

Medical Interpreting and the Law in the European Union

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Abstract

In 2011, the Danish government announced that from June that year it would no longer cover the costs of medical interpreters for patients who had been living in Denmark for more than seven years. The Dutch Ministry of Health followed with an even more draconian approach; from 1 January 2012 the cost of translation and interpreting would no longer be covered by the state. These two announcements led to widespread concern about whether or not there is a legal foundation for interpreter provision in healthcare. This article considers United Nations treaties, conventions from the Council of Europe and European Union law. European Union member states have been slow to sign up to international agreements to protect the rights of migrant workers. The European Union itself has only recently moved into the area of discrimination and it is unclear if the Race Directive covers language. As a result, access to interpreters in healthcare, where it exists, is dependent on national anti-discrimination legislation or on positive action taken at national or local level rather than on European or international law.

Keywords

Council of Europe; European Union; healthcare; Interpreting; United Nations

1. Introduction

One of the most striking aspects of the continent of Europe is the number of languages spoken. The European Union has 27 member states, 23 official languages and a number of minority languages. In addition, immigrants from all over the world speak many languages. According to Eurostat,¹ in 2008 the total population of the EU was 497.4 million, of which 6.2% or 30.8 million were foreigners. Of these, two thirds or 19.5 million were citizens from outside the EU and the remaining one third or 11.3 million people were from other EU states. There were also an estimated eight million illegal immigrants in the EU. In addition, some 700,000 immigrants from outside the EU had acquired EU citizenship. This means that some 40 million people in the EU are either from outside the Union or from another EU country. The largest numbers of foreign citizens – 75% of the total - live in Germany, Spain, the UK, France and Italy. Of course many of these people are proficient in the language of the country in which they live and the figures include Austrians living in Germany, Irish people living in the UK, UK citizens living in Ireland – all cases where there is a common language.

People who are not proficient in the language of the country where they live may have difficulty accessing health services. They may need access to translated information and to

¹ Eurostat. 2010. *Europe in Figures, Eurostat Yearbook 2010*. Retrieved 15 September 2011.
http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/CH_02_2010/EN/CH_02_2010-EN.PDF

interpreters when they see a general practitioner or attend hospital. The very large number of languages involved can make provision of translation and interpreting complicated and costly. At present, there is considerable variation in interpreter provision in healthcare across Europe.

In 2011, two surprising developments took place. First, the Danish Government announced that from 1 June 2011, any patient who had been living in the country for more than seven years and who could not communicate in Danish would have to pay a one off fee of 150 Danish Kroner (€20) for interpreting services when consulting a general practitioner or attending hospital. At the time, Denmark had a minority coalition government made up of two centre-right parties, Venstre and Conservative, which depended on the support of the far right Danish People's Party (DPP) party and 'Egged on by Ms Kjaersgaard, [DPP leader] the government has tightened immigration rules every eight months, on average, since 2001.'² Elections were held in September 2011 and in October a new minority coalition government was formed headed by the Social Democrats. The new government reversed the decision to charge for interpreters on the grounds that it would be too expensive to administer such a system. The President of the Danish Language Society, Jørgen Christian Wind Nielsen, commented that 'Some professionals in the health sector are sorry that this argument, and not integrational/healthcare arguments, has been used'.³

Second, in May 2011, the Dutch Ministry of Health announced that it had decided to abolish all subsidies for translation and interpreting from 1 January 2012 in order to save €19 million⁴. The Dutch decision was particularly surprising because the Netherlands had been the forerunner in Europe when it came to interpreter provision at the turn of the twenty-first century. As in Denmark, the change in approach seems to have come about for political reasons; the Dutch government is a minority one, made up of Christian Democrats (CDA) and Liberals (VVD) with the support of Geert Wilders's anti-immigrant Party of Freedom (PVV). The 2010 Coalition Agreement provides more detail:

The most important criterion is that participation in our society requires sufficient educational and language qualifications. An adequate level of civic integration among asylum seekers and migrants who have been admitted to the country is key to full participation in society for themselves and their children in terms of work and education. We are entitled to expect this of newcomers.⁵

It takes a long time to become proficient in a new language and most immigrants will not have any knowledge of Danish or Dutch before moving to Denmark or the Netherlands. These changes in policy led to concern among health professionals across Europe that changes in government and pressure from anti-immigration parties could lead to cuts in interpreting and translation services. They were concerned that measures taken to ensure non-discrimination and equality of access to services could be undone. Such changes would make it difficult to treat patients, to obtain medical histories, check symptoms and also to ensure that patients understand their diagnosis, treatment and prognosis. Health professionals in countries where interpreters are routinely provided wonder if it is legal to cut these services and question whether a change in government or dependency on an anti-immigration party or

² "Danish Politics: Far Right, Wrong Step", 2010, *The Economist*, 17 June.

³ Email communication

⁴ Migrant Health Network Retrieved 1 June 2011. <http://tinyurl.com/4ywazzr>.

⁵ Dutch Government coalition agreement. 2010. Retrieved 2 January 2012.

http://www.government.nl/Government/Coalition_agreement#internelink6

even an economic recession can and should lead to a reduced service or an abolition of services. Meanwhile, in countries where interpreters are not routinely provided, health professionals wonder if non-provision can be challenged.

This article will consider the legal background to access to interpreting services in healthcare. It will consider law from the United Nations, the Council of Europe and the European Union in order to establish if there is a right to an interpreter. First, however, we will discuss research on interpreter provision.

2. The Need For Interpreters In Healthcare

In a large interview-based study across 16 European countries (2011) with a total sample of 240 health professionals, language was the most commonly reported problem:

Concerns were expressed for migrants' inability to communicate their problems due to language difficulties, with the risk of being misunderstood and, ultimately, misdiagnosed. Respondents described how extensive physical examinations and diagnostic tests were sometimes required to compensate for the inability to communicate verbally. Administrative procedures were also prolonged and complicated through poor communication.⁶

The authors conclude that 'The provision of sufficient resources, e.g. for more practitioner time and good interpreting services, is a challenge for commissioners and funding agencies, and is likely to be influenced by political priorities.' These conclusions are of course corroborated by the recent developments in Denmark and Netherlands outlined above.

