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Language problems in access to public health care in the Brussels-Capital region in Belgium

Report
Social, Health and Family Affairs Committee
Rapporteur: Ms Minodora Cliveti, Romania, Socialist Group

Summary

Language being an important factor in the quality of health care, it is indispensable that there is satisfactory understanding between the patient and medical and nursing staff to avoid compromising the efficacy of medical care which absolutely must remain a priority.

On the other hand, access to health care and language problems in the Brussels-Capital region must be considered in the general context of Belgium's constitutional development and its complex language situation which is the result of historical events and compromises reached through lengthy negotiations.

The Brussels public hospitals operate under local authority supervision and are subject to fairly strict rules on bilingualism. Numerous administrative, political and judicial controls are carried out to ensure that these rules are effectively applied. In practice, however, strict application of these rules is not always easy to guarantee.

The Rapporteur considers that language problems in access to health care in the Brussels-Capital region can only be solved if all the efforts currently being made to create all the conditions for a strengthening of bilingualism in Brussels hospitals are continued in the same spirit of goodwill, openness, tolerance, pragmatism and flexibility, so as to foster peaceful cohabitation of the different language groups.

With that aim in mind, it would be advisable to ensure that reception services are bilingual, thereby enabling patients to feel they are understood from their first contact with the hospital. In addition, the Rapporteur encourages and supports the efforts to dispense language training to staff. Further training is a means of moving towards individual bilingualism. This naturally first and foremost requires efforts in the education and training field which is managed by the French-speaking and Flemish communities.

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§ 7.7. set in place a language training programme in medical schools of the region;

§ 7.8. strengthen and better define the responsibility of hospitals as a public service.

§ 8. The Assembly further invites the Belgian Government to:

§ 8.1. encourage cultural communication and co-operation across the language barriers in Belgium, for example by opening some bilingual schools in the three communities and in particular in the Brussels-Capital region;

§ 8.2. ratify the Framework Convention on the protection of National Minorities, in keeping with Assembly Resolution 1301 (2002) and to withdraw the reservations expressed when it signed it, recognising the French speakers living in the Flemish region as a national minority (as already requested in Resolution 1301 (2002) and Recommendation 1623 (2003)).

8. Under that status the Brussels-Capital region has its own Council and its own Executive, but certain powers are also vested in the communities (Flemish and French-speaking). The latter are competent in the Dutch-speaking and French-speaking sectors for, inter alia, public health, social assistance, cultural matters and education. A Joint Commission for Community Matters has been established to exercise these powers in respect of the population of Brussels. In its work this commission is independent of the Brussels-Capital region, the federal government and the communities. It has a legislative body, the United Assembly, comprising the 89 members of the Brussels Council, respectively the Assemblies of the Flemish and French-speaking Community Commissions, and an executive body, the United College, made up of the five ministers of the Brussels-Capital region.

9. The Joint Commission for Community Matters monitors and supervises the majority of the capital's health-care services which have not opted to belong solely to the Flemish or the French-speaking community ("dual-community health-care institutions"). In addition, the Governor and the Vice-Governor of the Brussels-Capital region, in their capacity as federal government representatives, and the Standing Commission for Language Supervision perform a number of supervisory functions regarding compliance with the legislation on language use.

10. Over the years Brussels has become a bilingual city, but the majority of the population is French-speaking. According to the petitioners 30% of patients in the Brussels public hospitals are Dutch-speaking, compared with 10% of the doctors who work there. However no precise information has been published on the bilingual staff's breakdown into Dutch and French speakers.

11. On many occasions representatives of the Dutch-speaking community have told me they consider protection of the Dutch-speaking population of Brussels, in view of that city's bilingual status, to be linked to the protection afforded to Belgium's French-speaking community at federal level. Brussels' bilingual status is regarded as comparable with the entire country's bilingual status. In other words, the Dutch-speaking community's representatives want this protection to apply fully in the health care sector, which means that 300,000 Dutch-speakers must be afforded access to health care in Brussels:

- in their capacity as an inhabitant of one of the nineteen municipalities of the Brussels-Capital region;
- or in their capacity as a commuter who daily travels from Flanders to work in Brussels;
- or in their capacity as a patient living in Flanders but being treated in one of the hospitals located in the Brussels-Capital region.

