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MASTER-THESIS

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“Constitutional guarantees of the basic level of health care in Latvia: Myth or reality?”

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Abstract *(English)*

The Article 111 of the Constitution of Latvia (Satversme) defines: “The State shall protect human health and guarantee a basic level of medical assistance for everyone.” Does it mean in the reality that the state explicitly guarantees the right to health, medical services, or public health to all citizens? After 25 years of regaining its independence, the Latvian health system is still in transition. Some reforms and policy initiatives are still in progress or under development. At the same time according to the social studies and the national reports, accessibility to the medical service in Latvia is much lower than in the other EU countries. The example discussed in this research shows cases in practice where the state does not provide the necessary treatment, even when human life is at stake.

What "the basic level of medical assistance for everyone" set by the constitution, implies, continues to be a topical issue in this context. The national law of Latvia does not provide a definite answer to this question.

The focus of this thesis is to observe the problems in the legal regulation in Latvia concerning the fundamental rights to health, as well as analyse the case law of the Latvian Constitutional Court and the practical application of the national laws. In this context, the compliance of the Latvian laws with international human rights standards as well as examples of good practice of the neighbouring country Estonia will be evaluated.

Abstract *(German)*

Der Artikel 111 der Verfassung Lettlands (*Satversme*) definiert: "Der Staat soll die menschliche Gesundheit schützen und eine medizinische Grundversorgung für alle Menschen gewährleisten." Bedeutet dies in der Realität, dass der Staat explizit das Recht auf Gesundheit, medizinische Dienstleistungen beziehungsweise ein öffentliches Gesundheitswesen für alle Bürger garantiert? 25 Jahren nach Wiedererlangung der staatlichen Unabhängigkeit ist das lettische Gesundheitssystem noch in Umwandlung begriffen, einige Reformen und politischen Initiativen sind noch im Gange oder noch in Vorbereitung. Entsprechend aktueller Studien und nationaler Berichte ist die Zugangsmöglichkeit zu den medizinischen Dienstleistungen in Lettland viel niedriger als in den anderen EU-Ländern. Das Beispiel dieser wissenschaftlichen Arbeit zeigt, dass es Fälle in der Realität gibt, in denen der Staat nicht die notwendige Behandlung ermöglicht, insbesondere auch in Fällen, in denen das menschliche Leben auf dem Spiel steht.

Das bedeutet, "die medizinische Grundversorgung für alle Bürger", festgelegt durch die lettische Verfassung, ist nach wie vor ein aktuelles Thema. Das lettische nationale Recht gibt derzeit keine klare Antwort auf diese Frage.

Schwerpunkt dieser Arbeit ist es, sowohl die Probleme in der lettischen Gesetzgebung bezüglich der Grundrechte in der medizinischen Versorgung aufzuzeigen, als auch die Rechtsprechung des lettischen Verfassungsgerichts und dessen praktischen Anwendung zu analysieren. In diesem Zusammenhang wird die Einhaltung der lettischen Gesetze mit internationalen Menschenrechtsstandards verglichen, positive Beispiele des Nachbarlandes Estland werden analysiert.

Abbreviations

CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
CoE	Council of Europe
ECHR	European Convention for the Protection of Human Rights and Fundamental Freedoms
ECtHR	European Court of Human Rights
ECSR	European Committee of Social Rights
EHIF	Estonian Health Insurance Fund
ENHP	Estonian National Health Plan
EPAA	Estonian Patient Advocacy Association
ESC	European Social Charter
EU	European Union
ICESCR	International Covenant on Economic, Social and Cultural Rights
OECD	Organisation for Economic Cooperation and Development
OOP	Out-of-pocket
NHS	National Health Service
NGO	Non-Governmental Organization
PHA	Pulmonary Hypertension Association
PIT	Personal income tax
TUHSCEL	Trade Union of Health and Social Care Employees of Latvia
UDHR	Universal Declaration of Human Rights
UN	United Nations
WTO	World Trade Organization

Introduction

The right to health has been included in the human right discussion for a significant period. The capacity to live a healthy life is a necessary precondition for enjoying many other fundamental rights, such as the rights to human dignity, life, non-discrimination and equality, privacy, food, housing, water and sanitation, work and education, healthy environment and access to health information. The UN Committee on Economic, Social and Cultural Rights in its General Comments No.14 (2000) has stated, "Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conductive to living a life in dignity."[1] From this statement, I would particularly like to emphasize the words "enjoyment of the highest attainable standard of health," which are essential in the further context of this entire research.

A modern and globally recognized definition of human health is included in the Constitution of the World Health Organization, which determines: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[2] This definition includes a complete state of human well-being, which is very challenging to achieve in real life because most people have physical, mental or social problems.

Moreover, it should be noted that disease often occurs suddenly and unexpectedly, turning life upside down. In sickness we are fragile and need to be taken care of, we need support. Life takes a different colour - hospitals, blood tests, doctors' council, pharmacies and medication. A situation when one has fallen ill with a rare or prolonged sickness unfortunately often goes hand in hand with low income or even a financial catastrophe for the whole family. At least such is the current reality in Latvia.

For example, planned operations in Latvia in the majority of cases are paid service. Sadly, pain is not a criterion either to receive an immediate operation from the state budget. If a person has no savings or the family is not well off, then he/she will suffer from pain for years and will use strong painkillers that damage other organs. It is also important to fall ill with „the right sickness" the medication of which is

[1] UN CESCR General Comment 14, The right to the highest attainable standard of health: 11/08/2000. E/C. 12/2000/4, paragraph 1.
[2] WHO Constitution. Preamble.

included in the list of drugs funded from the budget or for which treatment the necessary medical care is paid by the state. Otherwise, as it will be apparent from the examples given in this research, an option to receive even the most needed state support is prevented (see Subchapter 4.3).

After independence in 1991, Latvia initially moved to create a social health insurance type system. However, problems with inefficient financing and decentralized planning led to the establishment of a National Health Service type system in 2011. But already in 2013, the Latvian health care system was in an expectation of new reforms, which provided the introduction of the state compulsory health insurance payments. These constant changes have taken place against a backdrop of relatively poor health and limited funding, with a heavy burden for individuals; Latvia has one of the highest rates of out-of-pocket expenditure on health in the European Union (EU). [3]

My attention to these problems of the health care system in Latvia was drawn by an accidental meeting here, in Austria, with a woman from Latvia who underwent surgery in the General Hospital of Vienna University on 16 April 2014. Zane is the first inhabitant of Latvia that has undergone lung transplantation, and the transplantation was successful. Three years ago she was diagnosed with a rare and life-threatening disease. At the end of 2013 after performing investigations, both the Latvian and Austrian doctors gave a united but harsh prognosis – the disease is progressing and it is of utmost importance to perform lung transplantation in the coming months. The only hope for Zane was to undergo lung transplantation, which is not offered in Latvia and is not included in the basket of the state funded medical services. The provisional costs of this operation were amounting to 120'000 EUR.[4] The woman turned to the National Health Service with a request to co-finance the life-saving lung operation, but received a refusal. By the help of the local charity fund „ziedot.lv" the necessary amount of money was collected in less than a month.[5]

[3] Mitenbergs U, Taube M, Misins J, Mikitis E, Martinsons A, Rurane A, Quentin W. Latvia: Health system review. *Health Systems in Transition,* 2012; 14(8): 1 – 191

[4]According Central Statistical Bureau of Latvia data average monthly wages and salaries in Latvia at 2014 was 560 EUR (net). Available at: http://data.csb.gov.lv (accessed 20.06.2015)

[5] "After lung transplantation Zane returns to Latvia" (in Latvian), Available at: https://www.ziedot.lv/jaunumi/pec-plausu-transplantacijas-latvija-atgriezas-zane-4075 (accessed 25.05.2015)

Through this case, I found that the problem of rare diseases is an inevitable consequence of the weak legislation of the health system linked to state-guaranteed medical assistance. This case raised a series of questions, firstly: is the price of life in the Latvian health system too high and the state cannot afford it? Is it acceptable that someone's life depends solely on the compassion and solidarity of the society, whereas the state holds no responsibility because the Law does not provide it? This case stirred up considerable debate (see Subchapters 4.3, 4.4), also including debate about the constitutionality of the refusal.

Research questions

The main research question raised within the framework of this Master's thesis is already included in its title "Constitutional guarantees of the basic level of health care: Myth or reality in Latvia?" While living in the Soviet Union under the totalitarian regime with an ideal constitution, people in Latvia were accustomed to such myths. It should be noted, however, that most of that myth was related to the civil and political rights area. Some social, economic and cultural rights, including the right to health, were guaranteed for everybody in sufficiently good level. It was a reality for which the so-called "social state" paid with the money and the people paid with their civil and political freedoms at that time.

After 25 years of regaining its independence, the Latvian health system is still in transition. What in the meantime has changed? Some reforms and policy initiatives are in progress or under development. At the same time according to some social studies and national reports accessibility to the medical service in Latvia is much lower than in the other EU countries.[6]

The right to health has found its way into the Constitution of Latvia (*in Latvian - Satversme*) - Article 111 defines: "The State shall protect human health and guarantee a basic level of medical assistance for everyone."[7]

What does it mean "the basic level of medical assistance for everyone" set by the constitution, continues to be a topical issue in this context. Latvian national law does not provide a clear answer to this question. Therefore, it would be desirable to

[6] Supra note 3; OECD (2014), Health at a Glance: Europe 2014, OECD Publishing. Available at: http://dx.doi.org/10.1787/health_glance_eur-2014-en (accessed 15.07.2015).
7 The Constitution of the Republic of Latvia.

analyse the national regulations on this matter in some other countries. Within the limited scope of the Master's thesis, for comparative analysis I have chosen just one state and that is Estonia, whose health system according to some experts is considered to be example of best practice among the three Baltic countries.[8] Of course, the financing and delivery of health care differ across the two countries. However, it also raises some similar issues and questions.

Focus of my research is to analyse the problems in legal regulation in Latvia concerning States guaranteed rights to health care, as well as to review case law of the Latvian Constitutional Court and the practical application of national laws. Also compliance of Latvian legislation and jurisprudence with international human rights standards will be analysed. To answer the research question, a detailed analysis of the current situation in the health care system in Latvia and recent developments in it also is necessary.

Outline of the structure

The thesis is organized into five chapters. The first chapter gives a brief overview of the health system in Latvia. The second chapter concentrates on national legal framework of the notion "the minimum health care" by looking at the historical background of this notion, its content provided by national legislation and its application in the practice of the Constitutional Court.

The third chapter is devoted to the analysis of the international and regional standards, which is crucial for better understanding of the right to the health issue and its implementation. The goal of the third chapter is to evaluate these standards through the lens of case law and interpretations given by relevant enforcement institutions.

The fourth chapter will provide an overview about the accessibility of health care to everybody in Latvia, highlight some problematic aspects in this respect and observe the consequences.

The fifth chapter is devoted to the comparative analysis of the Estonian health care system as an example of best practice among the three Baltic countries by looking for possible solutions to the Latvian health system improvement.

[8] 2013 Annual Conference of the Ombudsman [online video in Latvian], Rīga, 11.12.2013. Available at: http://www.tiesibsargs.lv/petijumi-un-publikacijas/galerija/tiesibsarga-2013.-gada-konferences-video

Methodology

The primary research method of the work will be the study of Latvian national law and case law. The case law of the Constitutional Court as well provisions of the International treaties and documents – general comments, recommendations and observations concerning the situation of the right to health in Latvia will be analysed.

A comparative analysis of the legislation of Estonia will be conducted. As a result, the problems in national laws will be identified.

As for empirical information there will be several sources used – political documents adopted by the government of Latvia, international reports, internal information from institutions and documents of internal use. There were six semi-structured interviews conducted as well – two with the officials of Ombudsman institutions in Latvia and Estonia, two with the representatives of NGO and a Trade Union, one with the sworn advocate and one with a private person as a patient.

Legal literature, conference proceedings and opinion of legal and medical experts will be used as a secondary research source. At the same time it should be recognized that the right to health protection have so far drawn little attention in the Latvian legal literature.