International research demonstrates that financial savings are associated with the provision of medical interpreters to patients who are not fluent in the language of the country in which they live. A two-year study in Washington found that the availability of professional interpreters led to greater use of primary care and fewer emergency department visits.⁷ The results were replicated in a Swiss study focusing on asylum seekers where the provision of interpreters resulted in 'more targeted healthcare, concentrating higher healthcare utilisation into a smaller number of visits. Although the initial costs are higher, it can be posited that the use of interpreter services prevents the escalation of long-term costs.'⁸ In Chicago, the provision of an enhanced interpreter service led to patients spending 5 days in hospital compared to 5.97 days for patients using 'the usual understaffed service or *ad hoc* interpreters';⁹ a shorter hospital stay obviously means lower costs for the hospital. In contrast, patients in a paediatric emergency department in Chicago who needed an interpreter but were not allocated one 'had a higher incidence and cost (+\$5.78) for testing and were most likely

⁶ S. Priebe, S. Sandhu, S. Dias, A. Gaddini, T. Greacen., E. Ioannidis, U. Kluge, A. Krasnik, M. Lamkaddem, V. Lorant, R. Puigpinós Riera, A. Sarvary, J.J.F. Soares, M. Stankunas, C. Straßmayr, K. Wahlbeck, M. Welbel, M. Bogic "Good practice in healthcare for migrants: views and experiences of care professionals in 16 European countries", *BMC Public Health* 11 (187) (2011) 1-12.

⁷ E. Graham, T. Jacobs, T.S. Kwan-Gett, J. Cover "Health services utilization by low-income limited English proficiency adults", *Journal of Immigrant and Minority Health* 10 (3) (2008) 207-217.

⁸ A. Bischoff, K. Denhaerynck, "What do language barriers cost? An exploratory study among asylum seekers in Switzerland", *BMC Health Services Research* 10 (248) (2010) 1-7.

⁹ E.A. Jacobs, L.S. Sadowski, P.R. Rathouz, "The Impact of an Enhanced Interpreter Service Intervention on Hospital Costs and Patient Satisfaction", *Journal of General Internal Medicine* 22 (Suppl 2) (2007) 306-311.

to be admitted and to receive intravenous hydration but showed no difference in length of visit.¹⁰

The Centre for Maternal and Child Enquiries in the UK in their 2011 report¹¹ made ten recommendations, the second of which was that ‘professional interpretation services should be provided for all pregnant women who do not speak English.’ They advised against allowing relations or members of the community to act as interpreters as this could ‘inhibit the free two-way passage of crucial but sensitive information.’

When interpreters are not provided by the authorities, patients may delay making appointments, may try and communicate in a language in which neither they nor the health providers are fluent or they may have to resort to asking spouses, partners, relations, children and members of their community to act as interpreter for them. This affects their right to confidentiality because they have no choice but to tell others about their health problems. Parents may be reluctant to discuss certain problems in the presence of their children. It is also difficult to ensure that patients can give informed consent if they do not fully understand the information they are being given and if they cannot ask questions freely. From the point of view of healthcare staff it is difficult to obtain a medical history, to give instructions and to explain matters without the help of a professional interpreter.

3. United Nations

The Universal Declaration of Human Rights 1948 mentions health, well-being and medical care but is merely a declaration and has no force in law. The Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities 1992 is restricted to groups that have traditionally been a minority in a country and does not apply to recent or even second and third generation immigrants. The International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR), covers healthcare, mentions language in Article 2.2 and includes language as grounds for discrimination. Similarly, the UN Convention on the Rights of the Child 1989 includes a specific mention of language and Article 24 covers a right to health. The International Convention on Elimination of all forms of Racial Discrimination 1966 (ICERD) mentions the right to medical care but makes no mention of language. At the time of writing, no EU member state had signed the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families.¹²

The right to healthcare is clear in United Nations conventions and covenants, some of which mention language, but there is no specific mention of interpreter provision. However, even

¹⁰ L.C. Hampers, J.E. McNulty, “Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization”, *Archives of Pediatrics and Adolescent Medicine* 156 (11) (2002) 1108-1113.

¹¹ *Saving Mothers’ Lives Special Issue: Reviewing maternal deaths to make motherhood safer: 2006–2008. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom BJOG An International Journal of Obstetrics and Gynaecology* Suppl. 1. (2011) 1-203.

¹² For an analysis of possible reasons why the EU member states have not ratified the Convention, see E. Mac Donald, and R. Cholewinski “The Migrant Workers Convention in Europe 2007”. Retrieved 2 January 2012 <http://unesdoc.unesco.org/images/0015/001525/152537e.pdf>

when interpreters are not mentioned, it could be argued that to ensure equality of treatment, interpreters should be provided.

4. Council of Europe and the European Convention on Human Rights

The Council of Europe was founded in 1949 and predates the European Union. It is a much larger organization with 47 member countries including for example the Russian Federation, Turkey, Georgia and the Ukraine. Its best known convention is the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (ECHR). Article 14 focuses on the prohibition of discrimination:

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

As the Convention does not include healthcare among the rights and freedoms, it is not of direct relevance to the provision of medical interpreters and no cases have been taken on the grounds of non-provision. However, some cases related to health have been taken to the European Court of Human Rights under Article 2 the right to life, Article 3 the prohibition of torture and Article 8 the right to private life. A number of cases have been taken by prisoners who argue for early release on the grounds of ill health; asylum seekers who claim they will not be able to receive appropriate healthcare if deported; parents of prisoners who committed suicide or were killed in jail; people involuntarily committed to mental institutions, and cases alleging negligent medical treatment.

