June 27, 2005). Available at http://www.guardian.co.uk.

69. Report of a meeting of the NJCM, the Dutch branch of the International Commission of Jurists, on the Health Insurance Act, in *NJCM-Bulletin*, 30/3 (2005): p. 371.

70. General Comment 14 (see note 2): paras. 43–44.

71. WHO, *Primary Health Care, Report of the International Conference on Primary Health Care* (Alma-Ata, USSR: September 6–12, 1978); *Health for All Series No. 1* (Geneva/New York: WHO, 1987): Chapter 3, para. 50.

72. For example, one of the core obligations is "access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalized groups." General Comment 14 (see note 2): para. 43(a).

73. See, *inter alia*, P. Hunt, Interim Report of the Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health, UN Doc. A/58/427 (2003), Agenda Item 117(c). Available at http://www.unhchr.ch. A related approach concerns the reasonableness approach, which has been applied in contexts of prioritizing and rationing by South African and UK courts, among others. For an as-

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75. ILO Convention 102, Social Security (Minimum Standards) Convention (1952); ILO Convention 103, Maternity Protection Convention (revised) (applicable to employed women) (1952); and ILO Convention 121, Employment Injury Benefits Convention (applicable to the employed) (1964). Available at http://www.ilo.org. Also important and related to these conventions is a convention of the Council of Europe, the European Code of Social Security, and the Protocol to the European Code of Social Security (1964).
76. ILO Convention 102, Article 49; ILO Convention 103, Article 4. Available at http://www.ilo.org.
77. ILO Convention 102, Articles 10(1)(b) and 49(2); Central Appeals Court of the Netherlands, May 29, 1996: *NJB* [Nederlands Juristenblad], 3 (November 29, 1996): pp. 1826–27; *AB [Administratiefrechtelijke Beslissingen]*, No. 501, (1996): note P. Hazewindus; *RSV [Rechtspraak Sociale Verzekeringen]* 9 (1997): note F. Vlemminx. *Nemesis*, 631, (1996): note M. Driessen.
78. ILO Convention 118, Equality of Treatment (Social Security) Convention, 1962, denounced December 25, 2005; (The Hague: *Staatsblad van het Koninkrijk der Nederlanden*, 2004): p. 715. Available at http://www.overheid.nl. This treaty, which grants a right to receive social benefits abroad, was denounced in order to allow the introduction of a new law limiting the export of social benefits.
79. General Comment 14 (see note 2): para 33.
80. de Feyter and Gómez Isa (see note 4): p. 3.
81. Committee on the Rights of the Child, Day of General Discussion, The Private Sector as Service Provider and Its Role in Implementing Child Rights, UN Doc. CRC/C/121, 31st Session (September 20, 2002), Recommendation No. 8. See also note 39.
82. Explanatory report to the draft Health Insurance Act, Tweede Kamer (see note 38): p. 45.
83. The so-called *acceptatieplicht*, Health Insurance Act (see note 48): Article 3.