OBJECT

12. A number of studies and eye-witness reports have shown that the proportion of Dutch-speakers among health care sector staff in Brussels leaves much to be desired. In the majority of the city's hospitals Dutch-speaking patients find that they cannot be attended or treated by Dutch-speaking staff, although Brussels is, by law, a bilingual city where Dutch and French-speakers should be able to use their own language. According to the petitioners, in most hospitals the staff are French-speaking with the result that Dutch-speakers have the impression that they are second-class patients and are often unable to communicate in their mother tongue with both doctors and other medical staff. This has not just medical but also human implications.

13. In the petition lodged on behalf of the French-speaking citizens, the latter complain, inter alia, of serious infringement of the right to health protection and cite as an example free breast cancer screening, from which French-speaking women are excluded without any means of redress.

14. The aim of my report is not, in essence, to discuss issues linked to the protection of minorities, since both Dutch and French are official languages in the Brussels region. Furthermore, the question which languages should be recognised as official languages does not come within the scope of the instruments on protection of minority rights and remains solely a matter for national law.

23. The three **university hospitals** are each attached to only one community. Apart from their emergency services, they are accordingly monolingual, either Dutch or French. Brussels has two university hospitals belonging to the French-speaking community, and one to the Flemish. (The ULB and the UCL are attached respectively to the free and Catholic French-speaking universities. The AZ in Jette is Dutch-speaking and attached to the Vrije Universiteit van Brussel.)

24. The other ten **private hospitals** have opted for dual-community status. Although, strictly speaking, the language legislation does not apply to these hospitals, bilingualism is to some extent expected and required of them, since they are funded by both the Dutch-speaking and the French-speaking authorities. They have at least a moral obligation to cater for speakers of both national languages.

25. Brussels has nine **public hospitals**, which are managed by the Public Social Assistance Centres (CPAS). Under the language legislation a CPAS qualifies as a local service subject to the linguistic requirements in administrative matters. Section 19 of the law on language use in administrative matters provides that all local services in the Brussels-Capital region shall, when dealing with a member of the public, utilise the language spoken by that person, where it is French or Dutch. In addition, the proportion of staff belonging to each of the two main linguistic communities is also laid down by regulations, which guarantee that at least 25% of all staff shall belong to the minority community.

26. Compliance with these rules is subject to many forms of administrative, political and legal supervision (exercised by the Standing Commission for Language Supervision, the Vice-Governor of the Brussels-Capital region, the regional government, the ordinary courts and the Conseil d'Etat).

27. The **Standing Commission for Language Supervision** deals with complaints regarding application of the language legislation. It may investigate such complaints and issues opinions. I had a meeting with the Commission's President, Ms van Cauwelaert, during my visit to Brussels. It has published several opinions on language use in hospitals in Brussels, but is not empowered to penalise local authorities which fail to comply with the rules or to suspend administrative decisions. Ms van Cauwelaert informed me that, over a fifteen-year period, she had lodged only three appeals concerning application of the language legislation with the Conseil d'Etat.

28. In this connection, it is interesting to note that, over the period 1996 to 2003, only nine complaints were registered concerning hospitals belonging to the IRIS network. They mainly concerned invoices made out in French or use of French by doctors, although a nurse was frequently able to translate. Despite their importance, the extent of these complaints must accordingly not be exaggerated. Moreover, some complaints referred to in the Dutch-speakers' petition concerned private hospitals. However, according to the petitioners, this limited number of complaints is but the visible tip of the iceberg, as patients and their families fear that a complaint will have consequences in terms of the medical care provided.

29. Aware of the practical difficulties in achieving a satisfactory level of bilingualism in Brussels, the public authorities decided to reach a compromise through the conclusion of a **Linguistic Courtesy Agreement** in 1996. This agreement provided, among other things, that all applicants for public-sector posts involving dealing with the public should be required to furnish proof of their bilingualism. Those who could not were required to sit a language examination within two years of taking up their duties. The agreement was suspended by the Conseil d'Etat on 8 April 2003. In its judgment the Conseil d'Etat held that circulars issued by the government of the Brussels-Capital region and the United College of the Joint Commission for Community Matters could not freely interpret the language legislation and that the Linguistic Courtesy Agreement breached that legislation, which must be observed and enforced first and foremost.