Chapter 1. Overview of the health system in Latvia

As it is clear from the present one of the most extensive and comprehensive researches on the Latvian health system – Health System Review (2012), the Latvian health care system has undergone a remarkable process of transformation in the 25 years since independence. An impressive number of reforms were carried out in the period between 2007 and 2012. This has led to: (1) the development of a more centralized system with state functions consolidated in fewer institutions; (2) the establishment of one central institution for purchasing health care – the National Health Service (NHS); and (3) a health care delivery system with a strong focus on

primary care (and substantially fewer hospitals).[9] The key components of the health system are shown in Fig.1. [10]

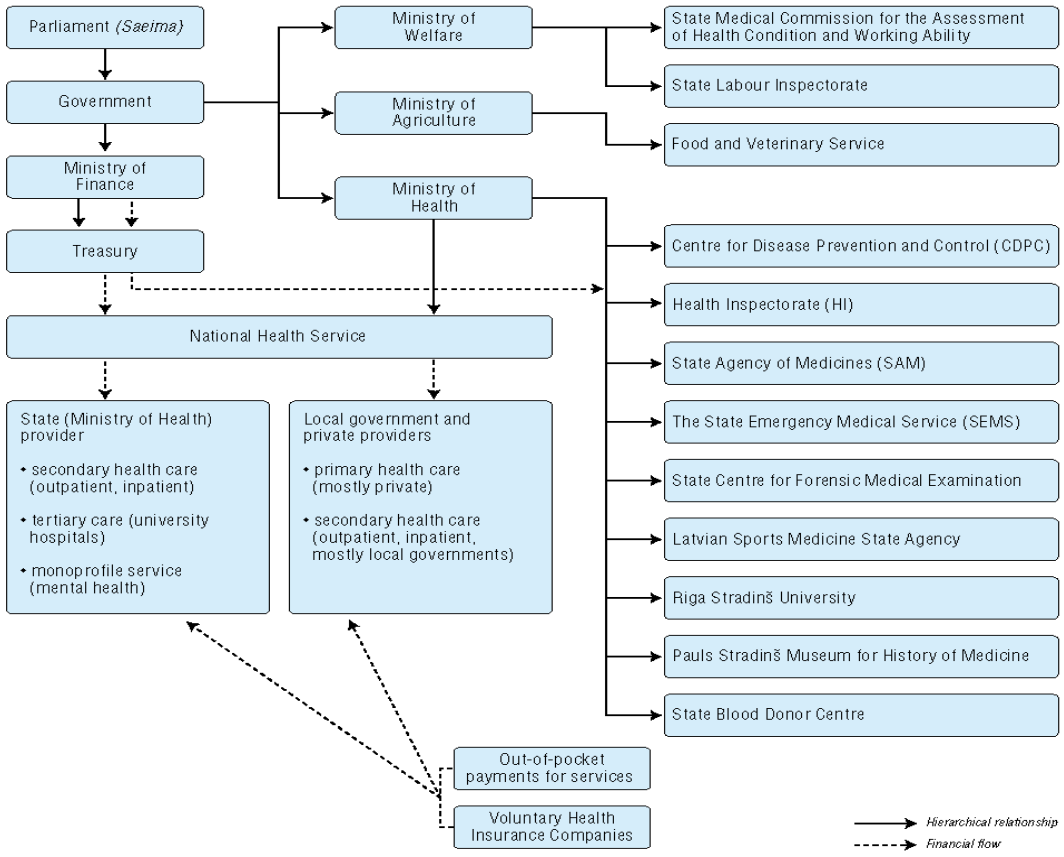

Figure 1

In general, the Parliament passes laws such as the Medical Treatment Law, which sets the framework for regulation of providers, pharmaceuticals and medical devices, while more specific regulations for each of these fields are defined by the Ministry of Health and approved by the Cabinet of Ministers. The Ministry of Health handles national health policy, its priorities and the overall organization and functioning of the health system. The independent institution NHS implements state health policies and ensure the availability of health care services throughout the country. Regulatory functions (standard setting, monitoring, enforcement) are predominantly concentrated in the hands of the central government, i.e. the Parliament and the Ministry of Health and its agencies (see Fig.1). Also, some regulatory

[9] Supra note 3, p.18.
[10] Ibid. p.19.

functions in the area of education and accreditation of physicians are delegated to the Latvian Medical Association.

The health care system is based on general tax-financed statutory health care provision, with a purchaser–provider split and a mix of public and private providers. Resources are raised mainly through general taxation by the central government, but Out-of-pocket (OOP) payments are important as well. Money flows from the Ministry of Finance to the NHS, a state-run organization under the Ministry of Health, which acts as the "pooler" of health funds and the main purchaser of health services. The NHS contracts with a variety of service providers, which may be public or private. [11]

The current organizational structure of the health care system of Latvia, its recent reforms, and the constitutional regulation are grounded in Latvia's history.

During Latvia's first period of independence (1918–1940), two health insurance laws were passed defining responsibilities of the state and regulating sickness fund structures, medical and cash benefits, fund revenues and fund governance. There were three types of sickness funds: independent, occupational and territorial, which together provided coverage to about 18% of the population in 1938.[12]

In 1940, Soviet troops occupied Latvia and the economy and the social system were reorganized according to Soviet principles. The so-called Semashko system, which was tax based, vertically organized and centrally administered and planned, replaced the social insurance system. Large hospitals were constructed, specialization of providers was promoted, and there was a strong focus on infectious disease control through hygiene and sanitation. The system provided coverage for the entire population, with a high level of equity, but with the relatively low quality of care. Separate outpatient clinics, hospitals, and spa institutions, providing a better quality of care, were established for Communist Party officials and representatives of the government and their families. [13]

In 1990, the independence was re-established. Initial reforms of the health system focused on decentralization and attempted to diminish the role of the state. In 1993, a major reform was set in motion that fundamentally changed the structure of the health care system. It aimed to transform the centrally planned system with budget

[11] Supra note 3, p.xviii.
[12] Ibid. p.20.
[13] Ibid., p.20.

allocations based on beds and personnel numbers to a social insurance type system with a purchaser–provider split and services paid for on a free for service basis. [14]

In terms of health care system financing should be noted that there are four principal types of health care financing available: 1) by alloting a specific part of the collected taxes; 2) by alloting a certain part of a specific compulsory tax (usually the social tax), often referred to as the state compulsory health insurance; 3) by voluntary health insurance (usually by means of private funds); 4) by direct payments made by patients.[15]

The experience of the Western countries shows that the first two types of financing ensure a greater equality of the public and are, in essence, equivalent. The main principle determining it: the more clearly resources are distributed from the wealthy groups of the population to the poor ones by means of a financing mechanism, the more equal access to health care the system ensures. For the first two types the main prerequisite for a sufficient state health care financing is the political will of a government to ensure adequate distribution of tax revenues. Consequently, when usin either the first or the second type of financing, it is the government's decision to employ a recognized international practice rather than the type of financing itself that determines the result.[16]

The first type of financing is currently employed in Latvia, but 14 years ago the second type was used – the state health care budget consisted of 28.4% of the personal income tax (PIT) and the government grant. It turned out to have two drawbacks. The first – collecting an insufficient amount of PIT resulted in a „hole" in the budget; second – the government held the opinion that in such cases increasing the amount of the government grant in order to balance the health care budget is not necessary; as a result, it was impossible to plan the industry work. Due to the above reasons the model of financing was changed.[17]

[14] Ibid.
[15] V.Keris "Latvian health care in Myth and Reality" (in Latvian), Doctus, October 2011, Available at: http://www.doctus.lv/2011/10/latvijas-veselibas-aprupe-mitos-un-realitate (accessed 14.05.2015)
[16] See WHO Regional Office for Europe. The European Health Report 2002. WHO Regional Publication, European Series, No 97.
[17] Supra note 15.

Chapter 2. Constitutional framework of the minimum health care

2.1. Definition of Terms

In Article 111 of the Constitution, several terms pointing to the constitutional rights to be protected are included. The duty bearer – the state – is determined, and the state holds the obligation arising from this norm. People collectively and each one individually may enjoy the rights provided in the Article. On the basis of the grammatical construction of the Article Dr.iur. S.Olsena, the author of a commentary on Article 111, concludes that the first part of the Article ("*The State shall protect human health"*) refers to protection of the public health as a collective way of health protection and second part of the Article *("[the State shall] guarantee a basic level of medical assistance for everyone"*) is devoted to protection of a particular person as an individual value to be protected.[18] With the limitations of the size of the Master's thesis in mind, questions related to the notion and contents of the public health protection, in general, will not be addressed, except for the cases when a more detailed analysis is required due to their relevance to the principal theme of the thesis. In accordance with the research question brought forward, henceforth the attention will be focused on issues related to provisions set forth in the second part of Article 111 of the Constitution.

In this part of the norm the individual rights of a person are referred to, i.e., the state guarantees medical assistance for „everyone". Medical assistance is the assistance that may be reached by using the realizations grounded and based on the medical science. Medical assistance in its broadest sense is often referred to as „health care", thus showing the goal of this aid – to impact the human health and by means of tools approved by the medical science carry out the necessary measures to enhance and improve the human health. It should be noted that the term „medical assistance" is not defined in the legislative enactments of the Republic of Latvia, it is broad, and in order to explain it, the definitions of the terms „health protection" and „health care" should be used.

[18] Commentary on the Constitution of the Republic of Latvia. Chapter VIII. Fundamental Human Rights. Rīga: Latvijas Vēstnesis, 2011, p.611.

Article 3 of the Medical Treatment Law defines that "health care is the complex of measures for ensuring and maintaining health".[19] According to a definition of the Council of Europe "health care" means the services offering diagnostic, preventive, therapeutic and rehabilitative interventions, designed to maintain or improve a person's state of health or alleviate a person's suffering. This care must be of a fitting standard in the light of scientific progress and be subject to continuous quality assessment.[20]

In Article 111 of the Constitution, the term „basic level" (in Latvian: "minimums") is used. In the Latvian language dictionary it is explained as follows: „basic level – the lowest required, the lowest value".[21] When interpreting the norm grammatically only, one may conclude that the norm provides for the assistance of the smallest volume, the smallest amount or value. However, by using other methods of interpretation, one must conclude that the term used in the Article should not be interpreted as the smallest amount of medical assistance, e.g., only emergency medical care. The idea of the limited possibilities to provide the medical aid that the state has due to restricted financial resources is reflected in the notion under analysis. According to some legal experts the notion „basic level of medical assistance" has to be interpreted in a broad context, examining whether the decisions by the legislator and executive branch that restrict the public rights to receive health care are grounded, just and proportionate.[22]

The grammatical meaning, definitions and explanations of notions referred to in Article 111 of the Constitution are significant when the norm is applied, nevertheless it should always be taken into account that Article 111 of the Constitution and the notions referred to in it are broad and to be interpreted in a given context, by taking into account both the facts and the realizations established in the legal theory. In order to clarify the meaning of a notion of the Constitution in Latvia, the

[19] Medical Treatment Law; 12.06.1997.
[20] Explanatory Report to the Convention on Human rights and biomedicine, http://conventions.coe.int/Treaty/en/Reports/Html/164.htm.
[21] Latvian language dictionary. 2nd edit. Rīga: Avots, 1998., p.485.
[22] Prof. Dr.iur.hc E.Levits, Dr.iur. S.Olsen presentations in the Academic seminar "Access to Healthcare – the Possibility to Implement the Rights Provided by the Constitution and by the laws", organized by the Faculty of Medicine of the University of Latvia, Rīga, 15.December 2014.

Constitutional Court case law, forming the basis for the future application of the norm, plays a particularly significant role (see further in subchapter 2.4.).

2.2. Historical background

The rights for health and the rights for health care were not mentioned in the pre-war constitutional documents of Latvia.[23] Although the initial bill consisted of two parts, the second part - which regulated citizens' rights and obligations - was voted down; a chapter on fundamental human rights was added only by amendment in 1998.[24]

By drafting a chapter VIII on fundamental human rights on May 19, 1997, the Drafting Commission of the Human Rights Department by the Parliament has discussed the adequacy of the notion „basic level of medical assistance". Proposals to cross out the notion „basic level of medical assistance" and to cross out only the words „basic level" have been brought forward. The Parliament kept the notion „basic level of medical assistance" without further explanation and specification.

However, research on the development of the Article shows that the legislator has coordinated the rights provided in the norm with the rights provided in Article 12 of The International Covenant on Economic, Social and Cultural Rights on ensuring human health protection. By setting the rights for everyone to receive the basic level of medical assistance, the legislator provided that the rights are not restricted solely to the emergency medical care, but are guaranteed on an unspecified, but larger scale not defined in the norm. The author of the commentaries on Article 111 of the Constitution, Dr.iur. S.Olsena, concludes that the obscurity of the notion „basic level of medical assistance" has been paid attention to, but the norm has not been developed more specifically. Thus the legislator has intended to specify the notion by issuing additional legislation and giving the opportunity by the implementation of the rights to

[23] "The Constitution of the Republic of Latvia (Latvian: *Satversme*) is the oldest Eastern or Central European constitution still in force and the sixth oldest still-functioning republican basic law in the world. It was adopted by, as it states itself, the people of Latvia, in a freely elected Constitutional Assembly, on 15 February 1922 and came into force on 7 November 1922. It was influenced by ideas of the Weimar Constitution and Swiss Federal Constitution." Available at: https://en.wikipedia.org/wiki/Constitution_of_Latvia

[24] The Amending law of the Constitution of 15 October 1998.

interpret the norm of the Constitution in each specific case and to specify its contents individually.[25]

2.3. Content of minimum health care provided by the Constitution

Article 111 of the Constitution provides both the rights for the general health protection and a guaranteed minimum medical care. Nevertheless, the constitutional norm does not provide any indication as to what a guaranteed minimum medical care encompasses. In order to find out the essence of the term „a guaranteed minimum medical care" in the context of the duty to protect health, this norm has to be analysed from a systemic, historical and teleological perspective. For a systemic interpretation of the norm, the laws and regulations have to be applied in their interconnection. By doing so, it is important to follow and apply the internationally acknowledged principles of law in the field of health care rights (for details see subchapter 2.4.).

