THE HUMAN RIGHTS OF OLDER PERSONS IN LONG-TERM CARE – ASPECTS REGARDING THE RIGHT TO HEALTH*

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Abstract:

Promovarea şi protecţia drepturilor persoanelor vârstnice trebuie să reprezinte o temă importantă pentru societatea românească, în condiţiile în care România se confruntă cu un proces rapid de îmbătrânire a populaţiei.

Standardele internaţionale din domeniul drepturilor omului subliniază necesitatea unei abordări integrate în îngrijirea persoanelor vârstnice, care să combine elemente de tratament preventiv, curativ şi de reabilitare a sănătăţii acestora. În acest sens, persoanele vârstnice aflate în centrele de îngrijire trebuie să aibă acces atunci când este nevoie la servicii medicale complexe furnizate de medicii de diferite specialităţi.

Cuvinte cheie: persoane vârstnice, drepturile omului, dreptul la sănătate, servicii medicale, centre de îngrijire.

Résumé:

La promotion et la protection des droits des personnes âgées devrait être un sujet important pour la société roumaine, car la Roumanie est confrontée à un processus de vieillissement rapide.

Les normes internationales relatives aux droits de l'homme soulignent la nécessité d'une approche intégrée des soins aux personnes âgées, combinant des éléments de traitement préventif, curatif et de réadaptation. À cet égard, les personnes âgées hébergées dans des centres de soins lorsqu'elles ont besoin, devraient avoir accès de services médicaux complexes fournis par des médecins de différentes spécialités.

Mots clés: personnes âgées, droits de l'homme, droit à la santé, services médicaux, centres de soins.

Introduction

Long-term healthcare services and facilities in today's Romania are regulated at several governing levels and implemented by different entities. Thus, in terms of social assistance, the system is a decentralized one, the Ministry of Labor and Social Justice and the General Directorates for Social Assistance and Child Protection being responsible for the implementation and supervision of the related legislation; as far as the healthcare system is concerned, the social health insurance system is intended to be a centralized one, the Ministry of Health being responsible for the elaboration of the national health policy, regulation of the healthcare system, etc.

Even though the national strategies elaborated so far stipulated improved links between healthcare and social protection services by means of a common, unified, long-term healthcare system, they had limited success and encountered difficulties with the implementation and application of the guidelines provided at national level.

The National Strategy for the promotion of active aging and the protection of old persons 2015-2020 refers to two priority objectives: to create a unified long-term care system and to provide the financial, human and infrastructure resources for that system. Also, alongside the Strategy, the Strategic Plan of Action for the implementation of the National Strategy was approved. The latter is a document that just resumes the strategic objectives and the corresponding measures provided for by the Strategy, without detailing them.

In Romania, the social assistance the State provides for elderly persons is of a subsidiary nature, while the family has the obligation to support and care for the elderly. The public sector, by its competent institutions, comes in only in the case of elderly persons who have no family, or whose family are partly or totally incapable to provide them support and care; in such cases, the public sector provides adequate social assistance and

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social services according to the elderly person's strict individual needs.

According to Law No. 292/2011 on social assistance, the central public administration authorities shall elaborate the legislative framework for social assistance such as to: support disadvantaged categories; combat poverty and the risk of social exclusion; develop policies meant to sustain the family for the life span of its members; elaborate programmes and strategies in the field and also regulate, coordinate and control their application; evaluate and monitor the quality of social services.

On the other hand, it is the duty of local public administration authorities to identify and evaluate the elderly persons' needs, to organize, plan and provide financing and co-financing for social and socio-medical services, while public and private social service providers have the duty to provide such services and abide by the quality standards.

Home care services[1]

As far as home care services are concerned, they have been promoted since 1990, particularly by non-governmental organizations, taking after the model offered by such services in Western Europe. In time, the Ministry of Labor and Social Justice issued a series of normative acts that give the possibility for public home care, both by creating the instruments required by the local authorities[2] to organize or subcontract the services and by subsidizing the social services provided by non-governmental organizations, in the framework of a central programme administrated by the Ministry itself[3].

In Romania, the providers of home care services may be: public (services managed by local or county public authorities); private, profit-making (companies, authorized natural persons); and private, non-profit (non-governmental organizations, organizations established by the religious cults).

Home care for elderly persons involves a combination of medical care and social services, while the regulation of these integrated services shall be so achieved as to allow for the largest possible number of persons to access high quality services, for a reasonable price. At the same time, the two types of services are regulated in different ways and by different entities in Romania.

