HEALTH – A HUMAN RIGHT ISSUE

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ABSTRACT: *The right to „the highest level of health" means the right of each individual to health itself and includes, besides the health services provided by the health care system, the provission of essential conditions for a good health such as: clean water, adequate food, sanitation and shelter. This right includes the access to quality and affordable health services, as well as the acces to information on health issues. The public health care system represents the guarantee of the life quality and one of the most important political commitment the guvernors have to assume to ensure the high standards of the population they represent.*

KEY WORDS: *Public health, human rights, the quality of life, healthy environment, health care services.*
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"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, poltical belief, economic or social condition." - World Health Organization constitution.

Any human being beneficiates of inherent human rights, irrespective of the state or region where he was born, place of residence, workplace, irrespective of nationality, race, gender, religious believes, political or philosophical views, irrespective of his fortune because all these peculiars have an universal character, the right to a good health condition being one of the fundamental rights.

Adopting some treaties at United Nations Organisation level as well as at European level, documents which establish principles regarding Human Rights protection, the International Society undertook to impose a consistent, solid and universal vision of these documents. This vision is to be adequate to a general international standard of their protection.

The universal vision on human rights does not expel the regional model of human rights. Europe claims itself as being the place where the human rights theory evolved from. Because of this, undoubtedly Europe had a pioneering role in this regard and it developed its own instruments in order to promote and protect fundamental human rights and fundamental freedoms.

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By integrating principles, mechanisms and proceedings of legal internal order as well as those of international order, the Human Rights Institution is a bivalent institution. In the same time, the Human Rights Institution has internal regulations as well as international regulations, all these having the character of a keystone that can be applied in relationship between states.

Human Rights have a political character (Zlatescu & Zatescu, 2003). This is to be said in a broad sense, as they look for the way things are going on in a country, reflecting on how principles of democracy are applied in each society. Then, political, as before becoming legal realities, they formed objective aims of a political fight but in the end the outcome was successful.

The right for „the highest healthcare system" means the right of each and every human to appropriate health care and beside the facilities offered by the health care system everybody should benefit from the conditions of good health, such as potable water, adequate food, adequate sanitation, and housing. This right includes the *access* at high quality healthcare services and for an affordable price as well as access to information regarding the health care settings. The public healthcare system guarantees the quality of life and one of the most important political commitment that governors should assume in order to make sure those they represent have a very good quality of life.

The right to life is conditioned by one's health condition. Therefore, the practice of this right implies having a very good health condition. When the citizens do not afford to use the healthcare system services due to the expenses – "*the right to life*" as it is defined in the art. no. 3 of the Universal Declaration of Human Rights ("*Everyone has the right to life, liberty and security of person")* the becomes evaporated into thin air. In other words, the right to health is stipulated and recognized as a fundamental right, but in order to be exercised the individual responsibility has to be taken into consideration, without any reference to the social responsibility for health. It does not contain any special protection and not even the inputs of the member states. (Vicol, 2013)

The social responsibility concept, as a factor of implication of the states in promoting and protecting these rights can be found in the Universal Declaration of Bioethics and Human Rights – UNESCO which underlines the importance of one's health and the importance of accessing the healthcare system as this „is essential for life and it has to be considered a social and human asset. According to this document, healthcare systems should be structured and based on respect for human rights. In order to strengthen this responsibility, WHO (World Health Organization) promotes the healthcare performance concept. The determinants are the population state of health, fairness in tax payments as well as the ability to meet the population needs and expectations.

Among the determinants considered important for health are those presented above: living conditions, potable water, adequate food, adequate sanitation, and housing. One's life in a healthy environment represents the certainty for a healthy life. (Moroianu & Octavian, 2008) These factors play a more important role in the quality of life than any biological or social factor. These affirmation was confirmed in a research made by WHO that shows the influence of biological factors in 15%, while the influence of physical factors is 10%.

This being acknowledged, the interplay between ensuring a minimal state of health and guaranteeing the right to health, the state takes all the responsibility to combat the

poverty, to promote a social protection policy. This policy should ensure minimal living conditions, including an unpolluted environment.