Currently in Latvia the essence of the term „minimum medical care" is enshrined in the Medical Treatment Law and the Regulations of the Cabinet of Ministers on medical care to individuals or specific groups of individuals. In accordance with Article 4 of the Medical Treatment Law the Cabinet of Ministers is authorised to provide the procedure for organizing and financing medical care, the order of organizing the waiting list of the candidates for receiving a planned medical service, the types and amount of the medical service that is financed from the state budget and the service receivers' budget, as well as the terms of payment. Based on the first paragraph of Article 4 of the Medical Treatment Law, the Cabinet of Ministers has issued Regulation No 1529 „Health care organization and financing" of 17 December 2013.[26]

Article 16 of the Medical Treatment Law provides everyone's rights for emergency medical care in accordance with the procedure set out by the Cabinet of Ministers. Article 17 of the Law provides the persons having the right to receive medical service paid from the state budget. Those are Latvian citizens and non-

[25] Supra note 18, p.614.
[26] Regulations of the Cabinet of Ministers No 1529 „Health care organization and financing" of 17 December 2013.

citizens, the EU, EEA and Swiss citizens, foreigners having acquired residence permit, refugees and persons having acquired the alternative status.[27]

Several laws and regulations provide persons' rights to receive free medical care. For example, the Medical Treatment Law stipulates that children have the right for receiving medical service paid by the state free of charge.[28] Assistance in child delivery[29] and vaccination in cases provided by the Cabinet of Ministers is provided free of charge.

2.4. Application in the practice of the Constitutional Court and relationship with other provisions of the Constitution

The right to health is a social rights. The Constitutional Court has admitted that in ensuring this right the extent of the state duties may be dependent on the resources available to the state.[30] Likewise, the state employs a broad discretion to choose the way in which it will fulfil its commitments within the scope of its limited resources. Nevertheless, this discretion to choose is not limitless.[31]

For example, in the lawsuit on prisoners' nutritional quotas the court has concluded: "the duty to ensure nutrition to persons in custody, by its nature, excludes the option to retreat from its fulfilment, as well as restricts the state's freedom of action in this area."[32] But after hearing the case on ensuring expensive medication free of charge, the Constitutional Court has concluded: the international practice of applying human rights law proves that the rights to health do not impose on the state the obligation to provide everyone with the necessary medication free of charge. Such an obligation is not derived from the rights to life and rights to private life either.[33]

Without questioning the close relevance of the realization of the social rights with each state's capabilities, it is nevertheless worth taking into account the following realization – if any social rights are included in a state's constitution then the state may

[27] Supra note 19.
[28] Ibid., Article 17, Part 4.
[29] Sexual and Reproductive Health Law of February 19, 2002, Article 4.
[30] The Constitutional Court. 2008-27-03. 29.09.2008. Paragraph 12.1.2.
[31] The Constitutional Court. 2001-12-03. 07.01.2010. Paragraph 8.3.
[32] Ibid.
[33] The Constitutional Court. 2008-27-03. 29.09.2008., with the references to ECtHR decisions in cases Nitecki v. Poland 65653/01, 21.03.2002; Sentges v. the Netherlands 27677/02, 08.07.2002; Pentiacova and Others v. Moldova 14462/03, 04.01.2005.

not abdicate them. These rights are not of a declarative nature only.[34] The Latvian legislator and executive may not refuse to provide health services, as the rights to receive them are included in the constitution. It is therefore particularly important to figure out the quantitative and qualitative value of the term „minimum medical care" included in Article 111 of the Constitution with regard to the rights of each inhabitant of Latvia to ask for and to receive medical care paid by the state. Firstly, it is noted that in order to fulfil the obligation provided in Article 89 of the Constitution[35] it should be a common priority of the state and the ruling politicians to implement the constitutional rights, including providing medical care.

Secondly, the state power or politicians making decisions about the funding to be allotted to medical care have to respect and fulfil the highest principles of a socially responsible democratic state provided in the Preamble[36] and in Article 1 of the Constitution – „Latvia is an independent democratic republic". Namely, the duty of the state power is to distribute the public money collected from the people rightly.[37] For fulfilling the constitutional rights, the appropriate amount of budgetary resources shall be ensured to enable the fulfilment of the particular rights. Therefore, when analysing the qualitative and quantitative contents of the term „minimum medical care", it should be evaluated if in each specific case (e.g., in a court action) or overall justice is ensured. It is a fact that in Latvia the legislator and executive allocates up to 3.5% from the state budget to medical service for an extended period, whereas in other European countries – on average twice as much is allocated.[38] It is obvious that in those countries where considerably more budgetary resources are allotted to health care, other constitutional rights, e.g. the rights to a fair court trial or education, are by no means ignored. It is therefore assumed that the political decisions related to resource allotment for health care do not respect the state's obligation to distribute the public resources to provide the constitutional rights rightly.

[34] The Constitutional Court. 2000-08-0109. 13.03.2001.
[35] Article 89: "The State shall recognise and protect fundamental human rights in accordance with this Constitution, laws and international agreements binding upon Latvia."
[36] The Preamble: "Latvia as democratic, socially responsible and national state is based on the rule of law and on respect for human dignity and freedom; it recognises and protects fundamental human rights and respects ethnic minorities."
[37] E.Levits, "Constitutional law problems from a socially responsible state "überprinzip" standpoint", Proceedings of the IX Bīriņu Seminar of the Constitutional Law policy, organised by the Public Law Institute, Bīriņi, 25.-27.July 2012.
[38] Supra note 3, p., V.Keris, email, 03.07.2015.

At the same time, the Constitutional Court has also mentioned that it is the state's obligation to reach a just balance in allocating the financial resources to health care by observing the necessity of isolated cases where patients need expensive medical service and the general necessity to ensure access to health care to as many in the society as possible.[39]

Thirdly, in Latvia the Cabinet of Ministers, which is the executive, but is not the legislator, has vast rights to determine the amount of health care available to the public. Until now the legislator has not adequately taken care of ensuring the amount of health care to the public in the Primary legislation as provided by Article 111 of the Constitution. In the opinion of many experts the situation when the executive branch has the right to issue regulations at the level of Secondary legislation that provide the degree of fulfilling the constitutional rights and sets its limits is in contradiction with Article 64 of the Constitution on the legislator's power in Latvia.[40] One of the reasons could be mentioned that the legislator in a case when the resources available to the state shrink should carry out particular legal analysis. To legally prove the reduction of the available level of medical service, the Law (as a source of the Primary legislation) should be amended by carefully considering the requirements of equity and protection of the public interests. It should be noted that reforms might not result in disentitling or considerably reducing the rights of the public to receive the necessary medical service. When carrying out structural reforms, it should be ensured that access to medical care is preserved, and the public is sufficiently informed about the essence of the reform and the procedure of providing the prospective service.

The Constitutional Court has indicated that it is not possible to evaluate the state's financial capacity, economic situation, the priorities of legislative policy and special needs of separate social groups by way of legal argumentation. All these considerations impact the decisions of the legislator or Cabinet of Ministers on allotting certain types and levels of service.[41] Courts of other countries have also admitted that trial is not an appropriate forum to solve the question of priorities in

[39] The Constitutional Court. 2009-12-03.07.01.2010. Paragraph 17.
[40] Levits E., Olsena S., 2013 Annual Conference of the Ombudsman [online video in Latvian], Rīga, 11.12.2013. Available at: http://www.tiesibsargs.lv/petijumi-un-publikacijas/galerija/tiesibsarga-2013.-gada-konferences-video (accessed 13.06.2015).
[41] The Constitutional Court. 2008-37-03. 29.12.2008. Paragraph 12.4

health care.[42] The above can be agreed with only partly. According to Baderin and McCorquodale, the "realization of social and economic rights is closely related to the state budget and economics overall, nevertheless it is not an obstacle to legal analysis of such questions particularly those related to evaluation of priorities and budget breakdown according to the international law principles."[43]

When applying the rights provided in Article 111 of the Constitution, it is crucial to comply with the principle of equality established in the first sentence of Article 91 and the principle of non-discrimination included in the second sentence of Article 91.[44] It is essential to ensure just and accessible health care to all. The Constitutional Court in its judgement in Case No 2008-37-03 has emphasized the importance of the principle of equality in a just distribution of health care resources. In implementation of human rights in the field of health protection the positive discrimination is permissible – the state has the right to allot more rights to the particularly vulnerable groups of society: for example, children, persons with disabilities and elderly individuals. The rights established in Article 111 of the Constitution together with the rights for a just compensation set in the third sentence of Article 92 of the Constitution[45], provide the duty of the state to ensure both the system of entitlement to compensation in general and a just compensation in cases where a person's health is harmed. Similarly, the state's obligation is to ensure a just compensation in cases where a person's rights to health have been endangered, as well as where a person has not been able to realize the right to receive the basic level of medical assistance and this has caused harm.

The right to life, protected by Article 93 of the Constitution[46] may be endangered if the state does not realize its obligation to protect people's health to the necessary extent.

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[42] Ibid, with a reference to King J.A. The Justiciability of Resource Allocation. The Modern Law Review. 2007 Vol.70. No.2, p.199.
[43] Baderin M. A., McCorquodale R. The International Covenant on Economic, Social and Cultural Rights: Forty Years of Development. From: Economic, Social and Cultural Rights in Action. NewYork: Oxford University Press, 2007.
[44] Article 91: "All human beings in Latvia shall be equal before the law and the courts. Human rights shall be realised without discrimination of any kind."
[45] Article 92, 3rd sentence: "Everyone, where his or her rights are violated without basis, has a right to commensurate compensation."
[46] Article 93: "The right to life of everyone shall be protected by law."

When analysing the rights established in Article 111 in the context of Article 93, the case law of the Constitutional Court is significant. In Case No 2009-12-03 the Court has analysed the state's obligations within the framework of Article 111 that have to be realized in order to carry out the right to life as provided in Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) and Article 93 of the Constitution. The Court agreed with the argumentation of the European Court of Human Rights (ECoHR) which concluded: "To date the Court's case-law has been limited to holding that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of Article 2 of the [ECHR]",[47] but the Court has attributed it mainly to systemic and structural obligations in the respective area, for example, setting requirements for hospitals, introducing the mechanism of rights protection in clarifying the cases related to a patient's death.[48]

In the opinion of the Constitutional Court, by abstracting Article 93 from Article 111 of the Constitution, the rights provided in Article 93 of the Constitution can not be interpreted more widely than required by the obligations arising from the Convention. Meanwhile, the permissible restrictions of these rights have to be interpreted in the narrowest sense.[49] The Constitutional Court has also indicated that a person's rights to receive the emergency medical care should be considered differently when the person's health is affected by the acute and specific threat.[50]

In the jurisprudence of the Constitutional Court, the importance of the norms of the international law in the context of Article 111 of the Constitution is established, too. When analysing the application of Article 111, the Constitutional Court, in its judgement No 2002-04-03, has pointed out: "The meaning of this Article has to be clarified in close association with Article 89 of the Constitution providing that the

[47] The Constitutional Court. 2009-12-03. 07.01.2010. Paragraph 14.2, with reference to the of ECoHR decision in Powell v. United Kingdom. 45305/99, 05.05.2000.
[48] The Constitutional Court. 2009-12-03. 07.01.2010. Paragraph 14.2, with reference to the of ECoHR decision in John Shelley v. the United Kingdom. 23800/06, 04.01.2008: "This has so far imposed systemic and structural obligations, such as to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives, and to provide for an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable".
[49] The Constitutional Court. 2009-12-03. 07.01.2010. Paragraph 15.2.
[50] Ibid. Paragraph 14.3.

state recognizes and protects people's constitutional rights in accordance with the Constitution, law and international agreements binding on Latvia". [51] The Constitutional Court has declared: "From this Article, it is apparent that the goal of the legislator was not to contradict the human rights norms included in the Constitution to the international human rights standards, just the opposite – to attain a mutual harmony between these norms. Where there are doubts about the meaning of human rights norms included in the Constitution, they shall be interpreted as close as possible to an interpretation used in the case law of the international human rights norms."[52]

With regard to interrelation of the norms of the constitutional rights, as a very representative example I would like to point out the recent judgment of the Constitutional Court regarding application of Articles 91 and 111 of the Constitution, passed on 12 February 2015.[53] The applicant requested the court to assess if the Regulation No. 1529 of the Cabinet of Ministers failing to provide a tariff (a service fee) for planned outpatient childbirth is in accordance with the Constitution.