While language was a significant factor in two cases, non-provision of interpreters could not be used as a legal argument. In *Vo v. France*¹³ (2004), two Vietnamese women with the same surname were attending hospital on the same day; one was five months pregnant and the other was there to have a contraceptive coil fitted. Mrs Vo was pregnant, spoke very little French, there was no interpreter; the doctor assumed she was there for contraception, inserted the coil and damaged the amniotic sac. Mrs Vo later had a therapeutic abortion. She took a case under Article 2 the right to life but the Court ruled that no rights were breached. *R.K. and A.K. v. U.K.*¹⁴ (2008), concerned a baby who had a fractured femur and was removed from his parents' care for seven months due to suspected abuse. Subsequently doctors diagnosed brittle bone disease. A.K. did not speak English and no Pushtu interpreter was provided. The Court found a violation of Article 13, the guarantee of an effective remedy before a national authority.

There are a number of protocols to the Convention, the most relevant of which is Protocol 12 (2005) which prohibits discrimination in the enjoyment of all of the rights contained in the law of the ratifying State:

The enjoyment of any right set forth by law shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

¹³ *Vo v. France* (no. 53924/00) 8.7.2004

¹⁴ *R.K. and A.K. v. United Kingdom*. (no. 38000/05) 30.09.08

No one shall be discriminated against by any public authority on any ground such as those mentioned in paragraph 1.

Article 1 is intended as an additional article to the European Convention. Protocol 12 came into force in 2005 and although potentially very useful in arguing the case for interpreter provision, in September 2011 only 8 EU member states had ratified it.¹⁵ It is noteworthy that the Netherlands is one of the eight and as a result Protocol 12 could be used by campaigners for the continuation of interpreter provision there.

One of the advantages of the European Convention on Human Rights is that individuals can take cases to the European Court of Human Rights in Strasbourg on condition that they have first exhausted all domestic remedies. Cases can also be taken by groups, companies and NGOs or by one state party against another. Many are taken by individuals. Judgments of the Court are binding on the states concerned and are monitored by the Committee of Ministers of the Council of Europe. Applicants can be awarded compensation but the sums involved are usually quite low. Arnardóttir argues that ‘the development of the law is highly dependent on the European Court of Human Rights’ (the Court’s) interpretation of the Convention in light of present day social conditions and on the translation of theoretical insights into the interpretation and modes of analysis applied by the Court.’¹⁶ All EU member states have ratified the Convention and the entry into force of the Lisbon Treaty in 2009 allows the EU to accede to it as well (Article 6.2, consolidated version of the Treaty on European Union). As a result the EU legal system can be submitted to independent external control by the Council of Europe. The EU and the Council of Europe are working closer together than ever: the two bodies signed a memorandum of understanding in 2007¹⁷ and agreed on an overview of arrangements for co-operation in 2009.¹⁸ They work together on joint programmes and there are regular meetings of senior officials.

The importance of human rights in the Council of Europe is further underlined by the establishment of the Commissioner for Human Rights in 1999, an independent institution within the Council whose mission is to promote awareness of human rights throughout the countries that are members. The Commissioner visits individual states, draws up reports and makes recommendations but cannot act on individual complaints.

4.1. *Other Council of Europe Charters and Conventions*

The Council of Europe European Charter for Regional or Minority Languages 1992 covers languages that are ‘traditionally used within a given territory of a State by nationals of that State who form a group numerically smaller than the rest of the State’s population’. Regional or minority languages that come under the charter are different from the official language and languages of migrants are not included. For example, Irish is spoken by a minority in Ireland

¹⁵ The 8 were Cyprus, Estonia, Finland, Luxembourg, Netherlands, Romania, Slovenia and Spain.

¹⁶ Arnardóttir, O.M., “Multidimensional equality from within Themes from the European Convention on Human Rights” in: D. Schiek, and V. Chege (eds.) *European Union Non-Discrimination Law* (Oxford: Routledge-Cavendish, 2009) 53-67.

¹⁷ Memorandum of Understanding between the Council of Europe and the European Union. 2007. Retrieved 15 September 2011 http://www.coe.int/t/der/docs/MoU_EN.pdf.

¹⁸ Council of Europe Directorate of External Relations. 2009. “Overview of arrangements for co-operation between the Council of Europe and the European Union” Retrieved 15 September 2011 http://www.coe.int/t/der/docs/DER.2009.1_En.pdf

but as it is the first official language under the constitution, it does not come under the Charter. Article 13.2.c on Economic and Social Life directs that Parties undertake:

to ensure that social care facilities such as hospitals, retirement homes and hostels offer the possibility of receiving and treating in their own language persons using a regional or minority language who are in need of care on grounds of ill-health, old age or for other reasons;

Thus, a Breton speaker in France, a Frisian speaker in the Netherlands, a Saami speaker in Finland, could claim the right to receive treatment in their own language but this Charter would not apply to a Polish speaker in England or a Portuguese speaker in France.

While Protocol 12 is potentially useful, the European Convention on Human Rights itself and the European Charter for Regional or Minority Languages are of little or no help in ensuring that migrants have access to medical interpreters. However, the Council of Europe has been active in the area of health. Three Conventions and one Charter are of potential use. They are the European Convention on Social and Medical Assistance and its Protocol 1953, the European Social Charter 1961, subsequently revised in 1996, the European Convention on Legal Status of Migrant Workers 1977 and the Council of Europe Convention on Human Rights and Biomedicine 1997. As we will see however, not all EU member states have ratified these treaties.