Financing of the care services is achieved from multiple sources, given the way the various sub-components of care services (medical, social, etc.) are regulated. The general lack of facilities and services for elderly persons who need care was compensated only to a lesser extent by introducing cash paid specific tasks and the possibility to employ informal caretakers, including family members, as "personal assistants"[4]. The role of informal caretakers and the related supporting mechanisms have been hardly dealt with by the legislation.

According to the studies performed so far, the access of service providers to public financing stayed extremely unequal in time. Even though the legal framework has been progressively developed, when it comes to practice one may find that, if we refer to the medical component[5], there is unfair competition between the profit-making private service providers and the non-profit ones in terms of access to the sums reimbursed by the Health Insurance House. Profit-making service providers are often companies controlled by the physicians themselves or having preferen-

[1] In the year 2016, the Institute monitored eight national caring centres, 4 in the urban area and 4 in the rural area, 6 belonging to the public system and 2 to the private one, which resulted in a report. Also, the Institute's representatives participated in a number of meetings and discussions devoted to a scrutiny of the international and the regional regulations on the promotion and the protection of the rights of persons with disabilities, while organizing interviews with representatives of the central and the local authorities with powers in the field, and also with representatives of non-governmental and professional organizations.

[2] Law No. 17/2000 with its subsequent amendments institutes the framework for the evaluation of elderly persons' care needs.

[3] See Law No. 34/1998 on giving subsidies to the Romanian associations and foundations with legal personality that establish social assistance centres.

[4] See the World Bank Report, Living Long, Staying Active and Strong: Promotion of Active Ageing in Romania, 2014.

[5] The time span for which an insured person may enjoy home medical care services is specified by the physician who initially made the recommendation, who is also bound to specify the frequency/periodicity of the services, which shall not totalize 90 days of medical care for the last 11 months in several stages (healthcare episodes). A healthcare episode is maximum 30 days of healthcare.

tial relationships with the CNAS[6]. As far as the social component is concerned, public financing is too small as compared to the local needs. Even though cost standards[7] have been elaborated for recent years, there has been no clear estimation yet of the amounts local budgets should make available for such services and neither has there been an evaluation of the way services of local or county interest might benefit from short-term or long-term county or national co-financing. This is also so because of the lack of systematic and unitary evaluations by the local public authorities[8] of the actual social needs.

According to some studies, it is estimated that by the year 2060 the proportion of Romania's population aged 65 and above will be double, from 15% to 30%, which may entail a strong pressure on the costs represented by pensions, medical services and long-term care services. This will be accompanied by an opposite phenomenon in relation to the population segment aged 20 to 64, which is expected to go down by 30% by the year 2060, which is one of the most severe decreases in the EU[9].

Accessing long-term care

The process by which social services are provided shall include the following compulsory steps: a) initial evaluation; b) elaboration of the intervention plan; c) complex evaluation; d) elaboration of the individualized plan for assistance and healthcare; e) implementation of the measures laid down in the intervention and the individualized plans; f) monitoring and evaluation of the provided services.

The present procedure for the provision of social services to elderly persons is based on the National Chart for the evaluation of elderly persons' needs that was adopted under Government Decision No. 886/2000. The document details the criteria for including elderly persons into one of eight degrees of dependency. The latter is defined as the situation of a person who, as a result of having lost his/her autonomy for physical, psychical or mental reasons, needs significant help and/or care so that he/she might be able to carry on the basic day-by-day activities.

It is in terms of this evaluation that residential centres for elderly people are organized into sections for: dependant persons; half-dependant persons; non-dependant persons.

Right to health

Article 34 of the Constitution provides that "The right to the protection of health is guaranteed." Therefore, the State is bound to take measures to ensure public hygiene and health. As a result of the application of art. 20 para (1) of the Constitution, interpretation of this article should take into account the provisions of art. 12 of the International Covenant on Economic, Social and Cultural Rights[10], art. 25 of the Convention on the Rights of Persons with Disabilities and art. 11 of the revised European Social Charter.

The right to the protection of health is closely related to other fundamental rights: the right to life and physical and psychic integrity; the right to privacy and family life; the right to information; the right to a healthy environment.