In its judgment, the Constitutional Court adjudicated that women receiving assistance in a planned physiological childbirth within the framework of the state guaranteed health care service financing, and women receiving such assistance outside of this framework, are in different circumstances, therefore these two groups are not comparable. Consequently, the Court found the norm in dispute to be compliant with Article 91 of the Constitution.

With regard to the state's duties in the field of health protection, the Court indicated that arising from the state's duties to protect health is the state's duty to perform measures aiming at people's health protection, including provision of health care services and ensuring their availability. Nevertheless, it does not imply that any person would always have the right to receive any medical services for free. The state holds a broad discretion in choosing the way people may exercise their rights of receiving health care services.[54]

In the context of this judgment, the longtime judge of the European Court of Human Rights (ECtHR), currently a judge of the Constitutional Court, Professor I.

[51] The Constitutional Court. 2000-03-01. 20.05.2002. Paragraph 1, Part 1.
[52] Ibid.
[53] The Constitutional Court. 2014-08-03. 12.02.2015.
[54] Ibid, Paragraph 11, Part 1.

Ziemele's dissenting opinion, which expresses her disagreement with several arguments and conclusions of the Court brought forward in the judgment, seems interesting and significant.

Prof. I.Ziemele considers the decision of the Court to assess the petition on failure to comply with Article 91 of the Constitution only in relation to Article 111 as unreasonable.[55] She agrees with the conclusion that Article 111 of the Constitution may not impose unenforceable commitments on the state. Consequently, the current case law of the Court regarding health care minimum, in principle, complies with the contents and boundaries of the mentioned Article. Nevertheless, according to Prof. I.Ziemele, in this case, the dispute is not about receiving any health care services for free, therefore it should be distinguished from all other cases related to health care minimum heard in the court before. Within the framework of this case, the Court should have preceded the relevance among three Articles of the Constitution. Namely, the essence of this case is the mutual relevance among Articles 91, 96[56] and 111 of the Constitution.

The judge points out that: "The legal system of Latvia is characterised by an openness to international law and principles. With regard to human rights, the Court always interpreted Chapter VIII (Fundamental Human Rights) of the Constitution in close relation to the international commitments of Latvia, by taking into account the case-law of the ECtHR in particular, and the fact that the interpretation of the Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) by the ECtHR is binding to Latvia. The contents of the rights for private life may develop both, as a result of the actions of the national legislator and by developing the international standard of human rights. It is currently known that according to the views of the ECtHR, a state, where a woman's rights to choose whether to give birth as an inpatient or at home are accepted, should assess if the system developed in the state promotes realisation of the right to make such choices. Therefore, the Court had

[55] Dissenting opinion of Ineta Ziemele, the Judge of the Constitutional Court in Case No 2014-08-03, Rīga, 26 February 2015.
[56] Article 96: "Everyone has the right to inviolability of his or her private life, home and correspondence."

no grounds to limit its opinion to a statement that home birth is acceptable in Latvia."[57]

The Court's opinion was that it is a regular practice in the health care system of Latvia that a person makes a choice either in favour of a state financed service or covers the costs himself/herself, and therefore these two groups of people are not comparable. The judge I.Ziemele admits that the Court could have arrived at such a conclusion when assessing the rights for equal treatment concerning Article 111 of the Constitution only. But the Court, by all means, had to take into account Article 96, which, in the specific case, provides for a woman's rights to choose receiving assistance in childbirth as an inpatient or at home. From the point of view of realisation of their rights for a choice, all women making a choice regarding this question are equal and comparable. The inequality is resulting from the state's attitude, which promotes one of the choices and fails to contribute to the other.

As pointed out by the judge I.Ziemele: "Not only each of the Articles of Chapter VIII of the Constitution but also the whole Chapter itself, is an interrelated and harmonious system. Therefore, the varied aspects of human rights should be interpreted by using a systemic approach and in mutual harmony."[58]

The last statement and the whole dissenting opinion of the judge precisely characterise the possibility that the Constitutional court (as well as the government), in its assessments of the public goods and general priorities, may choose to take one or another way, depending on which perspective it prefers.

Chapter 3. International background of the right to health and health care

3.1. Overview of the International and Regional Standards

An important source of interpretation of the right to health protection is derived from international human rights law. The right to health is recognized in numerous international instruments. Its role in interpreting the Latvian constitutional provisions, especially the human rights provisions, has been considerable. Most often, the Constitutional Court has used the ECHR, some references to the International

[57] Supra note 54, Paragraph 5.
[58] Ibid., Paragraph 8.

Covenant on Economic, Social and Cultural Rights (ICESCR) and references to the United Nations Convention on the Rights of the Child (CRC), have been made as well. Besides the fact that the international human rights law has direct domestic applicability in the Latvian courts, the treaty had been used for interpretation of the Latvian Constitution and other legal provisions.

Latvia has ratified most of the international documents regulating the right to health protection. Such provisions are included in the Universal Declaration of Human Rights (Article 25 (1)), the International Covenant on Economic, Social and Cultural Rights (Article 12 (2) d) and the European Social Charter (Articles 3, 11 and 13). Additionally, the right to health is recognized, inter alia, in Article 5, paragraph (e) (iv), of the International Convention on the Elimination of All Forms of Racial Discrimination, in Article 11, paragraph 1 (f), and Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women, in Article 24 of the Convention on the Rights of the Child, in Article 25 of the Convention on the Rights of Persons with Disabilities and in Article 3 of the Convention on Human Rights and Biomedicine. Latvia is also a member of the World Health Organisation (WHO), whose Constitution states that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being".[59]

The most recent regional human rights instrument, the Charter of Fundamental Rights of the European Union (the Charter), also provides provisions for the right to health care (Article 35).[60] In the second sentence of the Article 35, it is stated: "A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities." With the entry into force of the Treaty of Lisbon in December 2009, the Charter became legally binding also in Latvia.[61] As mentioned in the explanatory notes in relation to the Charter, the principles set out in Article 35 are based on Article 168 (ex Art.152 ECT) of the Treaty on the functioning of the European Union, and on Articles 11 and 13 of the European Social Charter.[62]

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[59] Supra note 2.
[60] Charter of Fundamental Rights of the European Union, 2007/C 303/01, 14.12.2007.
[61] Treaty of Lisbon. Amending the treaty on EU and the Treaty establishing the European Community, (2007/C 306/01).
[62] Explanations relating to the Charter of fundamental rights. Official Journal of the EU, 2007/C 303/02, 14.12.2007.

The relevant treaty enforcing institutions has interpreted these international provisions. Two important institutions have to be mentioned here: firstly, in May 2000 the UN Committee on Economic, Social and Cultural Rights (UN Committee) issued General Comment No.14, interpreting the right to the highest attainable standard of health. Latvian Constitutional Court has often used that comment for the interpretation of Article 111 of the Constitution. Secondly, the European Committee of Social Rights has developed a considerable case law on the health protection rights at the regional level in Europe. Both abovementioned interpretations are important in the context of the Latvian health care system and will be addressed below (for details see subchapter 3.2, 3.3).

In addition, it should be mentioned that by its resolution 2002/31, the UN Commission on Human Rights decided to appoint, for a period of three years, a Special Rapporteur to focus on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, as reflected in article 25 (1) of the Universal Declaration of Human Rights (UDHR) and another international documents regulating the right to health protection. The main tasks the Special Rapporteur is requested to: gather, request, receive and exchange right to health information from all relevant sources and make recommendations on appropriate measures that promote and protect the right to health. In 2014, the UN Human Rights Council appointed Dainius Puras from Lithuania as the third Special Rapportuer.[63]

3.2. CESCR General Comment No14

In international human rights law, the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides the most comprehensive article on the right to health. In accordance with article 12, paragraph 1, of the Covenant, States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12, paragraph 2, enumerates, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realization of this right".[64]

[63] UN Commission on Human Rights resolution 2002/31, The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 22.04.2002, E/2002/23- E/CN.4/2002/200
[64] Supra note 1, Paragraph 2.

The General Comment is based on the UN Committee's experience in examining States parties' reports over many years and structurally consist of the introduction and five parts, in which it focuses on the normative content of Article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V.

As the UN Committee explains in paragraph 8: "The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection that provides equality of opportunity for people to enjoy the highest attainable level of health."

In the context of this thesis, it is important to understand the notion of "the highest attainable standard of health". The General Comment clarifies that in Article 12.1 it takes into account both the individual's biological and socio-economic preconditions and a State's available resources. The right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.[65]

Following the General Comment the right to health in all its forms at all levels contains the following interrelated and essential elements: availability, accessibility, acceptability and quality. While all these elements are equally important, in the Latvian context I would like to highlight the issue of accessibility because its implementation is currently lagging the most (see Chapter 4).

As the Committee notes, Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility. The fact that health care is de facto available does not suffice. Health facilities, goods and services must be within safe physical reach to everybody, without discrimination, especially to the most vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children,

[65] Supra note 1, paragraph 9.

adolescents, older persons, persons with disabilities or detainees. Furthermore, health care must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principal of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households. Lastly, information accessibility includes the right to seek, receive and impart information and ideas concerning health issues.[66]

While the CESCR provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties certain minimum core obligations outlined in paragraph 43, which are of immediate effect. Such obligations as non-discrimination and equal treatment as well as the requirement to take steps towards the full realisation of the right to health must be guaranteed immediately.

With regard to the States Parties' obligations, the UN Committee stresses that the right to health, like all human rights, imposes three types or levels of obligations: the obligation to respect, protect and fulfil. In turn, the obligation to fulfil contains obligation to facilitate, provide and promote and requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.[67]

When the normative content of Article 12 (Part I of the Comment) is applied to the obligations of States parties (Part II), a dynamic process is set in motion, which facilitates the identification of violations of the right to health. The UN Committee notes that in this process it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under Article 12. The UN Committee concludes that a State, which is unwilling to use the maximum of its available resources for the realisation of the right to health, is in violation of its obligation under Article 12.[68] In case of a violation, it is critical that any victim of a breach has access to effective judicial or other appropriate remedies at both national and international levels. The UN Committee stresses the role of National ombudsmen,

[66] Ibid., paragraph 12.
[67] Ibid., paragraph 33.
[68] Ibid., paragraph 47.

human rights commissions, consumer forums, patients' rights associations or similar institutions in this process.

3.3. Conclusions of the European Committee of Social Rights

At the regional level, the 1961 European Social Charter (ESC) complements the ECHR in the field of economic and social rights. It guarantees various fundamental rights and freedoms and, through a supervisory mechanism based on a system of collective complaints and national reports, ensures that they are implemented and observed by States Parties. It was revised, and the 1996 Revised European Social Charter is gradually replacing the original 1961 Charter.[69]

The Charter has several provisions, which guarantee, expressly or implicitly, the right to health. Article 11 covers numerous issues relating to public health, such as food safety, protection of the environment, vaccination programmes and alcoholism. Article 3 concerns health and safety at work. Articles 7 and 17 protect the health and well being of children and young persons. Article 8 covers the right of employed women to protection of maternity. The health of elderly persons is dealt with in Article 23.[70]

The right to protection of health guaranteed in Article 11 of the Charter complements Articles 2 and 3 of the ECHR, as interpreted by the case-law of the ECtHR, by imposing a range of positive obligations designed to secure the effective exercise of that right.[71] Article 11 provides for a series of rights to enable persons to enjoy the highest possible standard of health attainable. These are reflected in: firstly, measures to promote health and, secondly, health cares provision in case of sickness.

The function of the European Committee of Social Rights (ECSR) is to rule on the conformity of the situation in States with the European Social Charter, the 1988 Additional Protocol and the Revised European Social Charter. The Committee is composed of 15 independent, impartial experts, elected for a 6-year term of office. In

[69] The right to health and European Social Charter. Secretariat of the ESC. March 2009. Available at: http://www.coe.int/T/DGHL/Monitoring/SocialCharter/Theme%20factsheets/FactsheetHealth_en.pdf (accessed 23.06.2015)
[70] European Social Charter (revised), 3 May 1996.
[71] ECSR Conclusions XVII-2 and Conclusions 2005, Statement of Interpretation on Article 11§5

respect of national reports, it adopts conclusions; in respect of collective complaints, it adopts decisions.