30. I was also informed that when the new government of the Brussels-Capital region was formed in 2004 a new language agreement was negotiated, which was largely based on the principal provisions of the old Linguistic Courtesy Agreement. It accordingly permitted the recruitment of staff who did not satisfy the language requirements. The circulars concerning that agreement sent by the Brussels-Capital

Nonetheless, it seems that the lack of Dutch language may prevent some women from benefitting from preventative breast cancer screening. The measure is not discriminatory in nature but rather corresponds to a logical application of the Belgian state's federal structure. (Moreover, a similar screening scheme exists in the province of Walloon Brabant. In that case invitations are naturally sent in French, including to Dutch-speaking women living in the province.)

37. Regarding the language situation in public hospitals in Brussels, I believe that the hospitals' primary concern is dispensing a high standard of care, but that they are also very careful about how they receive patients. The Saint-Pierre hospital's practice in this area is very clear. This hospital caters for a very broad multicultural, multilingual population, since it deals with patients in over 70 languages, thirty of which are spoken by its own staff. For other languages it calls on the services of the CIRE (a centre dealing with refugees and immigrants), which are available from 9 am to 5 pm. This hospital is just one example, and the other public hospitals also make a genuine effort to deal with patients in their own language whenever possible.

38. It must nonetheless be said that not all hospital staff are perfectly bilingual. Imposing such a constraint could jeopardise the continuity of the supply of public services and the provision of a high standard of care, and it is those two considerations that must remain the priority. As mentioned above, both the hospitals themselves and the public authorities regard reception as an essential aspect of the service and accordingly make bilingual reception arrangements.

39. The public hospitals in Brussels are attached to the local authorities and are subject to the fairly strict rules on bilingualism applicable in that sector. There are many administrative, political and legal safeguards to ensure compliance with those rules. However, it must be acknowledged that strict application of the guarantees sometimes proves difficult in practice.

40. A number of specific factors accounting for the considerable difficulties experienced in recruiting qualified bilingual staff can be noted:

- unfortunately, among the population of Brussels in general relatively few people are bilingual. This can be ascribed, inter alia, to the significant proportion of the population of foreign European or non-European origin, for whom French is already a second language. The great diversity which typifies the population of Brussels also requires the public hospitals to make a special effort to provide satisfactory reception services in a wide variety of languages;

- competition to recruit suitably qualified staff is fierce, since the hospitals located in Flemish Brabant and Walloon Brabant attract many applicants.

41. Despite these difficulties it must nonetheless be acknowledged that, more often than not, hospitals do succeed in guaranteeing bilingualism in practice. Although not all members of staff individually fulfil the bilingualism criterion, the departments are in the vast majority of cases organised so as to ensure the presence of at least one bilingual staff member or of staff with complementary language proficiency, thereby making it possible to deal with Dutch-speaking patients in their own language.

42. This accounts for the small number of complaints lodged by members of the public in recent years. Moreover, the Standing Commission for Language Supervision has given each complaint very careful consideration (See Appendix 2 for an example of complaints in linguistic matters concerning the Centre Hospitalier Universitaire Brugmann (CHUB)).

BY WAY OF A CONCLUSION

43. During my visits to hospitals in Brussels I was impressed with the very high standard of care, although that is not the focus of this report, which is concerned with the application of linguistic rights in the health care sector.

Appendix 1

Programme of the Rapporteur's fact-finding mission to Brussels (13-15 April 2005)

Wednesday 13 April 2005

10.55	Arrival at Brussels airport
12.30 – 13.00	Screening of the film report produced for the television channel "Canvas", in the presence of the journalist R. **Ramaekers** (Room I of the Senate)
13.00 – 14.30	Working lunch with Mrs M.-J. **Laloy**, Mrs F. **Pehlivan** and Messrs Ph. **Monfils** and L. **Goutry**, members of the Social Affairs Committee, at the "Poulbot de Bruxelles" Restaurant
14.30 – 15.30	Meeting with signatories of the petition in favour of the right of Dutch speakers to medical care in Brussels and the neighbouring Dutch-speaking municipalities (Room M of the Senate)
15.30 – 16.30	Meeting with signatories of the petition on access to medical care in their own language for French-speaking residents of the municipalities around Brussels (in the Flemish Region) (Room M of the Senate)
16.30 – 17.15	Meeting with administrators of the Brussels Public Hospitals governing body (*Interhospitalière Régionale d'Infrastructure de Soins – IRIS*) (Room M of the Senate)
17.15 – 18.00	Meeting with the Chairperson of the Standing Committee on Language Control, Mrs A. **Van Cauwelaert-De Wyels** (Room M of the Senate)