According to the legal document on preventing and combating all forms of discrimination, the following are classified as crimes: discrimination of a natural person, a group of persons on the grounds of their affiliation […] with a certain race, nationality, ethnicity, religion, social category […], age, gender or sexual orientation consisting in the denial of a person's or group of persons' access to public healthcare services – choice of the GP, medical assistance, health insurances, emergency services or other healthcare services[11].

Law No. 95/2006 on the healthcare system reform is the normative act defining and specifying the State's constitutional and legal obligations to guarantee the right provided by art. 34 of the

[6] See *Organizarea sistemului şi furnizarea de servicii de îngrijire la domiciliu, în România (2015). Provocări,* Rețeaua Senior Net, p. 12.

[7] See Decision No. 978/2015 of 16 December 2015 on approving the minimal cost standards for social services, Appendix 4 – Minimal cost/year standards for home care social services for elderly persons.

[8] Idem.

[9] See the World Bank Report, Living Long, Staying Active and Strong: Promotion of Active Ageing in Romania, 2014, p. 7.

[10] See I. Muraru, E. S. Tănăsescu (coord), Constituția României. Comentariu pe articole, Ch Beck, 2008, p. 319.

[11] See art. 10 of Ordinance No. 137 of 31 August 2000 on preventing and sanctioning all forms of discrimination.

Constitution[12]. It details the way medical assistance and the healthcare social insurance system are organized in Romania, on the basis of contributiveness.

At the same time, the rights of patients were legislated under Law No. 462/2003, which stipulates that they "are entitled to medical caring of the highest quality that society can provide, in conformity with its human, financial and material resources". The patients' rights law acknowledges a wide range of patients' rights such as the right to refuse a medical intervention and the right to be informed about the consequences of his/her refusing or stopping the medical treatments. Also, in case the legal representative is requested to give his/her consent, the patient has to be involved in the decision making process, to the extent allowed by the patient's comprehension capacity.

However, the studies achieved in recent years show that in spite of the fact that norms have been issued for the application of this law, it is hardly known by patients, either out of ignorance or the insufficient information efforts taken by the Ministry of Health[13].

Also, Law No. 448/2006 on the protection and promotion of the rights of persons with disabilities provides that persons with disabilities, their families or their legal representatives are entitled to all information related to the medical diagnosis and the recovery/rehabilitation, all available services and programmes, in whatever stage the latter might be, as well as the rights and the duties in the field. In Romania, persons with disabilities enjoy free medical care, including free drugs, both for the ambulatory treatment and throughout hospitalization, in the framework of the social health insurance system.

According to art. 14 of Law No. 17/2000, centres for old persons provide *both* socio-medical services consisting of: assistance for keeping or readapting one's physical or intellectual capacities; ergotherapy programmes; assistance for the achievement of personal hygiene; *and* medical services consisting of: consultations and treatments in the surgery, in medical institutions or at the person's bed in case he/she is immobilized; infirmary caring services; acquisition of the medication; acquisition of medical devices; as well as stomatological consultations and treatments. The costs of the medical services, sanitary materials, medical devices and drugs are covered according to the legal provisions regarding the healthcare social insurance regulations.

At the same time, according to Government Decision No. 867/2015 on approving the Register of social services as well as the framework-regulations for the organization and functioning of social services, old persons homes also include among their services/activities current healthcare services provided by medical assistants or as the case may be and healthcare provided by a geriatrician, an internist or a GP, therapies for physical/psychic/mental recovery.

According to the legislation in effect, persons with disabilities are entitled to free-of-charge medical assistance, including free drugs, both for the ambulatory treatment and for the treatments in hospitals, in the framework of the healthcare social insurance system.

In its Country Report, the United Nations Committee on Economic, Social and Cultural Rights recommended that the State party should intensify its efforts to ensure de facto access to affordable, good quality and timely health care and medical treatment for all segments of the population, including persons living in rural and remote areas, as well as disadvantaged and marginalized individuals and groups[14].

According to the new Official List of social services[15], the homes for old persons provide current medical care services ensured by medical assistants as well as other medical assistance activities, as the case may be, ensured by geriatrists, internists or GPs and consisting of physical/psychic/mental recovery therapies.

At the same time, according to the Minimal Quality Standards – Standard on healthcare assistance, "the Centre shall enrol the residents with

[12] See I. Muraru, E. S. Tănăsescu (coord), op. cit., p. 320.

[13] See O. Popescu, Sistemul de sănătate şi drepturile sociale, IRDO, 2009, p. 49.