Information on the Charter and the Committee, as well as statements of interpretation and general questions formulated by the Committee, appear in the General Introduction to the Conclusions.[72] In 2013, the European Committee of Social Rights examined reports submitted by 38 States Parties on the articles of the Charter relating to health, social security and social protection. The reports covered the reference period 2008-2011. In the its general Conclusions the Committee noted, "the economic crisis in Europe and the austerity measures adopted in response have had a negative impact on effective respect for human rights and especially for social and economic rights."[73] Already in its Conclusions 2009 the Committee stated, "The economic crisis should not have as a consequence the reduction of the protection of the rights recognised by the Charter. Hence, the governments are bound to take all necessary steps to ensure that the rights of the Charter are effectively guaranteed at a period of time when beneficiaries need the protection most."[74] This Committee's statement did not give the intended effect. On the contrary, the Conclusions 2013 showed that the proportion of violations was even higher than in the Conclusions 2009.

According to the general overview of Conclusions several countries (including Latvia) were in breach of the Charter under Article 11 paragraph 1 because of persisting high infant and maternal mortality rates and insufficient measures taken to improve the situation. The Committee held that where these mortality rates remain considerably worse than the European average this points to weaknesses in the health system and to the inadequacy of measures taken to reduce mortality.[75]

The guarantee of a genuine individual right to assistance together with a right to legal remedy is a major contribution made by Article 13 and in particular Article 13 paragraph 1. Social and medical assistance for persons in need and with no resources is a crucial safeguard against poverty, which makes it all the more striking, and a

[72] The conclusions, as well as state reports, can be consulted on the Council of Europe's Internet site. Available at: www.coe.int/socialcharter (accessed 20.06.2015).
[73] Press briefing elements. Conclusions 2013/XX-2. 19 January 2014. Available at: http://petition.etuc.org/IMG/pdf/Press_briefing_2014b.pdf (accessed 20.06.2015)
[74] Ibid. p.3.
[75] Ibid. p.5.

cause for concern that no fewer than 25 out of 31 countries examined (including Latvia) were found to be in breach of this provision. Only two countries, Sweden and the United Kingdom, were found to comply with Article 13 paragraph 1.[76]

The ESC was ratified by Latvia on 31 January 2002, but the Revised ESC came into force on 1 May 2013 (with some reservations).[77] Latvia has completely accepted the Articles directly concerning the right to health (Part I Art.13; Part II Art. 11, 13, but not 23).

The last report concerned the accepted provisions of the thematic group "Health, social security and social protection" was submitted by Latvia on 31 October 2012. Additionally were submitted the Governments reply with supplementary information, comments on the report from some NGOs and Governments response on these comments. The Committee came up with its Conclusions XX-2 (2013) at January 2014.[78]

What follows is a brief overview of ECSR Conclusions 2013 on the Latvian report concentrating on violations identified by the Committee under the articles concerning the right to health. Although the primary focus is on the violations, it should not be forgotten that the Committee has also taken note of positive developments where Latvia have changed its legislation or practice to bring the situation into conformity with the Charter.[79]

In its conclusions regarding the right to the highest possible standard of health the Committee notes from WHO that life expectancy at birth in 2009 (average for both sexes) was 73.28 (the EU-27 average that same year was 79.0). In Latvia, the life expectancy rate is still below that of other European countries, although it has slightly increased since the last reference period. At the same time, the death rate (deaths/1 000 population) was 13.43 in 2010, which is high compared to other European countries.[80]

As regards the maternal mortality rate, the Committee notes that in 2010 the rate reached 26.02 deaths per 100 000 live births, showing no improvement since the

[76] Ibid. p.7.
[77] Official journal "Latvijas Vēstnesis" ("Latvian Herald") No.183 (2570), 18.12.2001 and No.40 (4846), 26.02.2013.
[78] ECSR Conclusions XX-2 (2013), Latvia, January 2014.
[79] The chapter on Latvia concerns nine situations and contains five conclusions of conformity; four conclusions of non-conformity.
[80] Supra note 77, p.5.

last reference period, and high above the average in other European countries (the EU-27 rate in 2010 was 6.0 per 100 000).[81]

The conclusions acknowledge that a number of public health indicators in Latvia still fall significantly behind the average in EU countries, including life expectancy which is one of the lowest in the EU, and the mortality rate, which on the contrary is one of the highest. It mentions that like in previous years, there have been no significant changes in the structure of the main causes of death, with circulatory system diseases being responsible for over one death in two, and cancers one death in five. As an example, the Committee's assessment mentions that the standardized mortality rate from circulatory diseases under age 64 is three times higher in Latvia than the EU average.[82]

The report of the state indicates that significant changes in the health system were introduced in 2009. The reforms involved a substantial decrease in the number of hospitals with a parallel development of out-patient health care services. The number of hospitals decreased from 88 in 2008 to 67 in 2010, with a reorganisation of outpatient clinics. The closure and reorganisation of hospitals led to a considerable decline in the number of hospital beds, and to a decrease in the number of staff in the public health administration of more than 50% within a period of one year and the financial resources that were saved from these reforms were diverted to patients' treatment. [83]

In spite of the reforms carried out Latvia did not meet its new-born life expectancy target of 95% of the EU average set out in the Public Health Strategy 2004–2010: life expectancy remained more than six years below the EU average of 79.8 in 2009, principally because Latvia failed to achieve greater improvements in reducing cardiovascular mortality.[84]

The Committee considered that despite some positive trends, the prevailing high maternal mortality rate, when examined together with the other basic health indicators mentioned above, points to weaknesses in the health system. It, therefore, found that insufficient measures have been taken to reduce maternal mortality, and

[81] Ibid.
[82] Ibid. p.5.
[83] Ibid. p.6.
[84] Ibid. p. 5.

concluded that the situation in Latvia is not in conformity with the Charter on this ground (Art. 11 paragraph 1).[85]

Regarding the right of access to health care the Committee recalled that access to healthcare must be guaranteed equally to Latvian citizens and non-citizens as well as foreign nationals from other States Parties residing or regularly working lawfully in the country (see Appendix of the Revised European Social Charter).

In this respect the Committee noted that although the statutory health system provides coverage to the entire population and pays for a basic service package, it leaves patients exposed to substantial user charges and direct payments, in particular for pharmaceuticals, as well as informal payments. Out-of-pocket payments account for 37.8% of total health expenditure, one of the highest rates in the EU. It also mentions that the choice of provider set out in the statutory system is often limited, in particular in rural areas, because of waiting lists and unavailability of alternative providers. The Committee asked the Latvian Government to explain this high percentage of out-of-pocket payments, namely whether this means that certain health services are not publicly financed and fall outside the public healthcare system.[86]

Next to the aforementioned the Committee concluded that the situation in Latvia is not in conformity with Article 13 paragraph 1 of the Charter on the grounds that the level of social assistance benefits is manifestly inadequate and the granting of social assistance benefits to foreign nationals is subject to an excessive length of residence requirement. The excessive length of residence requirement for foreign nationals was also the reason to conclude that the situation in Latvia is not in conformity with Article 13 paragraph 3.[87]

At this point, actual could be the question, what have been the consequences of such the Committee's conclusions? Admittedly, in the Latvian public space they have been little discussed, and it seems the only ones who are referring to them are some NGOs. The Government responses will be further analysed in Chapter 4, looking at the issue of Health care guarantees in practice.

Interestingly that the Conclusions of the Committee was not unanimous and some members added their dissenting opinion saying:

[85] Ibid. p.7.
[86] Ibid. p.6.
[87] Ibid. p.13., 15.

"I am not satisfied with the reasons given by the majority of the Committee members for their conclusion that the situation in Latvia is not in compliance with Article 11§1 of the Charter. […] I consider that the real basis for a non-conformity decision concerning Latvia's implementation of Article 11§1 is the Latvian Government's reform during the reference period of the health care system. This reform includes measures that pose a serious and direct threat to the effective fulfilment of Latvia's obligations under Article 11§1, in particular, the obligation to ensure the right of access to health care."[88]

The Committee members P.Stangos and L.J.Quesada draw attention to the Latvian Government's decisions concerning the closure of public hospitals and the considerable reduction in the numbers of available hospital beds and of staff to administer the basic public health system. In their view the Government decisions are at the root of the lack of resources to finance the public health care system, as well as developments such as the need for households to meet very high costs of care, long waiting lists, particularly in rural areas, and the lack of patient choice concerning service providers. According to Stangos and Quesada, all these decisions or aspects are referred to in the adopted conclusion, yet the Committee does not draw the least legal consequence regarding Latvia's compliance with the right of access to health care arising from Article 11§1 of the Charter.[89] This finding of the Committee members is significant, but at the same time should be taken into account that the shift away from hospital care by introducing home care services was planned already before economical and financial crisis hit Latvia. Previous efforts to centralise the system and to move from hospital to outpatient care were just drastically accelerated by the crisis, with a dramatic reduction in the number of hospitals within the short period. Further both experts criticised the Conclusions of the Committee by saying:

"The Committee has erred in not paying close attention in this supervision cycle to the policies introduced by Latvia and several other Parties to reform their health systems in response to the economic crisis, with particular regard to the impact of these reforms on persons' right to equal and effective access to hospital and/or outpatient/community care. These reform policies will become

[88] Ibid. p.20.
[89] Ibid.

more marked in the coming years as the economic crisis continues and even deepens. In four years' time during the next supervision cycle relating to Article 11, the Committee will have to consider them, and in particular their detrimental effects on access to health care and the state of health of the groups concerned […]."[90]

From this dissenting opinion, it can be concluded that the Committee, similar to the Constitutional Court in several cases has chosen to retain rather a neutral position in relation to facts specified by P.Stangos and L.J.Quesada. The Conclusions are based only on reasons, whose objectivity in evaluating the state cannot be disputed, for example, inadequate measures have been taken to reduce maternal mortality or there is excessive length of residence requirement for foreign nationals.

A couple of years have passed, and Latvia is gradually recovering from the crisis mentioned before. The next Chapter will look at the current problems by health care guarantees in practice.

Chapter 4. Health care guarantees in practice

4.1. Health care – one of the most regulated areas?

In the Chapters 2 and 3, the legal framework of the constitutional guarantees on the national, regional and international level was outlined. The goal of this chapter is to find out the practical realization of these guarantees.

As several studies indicated, the main problem for the health care guarantees currently in Latvia is the allocated insufficient financing.[91] The government approved a conception on the model of the health care financing system, to solve the question of the health care financing, on 10 May 2013. At the core of the conception was a new approach to organizing health care, which provided the introduction of the state compulsory health insurance payments. A while before and after the conception was approved, a broad discussion arose in the public on the exacerbated problems in the health care system (more on the conception, see subchapter 4.4).

[90] Ibid. p.21.
[91] Supra note 3; OECD (2014), Health at a Glance: Europe 2014, OECD Publishing.

With the above in the background, on 20 September 2013, a joint conference of doctors and lawyers „Where are the laws and legal practice in health care heading?" took place.

The Prime Minister V.Dombrovskis, in his address to the conference, announced that:

„Health care is one of the most regulated areas both at the national and the European Union level, since it includes the patient rights protection, pharmacy, issues of responsibility and, undoubtedly, aspects of human rights. Globalisation and technological solutions continuously develop health care, and it is where one of the core challenges of the government work are in place."[92]

Regarding the issue of financing, the Prime Minister admitted that in recent years, particularly under the influence of the severe economic and financial crisis, health care, just like other areas, faced a lack of financing leaving a considerably negative impact on all aspects related to health care: "a lack of qualified medical personnel, lack of timely access to health care services, insufficient amount of reimbursed medications".

Meanwhile, he also stressed that:

„The Constitutional Court has evaluated the compliance of the regulation of the reimbursed medications and medical devices to the Constitution several times and has declared it appropriate. The Court has indicated that, when developing a health care policy, the state has to act within the limits of the available resources, which means that, within the scope of insufficient resources, the primary goal is to ensure the interests of a broader public."[93]

Two questions arise from this speech of the head of the government. First: what can be concluded from the statement „health care is one of the most regulated areas"? And second: what encompasses „interests of a broader public", ensuring of which within the limits of insufficient resources is the primary goal? I will endeavour to find the answers to these questions discussing the problems encountered when securing health care guarantees in practice.

[92] V.Dombrovskis V. "Health care - one of the most regulated areas" (in Latvian), Jurista Vārds, 08.10.2013, no. 41 (792), p.2.
[93] Ibid.