The European Convention on Social and Medical Assistance and its Protocol 1953 have been signed and ratified by 18 Council of Europe member states, 15 of which are also EU member states.¹⁹ Article 1 provides that:

Each of the Contracting Parties undertakes to ensure that nationals of the other Contracting Parties who are lawfully present in any part of its territory to which this Convention applies, and who are without sufficient resources, shall be entitled equally with its own nationals and on the same conditions to social and medical assistance (hereinafter referred to as "assistance") provided by the legislation in force from time to time in that part of its territory.

Article 1 limits social and medical assistance to legal immigrants from other countries that have ratified the Convention. The Protocol on Refugees adds in people who have obtained refugee status in a contracting party.

The Council of Europe was also responsible for the European Social Charter 1961, subsequently revised in 1996. A non-discrimination clause similar to that in the ECHR and that includes language appears in Part V:

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

¹⁹ The 15 EU member states that have signed and ratified the European Convention on Social and Medical Assistance are Belgium, Denmark, Estonia, France, Germany, Greece, Ireland, Italy, Luxembourg, Malta, Netherlands, Portugal, Spain, Sweden and the United Kingdom. The other three Council of Europe member states that have signed and ratified are Iceland, Norway and Turkey.

The revised Charter has been signed and ratified by 17 EU member states.²⁰ The Charter includes a right to protection of health in Article 11 but this concentrates on health promotion initiatives and the removal of causes of ill health. Article 13 is of more interest:

Article 13 –The right to social and medical assistance

With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;

4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

Article 13 is of interest because it provides that both nationals and non-nationals should be on an equal footing regardless of whether or not they have adequate resources. However, under Article 38, the Charter applies only to nationals of member states of the Council of Europe who are ‘lawfully resident or working regularly within the territory’. Therefore it does not apply to people from other countries outside the Council of Europe. Ellis finds that:

By its very nature it is a somewhat different type of instrument from the ECHR. In particular, it is not drafted in terms of legal rights which can be invoked before judicial authorities by individuals, although in a number of instances it recapitulates rights also conferred by EU law. It is instead supposed to set standards to be achieved by its Contracting States, with a fluid, time-consuming, and non-binding supervision procedure.²¹

The European Committee of Social Rights rules on the conformity of States with the European Social Charter, the 1988 Additional Protocol and the Revised European Social Charter.

The European Convention on the Legal Status of Migrant Workers 1977 applies to nationals of Council of Europe member states and is concerned with treating them ‘no less favourably than workers who are nationals of the receiving State in all aspects of living and working conditions’. It covers a wide range of issues and in Article 19 reiterates the health provisions of the Convention on Social and Medical Assistance 1953. In September 2011 the Convention on the Legal Status of Migrant Workers had been ratified by six EU member states.²²

The Council of Europe Convention on Human Rights and Biomedicine 1997, also known as the Oviedo Convention, came into force in 1999, includes equitable access to

²⁰ The 17 EU member states that have ratified the revised Charter are Belgium, Bulgaria, Cyprus, Estonia, Finland, France, Hungary, Ireland, Italy, Lithuania, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia and Sweden.

²¹ E. Ellis, *EU Anti-Discrimination Law*, (Oxford: Oxford University Press 2005) p. 324.

²² The six member states were France, Italy, Netherlands, Portugal, Spain and Sweden.

healthcare and, unusually, covers the topic of informed consent. Andorno²³ points out that this Convention is a framework instrument made up of general principles, which will be developed in the future with the help of additional protocols on specific issues. It is also a binding instrument under Article 1 which states that ‘Each Party shall take in its internal law the necessary measures to give effect to the provisions of this Convention.’ In June 2011, 15 EU member states had signed and ratified the Convention, 6 EU member states had signed but not ratified it and 6 had neither signed nor ratified it.²⁴ Articles 3 and 5 focus on access to healthcare and the issue of consent:

Article 3 – Equitable access to healthcare

Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to healthcare of appropriate quality.

Chapter II – Consent Article 5 – General rule

An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.

This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.

The person concerned may freely withdraw consent at any time.

While Article 3 includes a mention of ‘available resources’, the inclusion of Articles 3 and 5 gives this Convention potential relevance to patients who are not proficient in the language of the country in which they live. In order to be able to give ‘free and informed consent’, patients need to understand what exactly is involved in any procedure or operation. In order to understand, they need the help of an interpreter. Similarly, if a patient changes his or her mind, an interpreter may be needed again. There is no specific mention of interpreters in the Convention but for its provisions to be implemented, interpreters are required for people who do not speak the language.

The recommendations of the Council of Europe Health Committee of the Committee of Ministers would provide a useful starting point for a new convention. In 2006 they produced Recommendation (2006) 18²⁵ on health services in a multicultural society which includes a section on overcoming language barriers, where they advise that ‘professional interpreters should be made available and used on a regular basis for ethnic minority patients who need them’.

In summary, while the European Convention on Human Rights does not cover healthcare, Protocol 12 prohibiting discrimination is useful, but only in the restricted number

²³ R. Andorno “The Oviedo Convention: A European Legal Framework at the Intersection of Human Rights and Health Law” *Journal of International Biotechnology Law* 2(I) (2005) 133 -143.

²⁴ The 15 who both signed and ratified the Convention were Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, Greece, Hungary, Latvia, Lithuania, Portugal, Romania, Slovakia, Slovenia and Spain. The 6 signatory only countries were France, Italy, Luxembourg, Netherlands, Poland and Sweden. The 6 countries that had neither signed nor ratified the Convention were Austria, Belgium, Germany, Ireland, Malta and the United Kingdom. Retrieved 15 September 2011.