The health right draws attention to the economical and socio-cultural determinants of health and in general to the wellbeing. In this way, the link between poverty and disease, development and public health care systems becomes more clear. (Meier & Fox, 2008)

Other authors underline the fact that even if it does not help to solve the complex allocation problems, a call for human rights makes a difference between the issue of accessing a minimum healthcare, the market forecast and the unequal distribution of incomes. (Arras & Fenton, 2009)

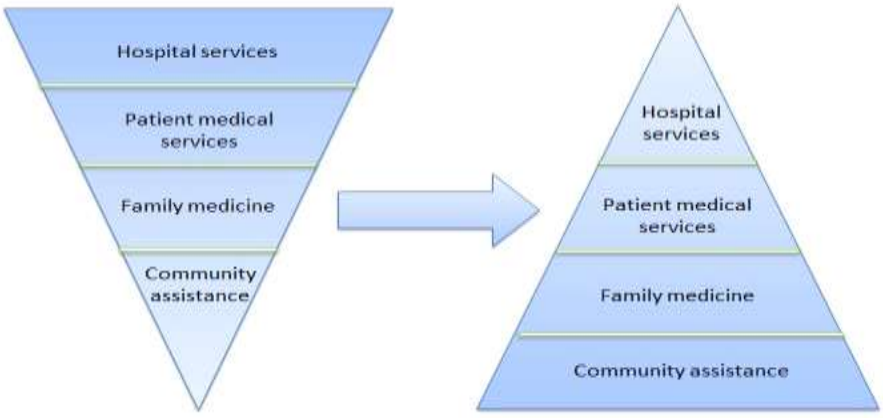
Because there is no legal framework to bring under regulation sanctions for the state, when it does not make the minimum of effort for interventions. This means to assume the social responsibility. We can notice the difference between the right itself and its application in daily life. That means, the individual is responsible for his health, denying the social responsibility – in other words, is the individual to be blamed because he does not have the material resources to keep his diet and undergo his treatment.

On the other hand, the medical staff is stigmatized and hold liable for all the issues regarding deficiencies in the system (lack of medicine, the impossibility of practitioners in developing their skills in this field, the endowment with equipment, lack of medical staff or malfunctions in providing the care services as stipulated in their contract). The public opinion is implemented the idea that medical staff is low-skilled or even ill will and this is why the medical staff is sanctioned by it. In this way, the decision makers somehow give up their *social responsibility role.*

In order to ensure compliance with the rules of law, states and international organisations as well as non governmental organisations have to monitor with adequate techniques and methods if the health rights are enforced.

The public health subject is topical today because of the global economic crisis. The financial crisis in the health care systems brought with it important changes in the European health systems. In Romania, the National Health Strategy 2014-2020 was issued under the name *„Health for Prosperity"* and most probably it will bring changes into the actual health system organization.

If we try to have a closer look to the way healthcare services are provided today in Romania, we can see most of them are provided in the hospital. Community healthcare services are far less than necessary (eg. Maternal and newborn health services, home care services, monitoring and care services for patients with diabetes, etc) According to the specialists who issued the National Health Strategy 2014-2020, this way of providing health services is not efficient.



The vision for 2014-2020 is to change this in the Romanian health system, to provide healthcare services for people guaranteeing services for basic needs (community healthcare services, services provided by general practitioners and by healthcare practitioners. This kind of services should be able to solve main needs of patients such as a first aid services as well as monitoring services for patients suffering of chronic disease like: diabetes mellitus, high blood pressure and chronic obstructive bronchopneumopathy (BPCO). Expensive healthcare services provided by the hospital should be requested just in case the patient needs very complex services. It is well known the fact that it is possible to prevent successfully an acute episode of illness or a relapse of the illness just when the living standard of population is at least at a minimum level, which is not the case in Romania.