The statement that health care is legally regulated in detail is undoubtedly true. A regulation is existent, and at the same time it is so complicated that the respective user of the norm (a doctor and patient) cannot even understand it. A statement of the Minister of Justice J.Bordāns proves it in the above conference:

> "One has to ask: what is this minimum that is ensured to us? As a patient and a lawyer not specializing in the medical law, I may only guess what is this guaranteed minimum. Whether it is one preventive examination a year or a right to women to give birth for free, or the paid general health insurance? The statement that Latvia is a socially responsible state may not be hollow words only. This legal principle has to be filled with a specific content, and it imposes certain obligations on the state. In this respect, both the Ministry of Justice and Ministry of Health have a lot to do, taking into consideration the interests of all possible groups of society. Being the Minister of Justice, I emphasize that the issue of the state responsibility has a constitutional nature, therefore requiring due attitude."[94]

This Minister of Justice in my view was one of the few politicians who advocated for legislation adjustments in many areas, including health care. Unfortunately, as for the current political elite awkward and staunch team player, he soon was changed, but his question posed "what is this minimum that is ensured to us?" has gained wider resonance in society (see subchapter 4.4.).

However, returning to what the Prime Minister said, it must be admitted that such political rhetoric is, in fact, a way to escape talking about awkward questions on health care that remain unsolved for years. The real evaluation of health care and its regulation is voiced in his following statement „a lack of qualified medical personnel, lack of timely access to health care services, an insufficient amount of reimbursed medications". It is the regulation for the realization of which the state has not provided sufficient financing for a prolonged period or this regulation is adjusted to these insufficient financial resources. Several independent pieces of research have been

[94] J.Bordāns "The current legislative issues on health care" (in Latvian). Jurista Vārds, 08.10.2013, no. 41 (792), p.p.13.-14.

published in recent years about the consequences of such path.[95] In the following chapter, we will address the current situation in the field of health care provision and find out what is provided or failed to provide by health care system.

4.2. What is provided or failed to provided by health care system?

Overall picture of the Latvian health system can be obtained from the ECSR Conclusions XX-2 (2013) (see subchapter 3.3.) However, since this view primarily based on the State's report, in addition, one of the most comprehensive recent studies about Latvian Health system have been conducted within the project of WHO Health Systems in Transition by the European Observatory on Health Systems and Policies. In this study has repeatedly been emphasized that Latvia was hit harder by the global financial and economic crisis of 2009 than any other EU Member State. Severe budget consolidation measures implemented in response to the crisis included reducing financing to hospitals, increasing user charges, reducing health worker salaries and lowering prices of pharmaceuticals. Previous efforts to centralise the system and to shift from hospital to outpatient care were drastically accelerated, with a dramatic reduction in the number of hospitals (by 18,5%) and far-reaching changes of health-care administrative institutions.[96]

A Social Safety Net Strategy was put in place from 2009 to ensure access to health services for low-income individuals. Supported by a 100 million EUR loan from the World Bank, this exempted people with very low incomes from user charges and provided financing for free overnight stays after day care (though the scope of the strategy was reduced in 2012 with the end of the World Bank loan). This strategy also supported the overall shift away from hospital care by introducing home care services for the chronically ill, the development of day care centres for the mentally ill, additional nurses in primary care and a family doctor telephone advisory service.[97]

On 17 December 2013, the Cabinet of Ministers adopted a new Regulation No1529 “Regulations on Organization and Financing of Health Care”. They replaced

[95] See Mitenbergs U, Taube M, Misins J, Mikitis E, Martinsons A, Rurane A, Quentin W. Latvia: Helth sistem review. Health Systems in Transition, 2012; 14(8): 1-191; OECD (2014), Health at a Glance: Europe 2014, OECD Publishing.
[96] Supra note 3, p.vxii.
[97] Ibid. p.xix.

the old regulations with the same name (adopted in 2006), which were amended and supplemented already 30 times in the course of time. Beginning from the year 2010, the health care minimum, due to every citizen of Latvia, had already been defined in the previous regulations (No 1046). Until then only the „negative basket" or the types of service that are not funded by the state was set, for example, dentistry to adults, cosmetological services, etc.[98] The new document determines almost all aspects of health care provision and financing, including the types and levels of the medical treatment services funded from the state budget and receiver of the service, the procedure for payment for the mentioned services, as well as procedure for establishing the waiting lists to receiving scheduled health care services.

What do the Regulation of health care provide now? The groups of people exempt from the patient's co-payment, when receiving state funded services, are listed in Section 23 of the Regulation. The Regulation also provide for reimbursement of a full medical care at home (as the consequences of a considerable decrease in the number of beds in hospitals during the years of the crisis). In order for a patient to receive health care services at home, the family doctor or specialist has to justify such necessity.

The state fully covers the assistance provided by an emergency medical assistance team, as well as the emergency medical assistance provided in hospitals and casualty wards. It should, nevertheless, be stressed that only the assistance needed to save one's life is for free. For instance, if an adult with his arm broken arrives at a casualty ward, he/she will have to pay a patient's co-payment.

Meanwhile, one has to admit that emergency assistance may not be boundless. When the vital functions of a patient are restored, treatment commences, and the patient's co-payment has to be made. For this reason, even when a patient is brought to a hospital with an emergency assistance vehicle, often he/she has to pay a patient's co-payment from the second day in the hospital onwards.[99]

Furthermore, the state partly or fully funds the state reimbursed medications and medical equipment. Every patient with a diagnosis set by a doctor that is

[98] The regulations of the Cabinet of Ministers No1046 "Regulations on Organization and Financing of Health Care", 19 December 2006, Section 11.
[99] L.Lūse "Health care minimum in Latvia" (in Latvian), Latvijas Vēstnesis, 20 April 2010.

mentioned in the Regulation on reimbursement of medications for certain diseases may receive the state reimbursed prescriptions for out-patient care.

Although the statutory health system provides coverage to the entire population and pays for a basic service package, it leaves patients exposed to substantial user charges and direct payments, in particular for pharmaceuticals, as well as informal payments. Government spending on health was only 61.1% of total health expenditure in 2010 (and was lower than at the start of the financial crisis). Out-of-pocket payments account for 37.8% of total health spending, one of the highest rates in the EU (behind only Cyprus, Bulgaria and Greece).[100]

Almost all inhabitants are registered with a general practitioner, their family doctor, who acts as the central point of entry into the health care system and as the gatekeeper to secondary ambulatory and hospital care. In rural areas (in which about a third of the population lives), a physician assistant (feldsher) or midwife still provides a considerable share of primary care. A patient with a referral from the general practitioner can freely choose any ambulatory or inpatient care provider (institution) that has a contract with the NHS. Some specialists can be accessed directly under certain conditions (e.g., access to a paediatrician for children) without a referral from the family doctor.[101]

The authors of the study also conclude that in practice, provider choice in the statutory system is often limited, in particular in rural areas, because of waiting lists and unavailability of alternative providers to choose from. If waiting lists are substantial, and if providers have exceeded the number of patients to be treated (e.g.: towards the end of the month or year) according to their contracts with the NHS, patients have the option to pay directly (100% of costs) for the treatment. In respect of waiting lists, the Latvian representative to the Governmental Committee (Report concerning Conclusions XIX-2, T-SG(2011)2 final) in written information to the Committee (ECSR) notes that these are the responsibility of each particular health care institution and waiting times depend on available resources (for details see subchapter 5.4.1).[102]

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[100] Ibid.
[101] Supra note 3, p.xx.
[102] Available at:
http://www.coe.int/t/dghl/monitoring/socialcharter/conclusions/State/LatviaXX2_en.pdf

Additionally, it is important to note the negative tendency that the public itself is ready to make unofficial payments to the medical personnel to ensure or speed up access to the state guaranteed services. It has been found out in a research of the Marketing and Public Opinion Research Centre in 2011 that every third (33%) inhabitant having had a treatment at a clinic and/or hospital in the last two years made unofficial payments. Whereas, the results of a research carried out by Market and Social Research Agency „Latvijas fakti" in November 2012, showed that the trend to pay for medical services unofficially has slightly decreased – unofficial payments, presents or knowing someone personally have been used by 28% of all respondents.[103]

As concluded in the study above, the high share of out-of-pocket payments and a high percentage of the population forgoing medical treatment because of its costs characterize the current health care system. Almost 14% of the Latvian population reported an unmet medical need because of costs while this number was below 1% in Estonia, Lithuania, Slovenia and most other EU member states. Furthermore, important inequities were evident as the proportion of the population with unmet medical needs was much higher in the poorest income quintile (34%) than in the richest income quintile (13%). According to a Eurobarometer survey in 2011, most Latvians rated health care provision in their country as bad (66%), whereas only 30% judged it as good, earning Latvia the fourth lowest rank among EU countries.[104]

According to the Sworn Advocate R.Rožkalns, in the field of health care, lawyers receive complaints from the patients mostly regarding the availability of the state financed medication and costly medical technologies. The reason of complaints is often also the defined state financed services, the receiving of which takes being on unreasonably long waiting lists. The state officials fail to follow whether the length of the waiting lists is acceptable. For example, a child needs an urgent post-traumatic rehabilitation, but any prolonged delay and waiting for months makes the state's commitment to finance the costs of these services senseless. In such a case, the parents, taking care of their children's health, are forced to finance the service from their own resources, although health care has already been paid for by paying taxes. At the time one needs help, he/she has to pay once again – from his/her own pocket –

[103] I.Mangule "Corruption in the health sector: challenges and examples of good practice in Latvia", 18 June 2015.
[104] Supra note 3, p.xxi.

which means, double, because the state has not been able to develop an effective state care system.[105]

4.3. Confusion with treatment of Rare Diseases and Organ Transplantation

Besides to the already described general problems in the health care, information about individual cases shows up regularly in the public media referring to problems accessing health care.

The problems to ensure health care for rare diseases is a clear example of an injudicious legal regulation, accompanied by a continuous lack of financial resources. In this subchapter the case, already referred to in the Introduction, of failing to allot the necessary financing to save a patient's life will be examined more carefully, as well as a general insight of the problematic of rare diseases and organ transplantation in the Latvia and EU will be provided.

4.3.1. Three real-life cases – Zane, Aleksandrs and Andris

As mentioned before, the meeting with Zane – the first citizen of Latvia having undergone lung transplantation drew my attention to the problems related to treating rare diseases in Latvia.[106] Zane's case I would like to reflect in particular detail because I believe that it shows a lot about the attitude of the responsible persons. Here I would like to remind the explanation given in the CESCR General comment 14 that it is important to distinguish the inability from the unwillingness of a state to comply with its obligations.

Three years ago Zane was diagnosed with a rare and threatening disease – severe idiopathic pulmonary arterial hypertension, and on 17 December 2013 a Council of Latvian doctors decided that she needs lung transplantation. In Latvia, such operation is not performed.[107] The treating doctor, however, continued look for opportunities how to help his patient.

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[105] R.Rožkalns "Rights to health care are guaranted, without any guarantees", Diena, 20.06.2014.
[106] I contacted Zane in person while she stayed in Vienna from April to July 2014, and we corresponded via e-mail during the preparation of this paper.
[107] Z.Lazdina, email, 30 June 2015

In December 2013, Zane visited the Vienna Transplantation Centre to have an additional examination. After receiving the examination results, the doctors confirmed that the disease rapidly progresses, and lung transplantation is vital in the coming months. The estimated costs of the operation amounted to 120'000 EUR.

On 27 December 2013, the woman turned to the National Health Service with a request to receive „Approval of the rights for planned treatment" (form S2) to receive a health care service – lung transplantation – in another European Union country, in other words, an approval that the state is ready to co-finance the lung transplantation vital to her. On 21 January 2014, Zane, however, received a refusal with an explanation that the health care service she needs is not covered by the state budget (the Regulations of the Cabinet of Ministers does not provide the financial resources for covering the operation costs).[108]

Even in this hopeless situation Zane, her doctor and relatives were looking for a solution, first, by seeking the help of the Latvian public. On 20 January, a charity organisation „Ziedot.lv" started to collect donations for operation. On 4 February 2014, Zane also turned to Prime Minister with a request to find a way to allot the missing 30'000 EUR (at that point 87'000 EUR had already been collected) from the budget contingency margin. On 20 February 2014, a reply from the Prime Minister's Office was received stating, „as a result of a rapid development of the modern medicine and science a vast array of medicines and medical equipment for treating different diseases is available, but the state's financial resources are limited."[109] At the same time, the Prime Minister's Office indicated that it has assigned the Ministry of Health to evaluate the situation and provide a reasoned reply on the opportunity to help. In the response of the Ministry of Health, dated 28 February 2014, it is pointed out „unfortunately, due to limited health care budget, lung transplantation is not included in the list of the state reimbursed health care services. With health care budget growing, the Ministry of Health will examine the possibility to include lung transplantation in the list of the state reimbursed health care services."[110] In my opinion, these letters of the Prime Minister's Office and the Ministry of Health to a person having the life in a danger can be evaluated as highly cynical and in a

[108] Decision of the National Health Service No.07.1/7.1-6/143, 14 January 2014.
[109] Respose of the Prime Minister's Office to Z.Lazdina No.20/L-281, 20 February 2014.
[110] Response of the Ministry of Health to Z.Lazdina, No.01-20fiz.16/809, 28 February 2014.

contradiction to Article 111 of the Constitution. Also, the respective regulation of the Cabinet of Ministers, which is used as the basis for refusal by the National Health Service officials, is inconsistent with the Constitution. But apparently, to achieve that the state admits it, this truth has to be fought for by using the legal mechanisms of appeal established in the country. Such mechanisms do exist in the country, albeit undoubtedly time-consuming and demanding additional resources. It would, of course, be good that, parallel to search for money, Zane and her relatives could involve in a court dispute over the officials' decision meantime getting herself ready for a serious operation. It is understandable that Zane could afford it neither physically nor financially and emotionally.