<http://conventions.coe.int/Treaty/Commun/ChercheSig.asp?NT=164&CM=&DF=&CL=ENG>

²⁵ Council of Europe Recommendation 2006(18) of the Committee of Ministers to Member States on Health Services in a Multicultural Society. Retrieved 22 September 2011

<https://wcd.coe.int/wcd/ViewDoc.jsp?id=1062769&BackColorInternet=DBDCF2&BackColorIntranet=FDC864&BackColorLogged=FDC864>

of countries where it has been adopted. The European Charter for Regional or Minority Languages applies only to languages that have had a long historical presence in a country and hence do not apply to migrants. The European Convention on Social and Medical Assistance applies only to legal immigrants from other countries that have ratified this Convention. The European Social Charter concentrates on health promotion activities and in any case applies only to nationals of member states of the Council of Europe. The European Convention on the Legal Status of Migrant Workers is potentially useful but has been ratified by a mere six EU member states. While the Convention on Human Rights and Biomedicine includes equitable access to healthcare and informed consent, it has been signed and ratified by only 15 EU member states.

5. European Union

The European Economic Community was established in 1957. Since then the organization has evolved into a much larger entity, the European Union (EU), with 27 member states in 2011. The EU is very different from most other regional or international organizations in that it has 23 official languages; laws must be published in all languages and the EU has developed a very inclusive approach to language and made special arrangements to accommodate translation and interpreting at institutional level with Directorates General for Translation and Interpreting. These measures do not, however, filter down to citizens and immigrants.

The Council Conclusions on Common values and principles in European Union Health Systems (2006/C 146/01) provide in an Annex that:

The overarching principles of universality, access to good quality care, equity, and solidarity have been widely accepted in the work of the different EU institutions. Together they constitute a set of values that are shared across Europe. Universality means that no-one is barred access to healthcare; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay. EU health systems also aim to reduce the gap in health inequalities, which is a concern of EU member states; closely linked to this is the work in the Member States' systems on the prevention of illness and disease by inter alia the promotion of healthy lifestyles.²⁶

The European Commission includes a Directorate General for Health and Consumers. A Commission White Paper²⁷ on a strategic approach to health for 2008-2013 makes no mention of language or interpreting. A communication from the Commission²⁸ mentions language once, in the context of barriers to healthcare; 'Barriers to access to healthcare can include lack of insurance, high costs of care, lack of information about services provided,

²⁶ Council Conclusions on common values and principles in European Union health systems. (2006/C 146/01) Retrieved 14 August 2011.

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF>

²⁷ White Paper Together for Health: A Strategic Approach for the EU 2008-2013 Retrieved 15 August 2011 http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf

²⁸ Solidarity in Health: Reducing Health Inequalities in the EU Retrieved 15 August 2011 <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0567:FIN:EN:PDF>

language and cultural barriers'. Translation and interpreting provision could help overcome the last three of these barriers.

5.1. *EU Treaties*

European Union law has traditionally focused on economic issues such as the free movement of people, goods and services rather than social issues such as healthcare. As Newdick points out:

In truth, however, although the EU has achieved much in respect of political and economic harmony, its jurisdiction in respect of social policy is limited. It holds very limited budgets of its own and the EU Treaty expressly reserves to the Member States the right to determine matters of health policy.²⁹

The EU has gradually moved into the area of human rights and article 2 of the Consolidated Version of the Treaty on European Union (2008)³⁰ provides that:

The Union is founded on the values of respect for human dignity, freedom, democracy, equality, the rule of law and respect for human rights, including the rights of persons belonging to minorities. These values are common to the Member States in a society in which pluralism, non-discrimination, tolerance, justice, solidarity and equality between women and men prevail.

Meanwhile, the Consolidated Version of the Treaty on the Functioning of the European Union³¹ (2010) provides in Article 10:

In defining and implementing its policies and activities, the Union shall aim to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.

Discrimination on the grounds of language is not mentioned. Part two of the Treaty concentrates on non-discrimination and citizenship of the Union. Article 18 (ex Article 12 TEC/Treaty Establishing the European Community) provides that:

Within the scope of application of the Treaties, and without prejudice to any special provisions contained therein, any discrimination on grounds of nationality shall be prohibited.

The European Parliament and the Council, acting in accordance with the ordinary legislative procedure, may adopt rules designed to prohibit such discrimination.

Article 19.1 (ex Article 13 TEC) provides that:

²⁹ C. Newdick, "The European Court of Justice, Transnational Healthcare, and Social Citizenship – Accidental Death of a Concept?", *Wisconsin International Law Journal* 26 (3) (2009) 845-68.

³⁰ Consolidated Version of the Treaty on the European Union. 2008. Retrieved 18 June 2011. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0013:0045:EN:PDF>

³¹ Consolidated Version of the Treaty on the Functioning of the European Union 2010. Retrieved 18 June 2011. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2010:083:0047:0200:EN:PDF>

Without prejudice to the other provisions of the Treaties and within the limits of the powers conferred by them upon the Union, the Council, acting unanimously in accordance with a special legislative procedure and after obtaining the consent of the European Parliament, may take appropriate action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.

Therefore, there is a broad non-discrimination aspect to the EU treaties.

5.2. *The European Charter of Fundamental Rights*

The European Charter of Fundamental Rights 2000³² came into force with the Lisbon Treaty in December 2009, has the same legal status as the EU treaties, but does not contain any new rights; all rights covered in the Charter are also covered in other EU Treaties. The European Commission, Council and Parliament check that any new proposals are compatible with the Charter. The Charter applies to Member States when implementing Union law, but not to other situations where there is no link with Union law.³³

The Charter contains four articles that are of interest. They are Articles 3, 21, 22 and 35.

Article 3 Right to the integrity of the person

1. Everyone has the right to respect for his or her physical and mental integrity.
2. In the fields of medicine and biology, the following must be respected in particular: the free and informed consent of the person concerned, according to the procedures laid down by law

As seen above, respect for free and informed consent implies the use of interpreters and the translation of informed consent forms where people do not speak the language of the country in which they find themselves.

Article 21. Non-discrimination

1. Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.

Unlike the Treaties, a specific mention of language appears in Article 21 as a possible ground for discrimination.

Article 22

The Union respects cultural, religious and linguistic diversity.