Romania is one of the European countries with the highest level of poverty. Around 42% of Romania's population has a high risk of poverty and social exclusion. In EU, this level is exceeded just by Bulgaria. The relative poverty rate reached 17,9% in 2011, after a quite stable evolution in 2009-2010 [MMFPSPV, 2011] . Because of the crisis, the absolute poverty rate has increased from 4.4% in 2009 to 5% in 2011. In 2011, 3.81 million of people in Romania were below the relative poverty threshold and 1.08 million of Romanians were affected by severe poverty. The deep poverty rate decreased from 0.9% to 0.6% between 2010-2011. The rate of poverty is higher in rural areas (the risk of poverty is three times higher), in some specific areas (+23-25% in NE and SE), for freelancers as well as for those working in agriculture (+38%), for women, in families with 2-3 children (the rate of poverty is almost two times higher), for children under the age of 15 (+43%) and for people over the age of 65 (just before social transfers). What is to be noted, is the fact that in many European countries, groups at high risk of poverty and social exclusion are ethnic minorities (Roma people), people having mental health problems and emigrants (Tamsma & Berman, 2004). Single-parent families and families having three or more children have a risk of poverty of 1,5-2 times or even higher. In the last years, material deprivation in families having 2, 3 children became higher.

Lacking a firm reaction from civil society, in the spontaneous protests from January 2012, people proved the fact that a good and proper functioning of public healthcare system is one of the main concerns of Romanians. They said loudly about their needs and wishes regarding the public health system and politicians have the obligation to take it into account and come with solutions for public health system in Romania. In the same time they have to make sure that everybody will beneficiate of high quality healthcare services.

In the same time, the health system should meet the people's expectations like respect for the citizen (autonomy and confidentiality) as well as the attention being drawn towards the customer/patient (prompt and high-quality healthcare services). Another objective is represented by an equitable funding in such a way that the expenses can reflect the payment capacity and not the risk of illness.

There is a fundamental tension between those two values, as the cost-benefit ratio deliberately ignores ethic considerations. So that even in this field of social life, the idea of reaching the equity ideal in allocating medical resources will be supported by recognising the health right. This can be done either in a narrow concept like ensuring some health services either in a wider concept, referring to health determinants such as a healthy living environment, healthcare education as well as to social programs against poverty.

The arguments that support the health right issued in the last four decades gave hope that an approach starting from the health right acknowledgement can lead to solutions for the issue of allocating limited funds for the healthcare system (Olaru, n.d.). However, this affirmation, the health right acknowledgement and the importance of this right can contribute in different ways in reaching the equity ideal in the healthcare system, and more than this it can contribute to all the factors that influence one's health condition. The idea of a minimum right of decency in medical care is the moral basis to make a call for the state to ensure the necessary minimum (Buchanan, 1984). Once recognized this minimal right, it is legitimate to talk about the progressive achievement of a health right but in a wide concept this time (Daniels, 2008).

If it is to refer strictly to the healthcare system in Romania, some considerations are to be said, in order to complete the picture of the Romanian system.

The progress in medicine is very fast but in the same time the costs increase. Medicinal products as well as medical equipment are more and more expensive. In addition, health condition of people in Romania becomes worst. This happens because of the old age population, because of the high level of stress, pollution and the chemicals we can find in food. In addition to this, the prevention is far away from being as it should be even if we talk about the way medical health system works even or about our behaviour patterns.

It is also true that our health care system suffers of a lack of funds. Many hospitals are in a bad condition, full of damps, having equipment which nowadays is used just in the third world countries. In Because of the lack of beds in many hospitals, patients are in the situation of sharing their beds. With all these, there are hospitals where patients have good conditions and the quality of services is very high. The unequal distribution of resources, the investment in high class technology made just in big health centres from big cities as well as a lack of interest from authorities in bringing healthcare practitioners in small cities/villages, condemn the II, III and IV type hospitals to the impossibility of

having good healthcare practitioners who are able to carry medical activities. It is said there is a problem of equity in accessing high quality services for all citizens of this country. On the other hand, we can invoke non-discrimination of people in what we call the right at *„the highest level of health"*.

Another major problem we have is the emigration of doctors and nurses. This is a loss because we might be in that situation of not having specialists to provide healthcare services and in the same time it is a major material loss.

After Romania became a Member State of the EU, in 2007, and after the opening of borders healthcare practitioners from Romania started to immigrate so that migration became a mass phenomena. According to the National Institute of Statistics, between 2007-2012 (the last year the information was made public) the public health system has incurred substantial losses in terms of medical staff.