By trying to protect the interests of a member of the Pulmonary Hypertension Association (PHA), the head of the organisation, I.Plūme has turned to three independent lawyers with regard to the case of Zane. Their conclusions were that the ECtHR may be tested, as lawsuits in Latvia would be lost. Having investigated the practice of the ECtHR in similar cases where the lawsuit was lost, none of the lawyers was ready to take up this case, as the PHA would not be able to cover the costs. The joint decision of the PHA and the family of Zane was to spend resources where life can be saved instead of testing court proceedings.[111]

In response to a question about access to legal aid, I.Plūme notes: "legal advice is available pro bono in the form of a consultation; if one wishes to go to court, time, money and other resources – contacts with good lawyers etc. – are needed. Very often patients and their families do not have access to them. Also, NGOs lack such access due to insufficient resources".[112]

Luckily, the entire necessary amount was collected already by 18 February 2014, and in March 2014 Zane left for the General Hospital of Vienna, where she had her lungs transplanted on the night of 16 April.

After the operation and respective rehabilitation, the attending cardiologist, Andris Skride, admitted that the new lungs function perfectly, and breathing and heart failure is non-existent. Currently, Zane spends her days performing special exercises for heart and lung health. She has also found a job and returned to normal life. „When

[111] I.Plūme, email, 17.07.2015.
[112] Ibid.

you are healthy you don't realize how it is when you can't do anything yourself, even the most simple things – dress yourself, go to the toilet, cook. It is an invaluable present that I can make my bed, dress myself and walk," says Zane. [113]

Unfortunately, last year Zane's experience was not an isolated case in Latvia when a patient's survival is made dependent on other citizens' support. In July 2014, another social support foundation www.labdaris.lv commenced to collect donations to Aleksandrs – a 31 years old patient of pulmonary hypertension – to help restore his health and ability to work. This time, for treating that same disease lung transplantation was not necessary, but a complicated operation costing 40'000 EUR was needed. "Aleksandrs can be saved by pulmonary endarterectomy that is performed in Austria. During this operation, all the blood clots formed in the blood vessels are removed. Such an operation has been performed to three people in Latvia, but Aleksandrs is suffering from the distal form of this disease, which is the reason it can be performed only in Austria," his cardiologist Andris Skride had admitted.[114] The Doctor noted, if the disease is not treated, the death rate from it is very high – it reaches 90% within three years. Aleksandrs' family had turned to the National Health Service in the beginning of May, when his mother said: „We have high expectations that the state's reply will be positive, and Aleksandrs can go to Vienna for an operation". In July, when the family turned for help to the public, a reply had not been received yet as the investigation of the case was extended till September. Although the National Health Service response was partly positive and the State agreed to pay most of the amount (28'000 EUR), the rest had to be covered by the patient himself.[115] This time again the missing amount was collected by the public support and in November 2014 Aleksandrs could finally undergo an operation in Vienna. The operation was performed, but post-operation rehabilitation was severe, and Aleksandrs did not manage to see Latvia.

On 14 April 2015, a charity organisation started collecting donations for a 24 years old Andris, who also was in need of the same lung operation – pulmonary

[113] "Ērglēniete Zane Lazdiņa after lung transplantation returned home" (in Latvian), Lauku Avīze, 24 July 2014.
[114] "To save the life of Alexander, should be stopped blood flow. Asking for help for the difficult operation" (in Latvian), Lauku Avīze, 8 July 2014.
[115] "Let's save Andris", 14 April 2015. Available at: https://www.ziedot.lv/realizetie-projekti/glabsim-andri-2174 (12.06.2015).

endarterectomy – which in the complicated cases is not performed in Latvia, but after the above-mentioned Precedent with Aleksandrs the state supports that the operation is performed at the General Hospital of Vienna by covering most of the necessary amount. To perform the operation, Andris needed additional 8'000 EUR that the poor family living in the countryside could not afford. Andris arrived for the operation on 18 May 2015 missing the entire amount necessary for the operation. On 3 June 2015, Andris died without having received the operation.[116]

Of course, no one can tell the outcome of the last two cases if time was not lost unnecessarily by waiting and hoping for the public support, and if, instead, the states Institutions had reacted without hesitation in these vitally critical times. In the case of Zane, a negative reply from the state cost almost a month; in the case of Aleksandrs – a partly positive reply cost 5 months, to which another month spent for collection of the necessary amount should be added; in the case of Andris, there is no information available on how quickly a decision on allotting a partial financing was made, nevertheless, at least two months were spent (lost) for acquiring the missing funding. The following statement will be some sort of a speculation, however, if one can trust the doctor saying that usually such operations proceed successfully, and the patient fully recovers, the probability that the public would not have to pay for the death of two young people is quite realistic. In this respect, Zane is an obvious example when after a successful treatment both, the patient and her relatives, have been able to return from deep hopelessness to a full-fledged life.

4.3.2. Problems with treatment of rare diseases overall

In the context with these above-analysed individual cases also raises the question about treatment of rare diseases in general.

In the limited budgetary conditions, the National Health Service refuses help both to children and adults, providing a quick judgement – thou shalt not live.[117] It is also proved by the described example of Zane, which, unfortunately, is not an isolated case. The state has rights and discretion to define the basket of health care services,

[116] Ibid.
[117] I. Plūme "Discrimination has the price of life" (in Latvian), 25 April 2014. Available at: http://www.delfi.lv/news/comment/comment/ieva-plume-diskriminacijai-ir-dzivibas-cena.d?id=44428364 (accessed 12.05.2015).

but with an unequal approach in place, the patients with rare diseases are deprived of the rights to health protection, a certain quality of life and life itself. Logically, a question arises, whether it is just and acceptable in a socially responsible state?

We will return to the principle of a socially responsible state later (see subchapter 4.4.), whereas here it must be pointed out that the course of the governing politicians with regard to adjusting the health care sector stays unchanged, by covering up with grammatical interpretation of the expression "the State shall guarantee a basic level of medical assistance" provided in the Constitution – and it means - just the minimum nothing more.

Therefore, it is of particular importance that in the comparatively inert post-Soviet society activity of the civil society arise, endeavouring to protect the interests of their contemporaries on their own. For example, on 3 October 2014, the Latvian Rare Diseases Alliance was founded by uniting several associations. One of the associations included in the Alliance, Pulmonary Hypertension Association (PHA), unites people with a rare, chronic and life-threatening disease – pulmonary arterial hypertension, which is included in the list of rare diseases. Currently, about 85 such patients are identified in Latvia, but according to statistical estimates, the number should be around 200.[118] The Head of the Latvian Rare Diseases Alliance, Ieva Plūme, who also manages the PHA, characterises the situation as follows: „In Latvia, in the field of treating rare diseases, chaos continues for years, but the public authorities in charge hesitate to take responsibility and adjust the system."[119]

As pointed out by I.Plūme, according to estimates, up to 140,000 people (~7.4% from all inhabitants[120]) in Latvia can encounter a rare disease at some point in their life. Nevertheless, a majority of diseases have not been diagnosed. According to estimates, around three thousand children and adults having rare diseases are currently identified.[121]

Some of the people with rare diseases work or could recover the capacity for work, provided that they are treated strictly following the therapy guidelines approved

[118] Available at: www.phlatvia.lv (accessed 12.06.2015).
[119] Supra note 115.
[120] Number of population 1 979 400 (on 26 June 2015), according data provided Central Statistical Bureau of Latvia. Available at: http://www.csb.gov.lv/en/statistikas-temas/population-key-indicators-30624.html (15.07.2015).
[121] Supra note 115.

in Europe. Nevertheless, the doctors in Latvia are forced to prescribe only the available medication, which in severe, specific cases do not provide the necessary result, and the health condition of a patient rapidly deteriorates. Consequently, there is an additional burden on the state budget: benefits, a relative does not work to take care of the patient, the number of the days spent in the hospital increases, etc.

I. Plūme admits that to adjust the field of rare disease treatment, one should not invent the wheel twice, because there are excellent results of treating rare diseases in many European countries.

Most actual information on problematic of Rare Diseases in EU is reflected in an Implementation Report on the Commission Communication on Rare Diseases. According to it rare diseases affect between 27 and 36 million people in the European Union and are a key health policy priority due to the limited number of patients and scarcity of relevant knowledge and expertise regarding particular diseases.[122]

In 2008, the Commission adopted a Communication on Rare Diseases, setting out an overall strategy to support Member States in diagnosing, treating and caring for EU citizens with rare diseases. The Council also adopted Recommendation on the action in the field of rare diseases and called the Member States to put national strategies in place. In the Council Recommendation, Member States committed themselves to adopt a plan or strategy to address rare diseases as soon as possible and by the end of 2013 at the latest.[123] By the first quarter of 2014, 16 Member States had national plans or strategies in place to address rare diseases. As follows from the Implementation report, the scope of the rare diseases plans differs between countries. For example, while rare cancers are a significant part of the rare diseases spectrum, several plans/strategies do not cover this group of diseases. This is true for Germany, France, Belgium, Denmark and Portugal. Denmark does not consider infectious diseases as rare diseases. Establishing a precise definition of rare diseases is a prerequisite for effective actions in this field. In Article 3 of the Council Recommendation, Member States committed to using for the purposes of Community-level policy work a common definition of a rare disease as a disease affecting no more

[122] Implementation report on the Commission Communication on Rare Diseases: Europe's challenges, COM(2008) 679 final of 11 November 2008, OJ C 151, 03/07/2009, p.7–10.
[123] Council Recommendation of 8 June 2009 on an action in the field of rare diseases (2009/C 151/02) /COM/2014/0548 final/.

than 5 per 10,000 persons. Some examples of the situation in various Member States as regards the rare diseases definition: Finland: uses the definition of no more than 1 in 2000 affected persons and of severe/debilitating disease; Belgium: defines rare diseases as life-threatening or chronically debilitating diseases that are of such low prevalence that special combined efforts are needed to address them; Estonia: has no approved official definition of rare diseases. Stakeholders in Estonia, however, accept the EU definition from the Regulation on Orphan medicinal products.[124]

Similarly to other EU countries, in Latvia the national plan for rare diseases is developed and approved by the Ministry of Health, but is not approved on the government level. All the measures provided by the plan are planned to carry out within the limits of the existing tenuous budget without asking for additional financing.

According to the information provided by the Head of PHA, there are a number of problems in the field of ensuring health to patients with rare diseases. Health care system specialist awareness of rare diseases in Latvia is low. It carries a risk of late or incorrect diagnosis, which increases the treatment costs and causes unnecessary suffering to the patient. With respect to providing the patients with rare diseases with state reimbursed medications, the situation is critical for many years. In Latvia, the ceiling – up to 14'228 EUR a year for a patient – to individual reimbursement of the medications not included in the list of the state reimbursed medications is set, but often the medications cost more, thereby many patients are left without medications. The state initiated massive diagnostics of rare diseases to newborns is insufficient, too. Inhabitants of Latvia with rare diseases are denied state reimbursed rehabilitation services, assistant help, psychological support services to patients and their relatives, who take care of people with chronic illnesses.[125]

As told I.Plūme then the state offers the Programme of Pharmaceutical Treatment to Children with Rare Diseases, but their parents are not provided instruments of social support – no psychological assistance and assistants are available for the parents to be able to work, also, specific rehabilitation is not included in the basket of state reimbursed medications. Awareness of the Programme for children is

[124] Ibid.
[125] Supra note 115.

quite limited, too – even among specialists there is confusion. When a child has grown, access to this programme is discontinued.[126]

It is absurd that even provision of such a vital medical equipment as oxygen device is left at the patients' own terms. An oxygen device or oxygen concentrator is needed in the case of the already mentioned pulmonary hypertension, as well as for many more diseases, when oxygen supply to body is obstructed. In this case it is a matter of life and death, not just health. Currently in Latvia such assistance is not provided to anybody from the state budget, and patients seek different options of „acquiring oxygen" as either paying for or renting an oxygen device is financially possible for them. As a matter of fact, patients of many diseases are left alone in the situation when they need to breathe, but without this equipment it is not possible. Here, instead of the state, assistance is offered by the already mentioned association (PHA), which has invested over 18'000 EUR to buy oxygen concentrators to help these people. It is the money of different donors. Nevertheless, the needs of all patients cannot be satisfied with this modest financing, and people are queuing to get the device. According to the association's calculations, each year the state should buy different oxygen devices costing around 70'000-100'000 EUR, in order to satisfy the needs of all those people living in Latvia who need oxygen due to disease. In 2015, organisations representing patients have managed the Parliamentary Commission to allot additional 40'000 EUR for purchase of oxygen device. According to approximate estimates, it means that at least half of the patients in need of these devices will have to wait or provide them themselves.