Article 35 Healthcare

³² European Charter of Fundamental Rights 2000. Retrieved 18 June 2011

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2010:083:0389:0403:EN:PDF>

³³ European Commission 2010 "Strategy for the effective implementation of the Charter of Fundamental Rights by the European Union" Retrieved 18 June 2011

http://ec.europa.eu/justice/news/intro/doc/com_2010_573_4_en.pdf

Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

The high level of human health protection could include the provision of translations and of interpreters to people who need such help to access healthcare.

The European Union Fundamental Rights Agency (FRA) was established in 2007 to collect evidence about fundamental rights in the EU, to advise the EU institutions on how to improve the situation, and to inform people about their rights. As De Schutter³⁴ explains, the FRA is not a monitoring body; it was set up to complement the Council of Europe. In 2008, a formal agreement was signed by the European Community and the Council of Europe on cooperation between the EU Agency for Fundamental Rights and the Council of Europe.³⁵

5.3. EU Directives

EU citizens are free to move to other EU member states to live, work or retire. Workers have had the right to move to other countries in the European Union to work since Council Regulation (EEC) No 1612/68 of 15 October 1968 on the free movement of workers within the Community. This is a very important right that was consolidated in the form of Directive 2004/38/Ec³⁶ and broadened out to cover citizens and their family members. Article 24 of the latter directive provides that:

Subject to such specific provisions as are expressly provided for in the Treaty and secondary law, all Union citizens residing on the basis of this Directive in the territory of the host Member State shall enjoy equal treatment with the nationals of that Member State within the scope of the Treaty. The benefit of this right shall be extended to family members who are not nationals of a Member State and who have the right of residence or permanent residence.

According to a Think Tank report from the University of Ghent,³⁷ this right to equal treatment includes medical care:

The ECJ has already confirmed in *Martinez Sala* (C-85/96) that all benefits covered by Regulation 1612/68 as well as by Regulation 1408/71 fall under the scope of the Treaty. Therefore this right to equal treatment also applies to medical care.

The EU has a number of directives designed to combat discrimination. The relevant one is the EU Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal

³⁴ O. De Schutter, "The EU Fundamental Rights Agency: Genesis and Potential" in: K. Boyle (ed.), *New Institutions for Human Rights Protection* (Oxford: Oxford University Press 2009) pp. 93-135.

³⁵ http://www.coe.int/t/der/docs/EUFRACoEAgreement_en.pdf Retrieved 24 June 2011.

³⁶ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:158:0077:0123:en:PDF> 24th June 2011.

³⁷ J.P. Lhernould (ed.), B. Schulte (ed.), J.C. Fillon (ed), J. Hajdu, H. Verschueren, Think Tank Report 2010. Retrieved 24 June 2011.

http://www.tressnetwork.org/TRESSNEW/PUBLIC/EUROPEANREPORT/ThinkTank_HealthcareUninsuredCitizens_Final_140111.pdf

treatment³⁸ between persons irrespective of racial or ethnic origin aka the Race Directive. The Directive begins by explaining direct and indirect discrimination:

Concept of discrimination

1. For the purposes of this Directive, the principle of equal treatment shall mean that there shall be no direct or indirect discrimination based on racial or ethnic origin.

2. For the purposes of paragraph 1:

(a) direct discrimination shall be taken to occur where one person is treated less favourably than another is, has been or would be treated in a comparable situation on grounds of racial or ethnic origin;

(b) indirect discrimination shall be taken to occur where an apparently neutral provision, criterion or practice would put persons of a racial or ethnic origin at a particular disadvantage compared with other persons, unless that provision, criterion or practice is objectively justified by a legitimate aim and the means of achieving that aim are appropriate and necessary.

Article 3 on Scope states that the Directive applies to public bodies and section (e) includes ‘social protection, including social security and healthcare.’ Article 5 on positive action states that ‘the principle of equal treatment shall not prevent any Member State from maintaining or adopting specific measures to prevent or compensate for disadvantages linked to racial or ethnic origin.’ Article 5 can be used by member states to introduce positive action such as interpreter provision in healthcare.

While the Directive appears on the surface to be quite positive, the reality is quite different. A European Commission report on Anti-Discrimination Law³⁹ indicated that:

One of the areas of ambiguity in the Racial Equality Directive is the extent to which characteristics such as colour, national origin, membership of a national minority, language or social origin fall within the scope of ‘racial or ethnic origin’.

People have the right to take cases alleging discrimination. Fredman argues that this approach ‘puts excessive strain on the victim; the intervention of the court is random and ‘a large number of cases of discrimination go unremedied; discrimination can be part of the way an institution works rather than the action of an individual; and complaints take time, cost money and are adversarial.’⁴⁰ It is particularly difficult or indeed impossible for those who are not proficient in the language to take a case, quite simply because they are unlikely to be aware of the law, their rights, or what steps they can take. Ellis argues that ‘the concept of indirect discrimination in itself is essentially a non-dynamic, non-redistributive one. Although it seeks to take note of the hidden obstacles facing protected groups of people and to set them aside where they are irrelevant to the matter in hand, it does nothing to dismantle those obstacles or to change customarily stereotyped roles.’⁴¹

³⁸ EU Council Directive 2000 Retrieved 4 June 2011.

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2000:180:0022:0026:EN:PDF>

³⁹ M. Bell, I. Chopin, F. Palmer 2007 “Developing Anti-Discrimination Law in Europe The 25 EU Member States Compared” European Network of Independent Experts in the non-discrimination field p. 19, European Commission Retrieved 15 June 2011 ec.europa.eu/social/BlobServlet?docId=2012&langId=en

⁴⁰ S. Fredman, “Positive Rights and Positive Duties: Addressing Intersectionality” 73-89. In: *Supra* 16.

⁴¹ *Supra* 21.