►Physicians- 780
►Nurses – 22.940
►Midwives – 1.851
►Auxiliary medical staff – 5.077

According to the World Health Organisation if we compare situation in Romania with the situation in other European Countries, the lack of medical staff becomes more obvious. (data for 2011)

In Romania:
- Physicians: 2,4 per 1.000 inhabitants
- nurses and midwives : 5,5 per 1000 inhabitants

In Germany:
- Physicians 3,8 per 1.000 people
- nurses and midwives: 11,5 per 1000 inhabitants

In Switzerland:
- Physicians 3,9 per 1.000 inhabitants
- nurses and midwives: 17,4 per 1000 inhabitants.

Effects we can see today are cumulative effects. More than these, more and more people question the usage of money from the healthcare system.

On the one hand the lack of transparency regarding money collection by the state for a well functioning of the public health system has as effect the financing based on discretionari principles. On the other hand, the way money is spent in a health care system substantially politicized is leading to the same effect of the Social Health Insurance Fund.

As there is no private healthcare fund which can assure the population about an average level of income or about a high income, for the public health system financing, very well developed in the last years, leads to a decline in the public institutions' budget. Again, we can invoke the equity matter when it comes about access to healthcare services, because the public health system should be funded from the Public Health Fund. The private healthcare system should be fund from the private insurers funds. Private hospitals lay a high co-payment for their services. In this way, they are beneficiaries of the double financing for the provided services. On the other hand, public hospitals can lay just one single co-payment approved by law. More than this, private healthcare providers have their own prices for their services.

The co-payment issue should also be discussed. The question is why should an insured citizen pay an extra tax any time when he needs a medical service, taking into consideration the fact that he already pays a sum of money for the Health Insurance Fund. It is not a Romanian way of doing things. Co-payment is made as a second way of financing, but it can also determinate the insurant to think twice before going to the physician. In Romania, there is a belief that this mechanism might risk to stop the access for healthcare services to those who have a very low income. This issue requests a maximum of interest as long as there is a specific structure of morbidity in our country.

As a consequence that in Romania, as in many other developed countries, modern pathology caused by stress, an unhealthy diet as well as traumas caused by car accidents is more and more complex requesting a more and more expensive medication, on the other hand the recrudescence of some so called „disease of poverty", specific to undeveloped countries, disease like tuberculosis, syphilis, infections with haemolytic streptococcus bacteria (the first 3 labelled) more and more financial resources and support is concerned in the health system..

A high rate of mortality caused by cardiovascular diseases is of a special interest. Very important risk factors for this are high blood pressure, smoking, a high level of serum cholesterol, obesity, alcohol consumption, a lack of fruits and vegetables in diet, as well as physical inactivity are considered to be the main causes of death.

National Health Strategy 2014-2020 aims for ambitious objectives like developing services such as community healthcare services which suit better to the needs of vulnerable groups and for the main needs in the public health system. They also aim to develop the role of other services like primary medical care, ambulatory care and the health care provided for old people – as an anticipatory response to the demographic challenges we will face. The National Health Strategy 2014-2020 aims to improve the quality and the efficiency in the system investing in technology, in E-health, human resource and infrastructure. This is why an adequate administration of programs and planned interventions as well as monitoring and evaluation with the systematic analysis of the evolution in implementing the planned measures in order to reach results on a medium term and on a long term (the year 2020) are very important.

In some certain prioritised fields it is extremely necessary to elaborate some *strategies and/or sectoral strategic plans* according to the existent needs in Romania, beyond the assumptions and obligations that come from the European context, obligations which can potentiate the global strategy concerning the health system (Nita, 2003)

In the context of descentralization in the healthcare system, descentralization that will bring closer of the citizen's needs not just the decision and resources but the responsibility of decision making, and an important role will be played by the local authorities.

The decision and responsibility must be brought closer not just to the citizen but to those who are specialised in this field – specialists in public health and management, clinicians – close to those who represent professional associations and non-governamental organizations. This is why their implication in working groups and functional committees of experts who can contribute more in defining and implementing Health System Sectoral Policies is really necessary, but there is a necessity of this especially in monitoring and evaluating the achieved performances.

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