Thursday 14 April 2005

07.45 – 08.45	Working breakfast with Mr Y. **Leterme**, Minister-President of Flanders, and Prof. P. **Van Orshoven**, 19 place des Martyrs, 1000 Brussels
09.00 – 09.45	Visit to the S.I.A.M.U. (Fire and Emergency Medical Aid Department of the Brussels-Capital Region)
10.00 – 11.00	Visit to the Brugmann University Hospital (ULB)
11.30 – 12.30	Visit to the I AZ-VUB Hospital
13.00 – 14.30	Working lunch at the Flemish Parliament Restaurant with: Mr Frank **Vandenbroucke**, Vice-Minister-President of Flanders Mr Bert **Anciaux**, Flemish Minister of Culture, Youth, Sport, and Brussels Mrs Inge **Vervotte**, Flemish Minister of Welfare, Public Health and the Family Mrs Brigitte **Grouwels**, Secretary of State of the Brussels-Capital Region, responsible for Public Services, Equality of Opportunities and Brussels Harbour, and Member of the College of the Flemish Communautary Committee, responsible for Welfare, Health and Public Services Mr Guy **Vanhengel,** Minister of the Brussels-Capital Region, responsible for Finances, Budget, External Relations and Information Technologies; President of the College of the Flemish Communautary Committee, responsible for Education,

Appendix 2
Complaints in linguistic matters concerning the Centre Hospitalier Universitaire Brugmann (CHUB)

Name	Date of receipt	Department concerned	Subject matter	Outcome
L.S.	26/05/2004	Emergency	Language problem - the admission process was not conducted in Dutch and the bill was issued in French	The hospital apologised to the patient, pointing out that, as a public hospital, the CHUB attached importance to bilingualism and was doing everything in its power to improve it
Municipality	04/11/2004	Invoicing	Complaint of receipt of a letter in French	Administrative error; a letter of apology in Dutch was issued, confirming that departments' attention would be drawn to this matter. Initial letter re-sent in Dutch
B.V.	29/11/2004	Psychiatry	The patient complained of receiving a medical report in French, when he had expressly informed the hospital that he was Dutch-speaking	Administrative error; the report was re-issued in Dutch
B.	15/09/2003	Emergency	Lack of bilingual services	The doctor dealing with the patient was completely bilingual - the patient herself pursued the conversation in French
Anonymous	24/01/2002	Physiotherapy	Lack of bilingual services	Reiteration of the in-house rules on bilingualism
S.	03/01/2001	Ophthalmology	Lack of bilingual services	Letter of apology - observations forwarded to the department concerned
T.	03/01/2001	Medicine	Failure to fulfil linguistic role	Letter of apology - observations forwarded to the department concerned
G.	25/08/2001	Radiology and cardiology	Lack of bilingual services	Letter explaining that appropriate steps would be taken, if necessary
H.	26/10/2001	Plastic surgery	Lack of bilingual services	Letter explaining that the CHUB recruited bilingual staff
C.	25/04/2000	Medicine/ cardiology	Failure to fulfil linguistic role	Letter of apology - observations forwarded to the department concerned
D.W.	09/10/1999	Polyclinic	Failure to fulfil linguistic role	Staff were aware of the rules and documents were available in both languages. Precise nature of complaint difficult to determine
C.	26/01/1998	Surgery and physiotherapy	Failure to fulfil linguistic role	Letter of apology (NB: the patient was fully bilingual with a French-speaking wife and even addressed the Dutch-speaking staff in French).

For information, the table below sets out the CHUB's consultation, emergency and admission statistics for the period 2000 to 2004

	Consultations	Emergencies	Admissions
2004	220,460	42,141	17,198
2003	217,539	41,585	16,993
2002	220,986	42,434	17,123
2001	216,500	42,138	17,072
2000	205,981	40,959	17,603