People who are not proficient in the language of the country in which they live do not form a recognisable group. They include men and women, adults and children, heterosexuals and homosexuals, EU citizens and non EU citizens, and people with and without a disability. They find it difficult to access information and may not be aware of their rights. It is particularly difficult for them to organise because by definition they do not speak a common language and this in turn makes it more difficult for them to fight their case.

The European Agency for Fundamental Rights (FRA) states in a factsheet that:

EU law only provides protection against discrimination on grounds of sex and racial or ethnic origin when accessing healthcare. A proposed ‘horizontal directive’, which would also provide protection against discrimination on the grounds of religion or belief, disability, age and sexual orientation, is currently under negotiation.⁴²

The FRA is focusing on the area of multiple discrimination which could cover ethnic origin, not speaking the language of the healthcare provider, being female, being disabled, being elderly. However, multiple discrimination could merely involve ethnic origin and not speaking the language. A white male who is not proficient in the language of the country could be treated less favourably if an interpreter is not provided.

The Directorate General for Employment, Social Affairs and Inclusion has also recommended new anti-discrimination legislation which would cover healthcare. The grounds for discrimination mentioned are ‘age, disability, religion/belief and sexual orientation’. Language is not included on the list.

Recommendation No 2: Legislation

The scope of the existing anti-discrimination legislation does not provide effective protection against Multiple Discrimination in areas outside employment and occupation. EU anti-discrimination and equal treatment legislation should cover age, disability, religion/belief and sexual orientation in the fields of: (a) social protection, including social security and healthcare; (b) social advantages; (c) education; (d) access to and supply of goods and services that are available to the public, including housing. The new legislation must provide provisions to address Multiple Discrimination.⁴³

One has to wonder why language is omitted from the lists of possible grounds of discrimination. Are the EU bodies concerned that member states will refuse to support such measures if they involve a financial commitment?

There is a 2008 Proposal for a Council Directive implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation⁴⁴, but this is unlikely to be of help to the cohort of people that is the focus of this article.

⁴² EU Agency for Fundamental Rights “Inequalities and multiple discrimination in access to healthcare” n.d. Retrieved 24 June 2011

http://www.fra.europa.eu/fraWebsite/attachments/Multiple-discrimination_Factsheet_EN.pdf

⁴³ European Commission “Tackling Multiple Discrimination: Practices, Policies and Laws 2007” Retrieved 24 June 2011 <http://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=51&type=2&furtherPubs=no>

⁴⁴ Proposal for a Council Directive implementing the principle of equal treatment. 2008. Retrieved 24 June 2011 <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0426:FIN:EN:PDF>

Another Directive, on cross-border healthcare, may appear useful but in reality this is not the case. A draft version⁴⁵ of Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare⁴⁶ included a paragraph on equity and non discrimination among the responsibilities of authorities of the Member State of treatment:

Moreover, patients from other Member States should enjoy equal treatment with the nationals of the Member State of treatment and, according to the general principles of equity and non discrimination, as recognized in Art.21 of the Charter *they should in no way be discriminated upon on the basis of their sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation.* (author's emphasis)

However, this paragraph was not included in the final, agreed version of the directive which is restricted to patients covered under insurance in one EU member state who wish to travel to another EU member state for medical treatment. This could be a German citizen who lives near the border with the Netherlands for example. It could also be a person from the UK or Ireland who travels to Hungary for dental treatment. The country where the patient is insured pays for the treatment. This directive seems to have come about largely in response to cases taken to the Court of Justice of the European Union (Kohll, Decker, Smits-Peerbooms, Watts). However, the omission of the non-discrimination clause means that interpreters will not necessarily be provided in the country of treatment. Travel and accommodation costs do not have to be reimbursed. It is likely that only patients who are well off and fluent in a second language will be able to avail of the rights under this directive.

As we have seen, the European Union is built on the free movement of people. The European Treaties contain broad commitments to fighting discrimination but it is unclear if the Race Directive covers language. No cases have been taken to the European Court of Justice on the theme of access to medical interpreters. It is up to each member state to decide how to implement the directive and some member states have implemented it in such a way that it does cover healthcare and interpreter services. However, this is not the case throughout Europe. The directive on cross-border healthcare is useful for people who are insured in one EU country and need to access healthcare in another member state but is not designed to enable a Polish person working in the UK or a Portuguese person working in Germany to access healthcare there. There is a move to work on a new horizontal directive to tackle multiple discrimination, but it is unclear if such a measure will include language.

The European Union has signed up to the European Convention on Human Rights, rights that were already enshrined in the EU treaties. It is somewhat disappointing that there has been so little enthusiasm for other Council of Europe conventions such as the Convention on Human Rights and Biomedicine 1997 and the UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families. While a number of laws provide that legal migrants should be treated equally to citizens and should

⁴⁵ Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare. 2008. P. 12. Retrieved 24 June 2011.

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0414:FIN:EN:PDF>

⁴⁶ Directive 2011/24/EU of the European Parliament and of the Council. 2011. Retrieved 24 June 2011. on the application of patients' rights in cross-border healthcare

<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF>

be provided with healthcare on an equal footing, the various international treaties, conventions, charters, EU directives and so on do not provide a right to an interpreter. However, it is self-evident that where interpreters are not provided, treatment is in fact unequal.

6. Patient Rights

Another possible focus is patient rights. The World Health Organization Declaration on the Promotion of Patients' Rights in Europe 1994⁴⁷ aka the Amsterdam Declaration, includes a right to information in Article 2.2 and to interpreting in Article 2.4:

Patients have the right to be fully informed about their health status, including the medical facts about their condition; about the proposed medical procedures, together with the potential risks and benefits of each procedure; about alternatives to the proposed procedures, including the effect of non-treatment; and about the diagnosis, prognosis and progress of treatment.

Information must be communicated to the patient in a way appropriate to the latter's capacity for understanding, minimizing the use of unfamiliar technical terminology. If the patient does not speak the common language, some form of interpreting should be available.