[14] See CESCR, Concluding observations on the combined third to fifth periodic reports of Romania, E/C.12/ROU/CO/3-5, p. 7.

[15] *Government Decision* No. 867/2015 of 14 October 2015 on approving the Official List of social services, as well as the framework rules for the organization and functioning of social services.

a GP or facilitate their access to a GP surgery". Also, where the Organization and Functioning Regulation of a Centre provides for medical services ensured by physicians, the Centre/service provider may employ one or several specialist physicians or may conclude service agreements with them.

In order for a person to enjoy free medical services (recommendation for examination by a specialist physician) and, at the same time, enjoy subsidized drugs, that person has to be registered with a GP who has an agreement with a Health Insurance Company.[16]

All visited centres have a form of collaboration with a GP/GP surgery where the residents are registered at the time of their admission. The actual possibility to choose a certain GP only exists in urban areas, where several medical services providers are available and where the residents coming from the same place as the Centre can keep their GP with whom they have already established a certain relationship.[17]

On the contrary, the rural areas are facing a scarcity of physicians which often results in one single physician taking care of the health of the citizens of 2-3 villages, communes, sometimes even more.[18] Nevertheless, two centres of the five visited in rural areas reported collaboration with two GPs with whom they had half time medical services agreements.[19]

The personnel in the visited centres reported various types of collaboration with the GPs. Thus, in four centres the physicians paid weekly visits observing the surgery schedule and whenever they were requested by the medical assistants. The interviewed residents confirmed that the GP paid visits when he was summoned. For more thorough examinations they were sent to the hospitals in the neighbourhood.[20]

In one of the visited public centres in the rural area there was a collaboration with the physician in the commune to which the village belonged (10 kilometres away). It was mainly a collaboration in terms of providing the residents with subsidized recipes, while the physician did not pay visits to the Centre to examine the patients. For any problem beyond the training of the medical assistants they used to call for an ambulance as

[16] According to art. X in the Framework Agreement stipulating the conditions to be met for enjoying medical assistance within the healthcare social insurance system for the years 2014-2015, patients are entitled to choose the medical service provider as well as the health insurance company with which they register, in compliance with the effective legislation and the Framework Agreement. They are also entitled to register with a GP of their own choice, provided that all the provisions of the effective legislation are met and covering the transportation costs if they choose a physician in a different place.

[17] "A resident may choose to keep his/her GP or, if he/she so wishes, transfer to the Centre's GP. They have this latter possibility, it is easier for them to get their subsidized medication. 80% of the residents are registered with the Centre's GP, the rest of them preferred to keep their GP but they bring the recipes to the Centre as well." – Head of Centre B (public, urban)

"I've stuck with my old physician for we know each other. Here the doctor comes and goes." – Resident Centre B (public, urban)

[18] See CNPV, Problematica vârstnicilor din mediul rural, 2015, p. 30.

[19] "The working hours of the physicians are everyday in the morning or in the afternoon, depending on the working hours at the private surgery. No physician would come full time because the salaries are very low. It was quite hard to find two persons willing to collaborate". – Head of Centre A (public, rural) (at the moment of the visit, neither physician was in the Centre)

[20] "Every time I come here I see them all, I prescribe the medication. Half of them are registered with me as their GP, the other half with another physician. I collect their health cards, prescribe their recipes, bring the cards back and the Centre takes care to acquire the medication on the basis of the recipes. A needed minimum can be found in the home itself. They possess a small pharmacy."

What are the medical services you provide? "Periodic examination and prevention. In case of acute diseases or controls for chronic diseases, we send them to the hospital (the ambulance or, for the regular controls, the Centre's car takes them there)." – Centre H halftime GP (public, rural)

"I wish I had a physician here, preferably a geriatrician, but a GP would also do; it is good to their mental state to have him see them every one or two days (it increases their pleasure of living, this means a lot). The physician who sees them at present is a GP and has a lot of patients, her surgery is 6 km away from the Centre (she is to be found there, at the surgery, everyday); if needed we phone, take a car and go there, but usually I ask her to come round. We have a good collaboration relationship. On the average, she comes to the Centre once a week, sometimes she comes twice a week, but then the next week you can't see her at all.

She has 3,000 patients, it's difficult. We tried unsuccessfully to find another physician. We collaborate a lot by phone, we send the files to her; in case of chronic diseases, we agreed to send the file 2-3 days in advance, she writes the recipe and sends it back to us." – Head of Centre C (public, urban).

the village was 30-40 kilometres away from the nearest hospital. The interviewed residents confirmed that they hadn't been visited by the physician for several months. At the same time, the specialized personnel believed that there was no need for a permanent physician within the Centre.