The phrasing, 'some form of interpreting' is disappointing because it could be understood as a family member, friend or member of hospital staff providing the interpreting rather than a professional interpreter. However, the right to information is quite complete and it is difficult to envisage a situation where such a right could be guaranteed to patients without the help of professional interpreters.

A second item of interest is Article 4 of the European Charter of Patients' Rights (2002):

Healthcare providers and professionals must give the patient all information relative to a treatment or an operation to be undergone, including the associated risks and discomforts, side-effects and alternatives. This information must be given with enough advance time (at least 24 hours notice) to enable the patient to actively participate in the therapeutic choices regarding his or her state of health.

Healthcare providers and professionals must use a language known to the patient and communicate in a way that is comprehensible to persons without a technical background.⁴⁸

Despite the participation of people from eight European countries in developing the Charter, it makes no mention of interpreters and seems to encourage health professionals to use their foreign languages.

While such declarations and charters can be used to argue for certain rights, they are only aspirational unless accompanied by legislation on patients' rights.⁴⁹ Similarly, national and hospital charters are not really enforceable unless they are part of legislation.

⁴⁷ World Health Organization. 1994. "A declaration on the promotion of patients' rights in Europe". Retrieved 24 June 2011. http://www.who.int/genomics/public/eu_declaration1994.pdf

⁴⁸ Active Citizenship Network. 2002. "European Charter of Patients' Rights" Retrieved 6 July 2011. http://www.patienttalk.info/european_charter.pdf

7. Conclusion

As the world becomes increasingly globalised the need for improved access to healthcare for immigrants who are not proficient in the language of the country in which they live is likely to continue to increase this century.

The United Nations has worked since its foundation to ensure that people have access to healthcare. However, it has not tackled the issue of interpreting. The word 'language' is mentioned in the International Covenant on Economic, Social and Cultural Rights. It is also mentioned in the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families but as discussed above, no EU member states have ratified this Convention.

The Council of Europe and the European Union are closely linked and all EU member states have ratified the European Convention on Human Rights. However, only eight EU member states have ratified Protocol 12 which prohibits discrimination. The European Charter for Regional or Minority Languages serves a useful purpose in protecting long established languages spoken in Europe but is of no assistance when it comes to new languages. There has not been huge enthusiasm for the European Convention on Social and Medical Assistance (ratified by 15 EU member states) or for the European Social Charter (17 member states) or for the European Convention on the Legal Status of Migrant Workers (6 EU member states) or for the Convention on Human Rights and Medicine (15 EU member states). The European Social Charter is the only one of these to mention language as grounds for discrimination.

Language is mentioned as one of the grounds for discrimination in the European Union Charter of Fundamental Rights but it is unclear if the Race Directive includes language. The Directive on cross-border healthcare makes no mention of interpreters or language. By way of contrast, the European Union has intervened in the area of legal interpreting, where it has introduced Directive 2010/64/EU of the European Parliament and of the Council on the right to interpretation and translation in criminal proceedings to strengthen the right to the free assistance of an interpreter in criminal proceedings. A similar directive is needed for people who need to access health services but are not proficient in the language of the country in which they reside.

Patient charters can be a useful exercise but are only really beneficial where they are part of legislation.

Given the absence of international and European legislation on interpreter provision in healthcare, people are dependent on regional and national laws or on local provision. Countries can decide to introduce their own anti-discrimination legislation as has happened in Northern Ireland, where Article 21 of the Race Relations (NI) Order 1997⁵⁰ provides that:

It is unlawful for any person concerned with the provision (for payment or not) of goods, facilities or services to the public or a section of the public to discriminate against a person who seeks to obtain or use those goods, facilities or services.

⁴⁹ Katholieke Universiteit Leuven, Centre for Biomedical Ethics and Law European Patient Rights. n.d. Retrieved 6 July 2011. http://europatientrights.eu/general_overview_patient_rights_legislation.html?LAN=E

⁵⁰ Race Relations (Northern Ireland) Order 1997. Retrieved 15 September 2011.

<http://www.legislation.gov.uk/nisi/1997/869/contents/made>

In addition, the 1998 Good Friday Agreement included ‘a statutory obligation on public authorities in Northern Ireland to carry out their functions with due regard to the need to promote equality of opportunity’ and all public bodies were required to ‘draw up statutory schemes showing how they would implement this obligation’. These laws led to the establishment of the Northern Ireland Health and Social Services Interpreting Services (NIHSSIS) in 2004, managed by the Belfast Health and Social Care Trust⁵¹.

Similarly, Norway, a member of the European Economic Area, but not of the EU, has an Act on Prohibition of Discrimination which prohibits direct and indirect discrimination on the basis of ethnicity, national origin, ancestry, skin colour, language and religion.^{52 53}

Interpreter provision in healthcare is not of course cost neutral. It would involve considerable expense and for a worthwhile service it would be necessary to ensure that interpreters are trained and qualified. However, it would mean that people who do not speak the language of the country where they reside or where they happen to be at a particular time, could expect to receive equal treatment.

⁵¹ M. Phelan, “Interpreting in Northern Ireland” in: M. Phelan and K. Zimányi (eds.) *Translation Ireland* 18(2) (Dublin: Irish Translators’ and Interpreters’ Association, 2010) pp. 99-107.

http://www.translatorsassociation.ie/component/option.com_docman/task,cat_view/gid,47/Itemid,16/

⁵² H. Skjeie, “Multiple equality claims in the practice of the Norwegian anti-discrimination agencies” 295-309. *Supra* 16.

⁵³ Norwegian Government. The Act on prohibition of discrimination based on ethnicity, religion, etc. 2006. Retrieved 18 June 2011.

<http://www.regjeringen.no/en/doc/laws/Acts/the-act-on-prohibition-of-discrimination.html?id=449184>