A particular situation is that of a private centre for old persons with somatic, neurological, associated and other diseases (hearing, visual) where, because of their diseases the residents enjoyed a caring and recovery programme carefully monitored by physicians. The Centre collaborated with two GPs, a psychiatrist and a neuropsychiatrist, while one physician was in the Centre every day.

According to the United Nations Committee on Economic, Social and Cultural Rights, healthcare services should be physically and safely accessible for all segments of population, particularly so for older people and persons with disabilities.[21]

Access to specialized services/physicians

The international human rights standards emphasize on the need for an integrated approach to the caring of older persons that should combine elements of preventive treatment with curative treatment and rehabilitation/health recovery treatments.[22] In this respect, older persons should have access to additional specialized physicians when needed, such as psychiatrists, geriatricians, stomatologists, gynecologists, etc.

Access to a geriatrician was practically inexistent in all the visited centres, from the absence of such a specialist from the multidisciplinary team initially evaluating older persons for admission in the Centre down to his/her absence from the hospitals where the residents were sent for various medical tests.

As far as the psychiatrist is concerned, most public centres provide access to such a specialist via the Directorates to which they are subordinated. Either the specialist is brought to the centre to evaluate/re-evaluate the residents periodically (some centres reported re-evaluations made every month while others couldn't specify a clear time period) or the residents are sent to the surgery when there are changes with their behaviour and need to have their treatment altered.[23]

In a private centre for older persons with neurological diseases, the residents are carefully monitored, the psychiatrist collaborating with the centre having special training for insanity cases.

All the visited centres, public and private, reported that residents presenting changes of behaviour were sent to be examined by a specialist.

According to the Minimal Quality Standards, a residential centre should provide **recovery/ rehabilitation programmes** in order to maintain or improve the resident's functional autonomy. Access to physiotherapy and physiotherapy services, which could have an important role with the recovery of the residents, is achieved in different ways. Thus, four of the six visited public centres for older persons offer, through the DGASPC to which they are subordinated, access to such services organized within recovery centres. Access is achieved on the basis of appointments and waiting lists, in some centres the number of those who come to actually benefit from such services being relatively small. One single centre had its own surgery equipped for such services and the residents confirmed that they used them.

In a single visited public centre the residents did not have access to such services. A woman who could walk with the help of a walking frame explained that she was discontent with the fact that there was no room devoted to such services and that she had to give her the massage herself. The personnel confirmed that the centre lodged several residents with sequelae of stroke who needed physiotherapy services.

The visited private centres provide such services for the older persons under their care at their own premises. This is achieved either by the voluntary work of specialists in the field, or the collaboration with a Faculty of medicine offering the students the possibility to perform their com-

[21] See CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para 12. b.

[22] See CESCR, General Comment No. 6 on the Economic, Social and Cultural Rights of Older Persons.

[23] "There was a resident who became violent because of his disease, so we called for an ambulance to take him to specialized hospital Y; we call for an ambulance when the working hours are over or in special cases. The patient was examined by the physician in the hospital and was given a different treatment, was not hospitalized. There haven't been any problems with that patient ever since". Head of Centre (public, urban)

pulsory practice activities in the Centre, or a paid collaboration with a specialist.

Transportation to the places where specialized services are provided is made by the Centre's/ Directorate's car if the resources are sufficient. Where there are public transportation services, and the Centre's resources are limited, autonomous persons also use the public transportation system.

Conclusions

The socio-medical assistance for elderly persons faces the problem of the lack of specialists (social workers, geriatric physician), who should initially and periodically evaluate the elderly people and make recommendations for the development of the individual intervention plan.

It was noted that the multidisciplinary team envisaged for the resident's evaluation and revaluation stages does not function properly so that in most of the cases the evaluation, the decision and the implementation of the care needed by the respective resident become fractioned without an efficient communication between specialists.

There is need for a higher degree of consultation with the elderly regarding all aspects concerning them directly and at the level of public policies. It is necessary to empower all the groups of representatives at all levels (local, county, national) since their involvement is needed in the evaluation of the services needs at the community level.

It is important to diminish the massive phenomenon of migration of qualified staff and it is necessary to correlate strategic actions in the field of services for the elderly with those of youth employment, combating poverty and migration.