As the primary measures to be carried out to solve these problems I. Plūme refers to incorporating a programme of rare diseases in the new political initiatives, as well as adjusting the framework of laws and regulations, defining what „rare disease" stands for according to Regulation No 141/2000 of the European Commission. It is also crucial to develop a centralized register of patients with rare diseases, which would help to assess the costs needed for providing care to patients with rare diseases. It would allow to purposefully plan financing for this area. Furthermore, it is necessary to develop a separate list of state reimbursed medications for children and adults with

[126] I.Plūme, email, 17 July 2015.

rare diseases, which would develop a transparent mechanism for administering the finances.[127]

The refusal of the state to co-finance Zane's lung transplantation created a huge perplexity among the public and rare disease organisations, and there was hope that the state institutions will finally get to real improvements in treating patients with rare diseases. An agreement was reached that by the end of 2014 the Ministry of Health and National Health Service will compile information on the number of patients with rare diseases in Latvia, diagnosis, costs and requests to cover costs for medicines, and will seek opportunities to cover lung transplantation costs from the budget

However, the progress of this promises fails. I.Plūme points out that the due date of the National Plan for Rare Diseases is 31 December 2015. The working group that would develop the project of the new plan is not convened yet, and the Ministry of Health ignores the question.[128]

The patient's organisations point to the possible reasons why this issue has not been solved for years by referring to the well-known expression of the Stalin era: „No people, no problems." In other words, treating rare diseases often takes enormous resources, and from this point of view it is in the state's interest to ignore it in order to avoid solving questions about additional financing or reforms in the health care system.[129]

Describing the situation of diagnostics of rare diseases, professor of the Rīga Stradiņš University, Dz.Mozgis, indicates that "in 80-90% of the cases the problem is not the competency of the specific doctor, but the system, as a result of which the patient with a rare disease doesn't have an access to the appropriate health care. In essence, rare diseases are an exam for our state health care policy – how capable we are to cope with these issues."[130]

[127] Paparde I. "Patients with severe disease have to rent the oxygen" (in Latvian), Neatkarīgā rīta avīze, 9 June 2015.
[128] I.Plūme, email, 17 July 2015.
[129] A.Bērziņa "Easier to turn a blind eye than to look in the long term", Diena, 10.07.2015.
[130] Ibid.

4.3.3. Discrimination with regard to organ transplantation

The case of Zane provoked a broad discussion not only about the problems in treating rare diseases, but also about unsolved issues related to organ, including lung, transplantation.

To the question if lung transplantation should be developed alongside kidney, pancreas, heart and liver (the first and only transplantation of liver was performed in 2011) transplantation in Latvia, the Head of Surgery of Pauls Stradins Clinical University Hospital, Prof. Dr. Jānis Gardovskis, replies: „I don't think it should be done". "Lung transplantations are highly complicated operations performing of which requires experience and respective equipment. In Latvia, only about two patients would need such operations, it is therefore appropriate to cooperate with a transplantation centre of another European country having the expertise and good results in this area."[131]

In Slovenia, with about the same number of population as in Latvia, around two million, kidney, liver, heart and cornea transplantation is performed in University Medical Centre in Ljubljana and Maribor (cornea), but lung transplantation – in Vienna Clinic (Austria), partial liver transplantation to children in Bergamo (Italy), whereas the waiting queues and preparation of patients for lung and liver transplantation (for children), as well as post-surgery treatment is provided by University Medical Centre in Ljubljana. In Czech Republic, with more than 10 million inhabitants four transplantation centres have specialisation in kidney transplantation, whereas three centres specialise also in lung, heart, liver and pancreas transplantation.

Good results of lung transplantation are observed in Tartu University Clinic (Estonia), Lithuania, and Belarus, where it costs around 30'000 EUR, in Estonia – 50'000 EUR. In Czech Republic it costs around 40'000 EUR, but in the Vienna Clinic – 120'000-150'000 EUR. Zane's pulmonary arterial hypertension had developed to such a severe stage that transplantation was possible only in the Vienna Clinic.[132]

Nevertheless, according to professor Gardovskis, liver transplantation should be resumed in Latvia. There are many patients with severe liver diseases, hepatitis C, cirrhosis etc. Each year 20 – 30 patients would need such operations. According to J.

[131] Hailova A. "Ērglēnietes Zane's plague makes to resort to improvements in the treatment of rare diseases" (in Latvian), Lauku Avīze, 7 March 2014.
[132] Ibid.

Gardovskis, the average costs of liver transplantation in Latvia could amount to 30'000 – 50'000 EUR. The professor has not lost the hope that these operations will be resumed already in the nearest future, because everything that is needed is there. "Nevertheless, we are not adventurers and are waiting for a clear answer, whether and how much financing the state will allot to it. Afterwards, we will renew the waiting list to liver transplantation and will start to carry out analysis," he stresses.[133]

Currently, liver transplantation method, similarly to lung transplantation, is not included in the list of state reimbursed services, therefore neither in Latvia nor to patients who might receive it abroad, it is not reimbursed (excluding children).

This year the state has allotted around 60'000 EUR for heart transplantation. The costs of transplantation of one heart in Pauls Stradins Clinical University Hospital amounts to 29'000 EUR. Each year the state allots financing for 55 kidney transplantations on average. In 2014, 51 such operations were covered from the budget.[134]

Prof. Dr. Gardovskis projects that soon the situation in the field of transplantation might improve in Latvia as the strict requirements set by the EU directive to the whole chain of the transplantation process will be introduced in the law and real life and transplantation centre certification will take place. "By integrating the EU standards in medicine, Latvia will not be able to sort people in groups anymore and allot financing to some and refuse to others," professor Gardovskis is convinced.[135] Obviously, the doctors are well aware of the current lack of a regulatory framework and unequal attitude to patients, nevertheless, it is clear that rather than adjusting the regulatory framework their principal task is treating patients. The regulatory framework adjustment is a problem of the respective ministry in charge.

From the above one has to conclude that in the realisation of the Article 111 of the Constitution, a discriminating attitude by the state to an individual is observed in this area, too. If costs of heart or lung transplantation in Belarus or Estonia are compared to Latvia, there is no considerable difference. A question arises – why does the state sort the patients according to their diagnosis and provide treatment to some,

[133] Supra note 115.
[134] "Last year 2 heart and 51 kidney transplantations have been performed", LETA, 24 May 2015.
[135] Supra note 114.

whereas to others it is refused and their life is threatened? Such a situation is not acceptable and should be avoided.

Concluding this subchapter I have to say, I am happy for Zane. At the same time my questions about the actions of the government in accordance with Article 111 of the Constitution on the rights of individual, the principle of a socially responsible state established in the constitutional preamble, as well as on the rhetoric of the Prime Minister that „within the limits of insufficient resources, the primary goal is to ensure the interests of a broader public" still remain unanswered.

The examples discussed and the general problems in treating rare diseases and organ transplantation demonstrate that even when it is a matter of life and death, the attitude of people in charge of the state policy to solving such issues is simplified – the law does not provide help, therefore – one is not entitled to it. The answer to the question – why does the law not provide it? – is simple, too – there is no financing, whereas the existing resources are directed "to ensure the interests of a broader public". What are these interests? In my opinion, it is revealed by the generous response of the public when someone's health and life is threatened. The missing money is promptly donated without undue delay. The public's interest is that, in each individual case, one receives the necessary help. It is the conviction for which they are ready to pay twice – first, by paying taxes, and second, in each individual case when the government has failed to provide it in its regulations. This is quite a controversial situation. On the one hand, the constitution provides that the government should ensure at least the minimum health care to everyone, on the other hand, the solution offered by the government is leaving complicated situations on the individuals' own or public terms. This controversy assures that the constitutional guarantees of health care in Latvia, at least for now, are a myth, not a reality.

4.4. Recent developments – a way out?

As we have seen from a general picture given in the subchapter 4.2. and the examples shown in the subchapter 4.3., the accessibility and financial risk protection to the patients offered by the Latvian health care system is insufficient. The lack of financial resources resulting from the financial crisis still challenges the Latvian

government to tackle issues such as reducing dependence on out-of-pocket payments and improving the overall efficiency of the system.

4.4.1. Action plans, Guidelines and a failure to implement them

It is promised in the Cabinet Order No 84 „The State Action Plan for Implementing the Declaration on the Proposed Actions of the Cabinet of Ministers led by Valdis Dombrovskis[136]" that „yearly health care budget is increased at least by 0.25% from the GDP, in 2014 reaching the index – health care state budget – 4.5% from GDP". According to the President of the Trade Union of Health and Social Care Employees of Latvia (TUHSCEL)[137], Dr.Habil.med. V.Keris, this promise is not fulfilled: according to Ministry of Health data, in 2014, health care state budget was a meagre 3.06% from GDP.[138] In 2015, in terms of percentage, it remained around the same amount of GDP. He also indicates: „Laimdota Straujuma[139] has been more successful fulfilling promises: in 2014 health care was indeed alloted additional 10 million EUR, whereas in 2015 instead of the promised 40 million EUR only 30 million EUR were alloted."

On 30 September 2014, the Cabinet of Ministers approved "The Public Health Care Guidelines for the years 2014-2020" (Guidelines). According to the Guidelines, the ultimate goal of the public health policy is to increase the number of healthy life years and prevent early death. It provides for an increase of healthy life years by 3 years by year 2020 (with men reaching 57 years and women – 60 years), as well as a decrease of the ratio of potential years of life lost by 11%.

It should be noted that following the Guidelines, the Ministry of Health had requested additional 109 million EUR for 2015. As can be seen, the difference between the intention and the reality is considerable. Regarding the budget of 2016, the government has not expressed any specific promises about increase of health care sector financing.[140]

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[136] Valdis Dombrovskis – Prime Minister of Latvia from 12 March 2009 – 22 January 2014.
[137] The actual number of members of TUHSCEL in the beginning of 2015 – 10 931, V.Keris, email, 3 July 2015.
[138] Public Health Guidelines for the years 2014 – 2020, approved by Cabinet of Ministers, 30 September 2014.
[139] Laimdota Straujuma - Prime Minister of Latvia from 22 January 2014 till now.
[140] V.Keris, email, 3 July 2015.

The increase of financing to health care sector provided by the Guidelines is based on the target to reach 4.0% from the GDP in 2020. TUHSCEL sees it as insufficient, because World Health Organisation has suggested that Latvia reaches 5.0% from the GDP already in 2014. Meanwhile it should be pointed out that, for the time being, even this more modest schedule of the Guidelines is ignored both, by the government and the Parliament.[141]

A dialogue among social partners (Employers' Confederation of Latvia, trade unions and other organisations protecting the interests of those involved in the sector) and the Ministry of Health is mainly conducted at the Health Inspectorate of the National Tripartite Cooperation Council (NTCC). As pointed out by V.Keris, unfortunately the Ministry has not convened any meeting this year. The President of the Trade Union reaffirms that the government's willingness to address the growing challenges is minimal, so the government also avoids talking with industry representatives.

4.4.2. Plans for changes in the field of health care financing or imitation of action

Although the situation with health care guarantees described above can be regarded as disturbing, one may not claim that the government of Latvia has not tried to improve the situation.

As mentioned before, in February 2012, the government action plan was approved and on 10 May 2013 the government adopted a Conception on the model of health care financing system. This plan and the following Conception intended significant changes in the field of health care financing, once again – leading in the direction of a social health insurance type system.

In its latest version, the plan provided an introduction of the general compulsory health insurance system, but it should not be paid for by those who pay the personal income tax. The others, however, would have the possibility to acquire „self-insurance".

Having acquainted with the health care reform plan, a Latvian judge of the Court of the European Union, prof., Dr.iur.hc Egils Levits objected, assessing the constitutionally legal issues with the highest principle (überprinzip) of a socially

[141] Ibid.

responsible state in mind. As pointed out by him, the consequences of this reform would be a considerable number of inhabitants (that are not paying taxes and their status does not fall into particular categories) financially not able to provide „self-insurance" would, in fact, be excluded from the regular health care. That would, therefore, be considered the success of the reform.[142] E.Levits indicates that two different aspects – tax paying and (compulsory) health insurance – are confused in the plan. That creates an array of constitutionally legal problems. In his opinion, the social aspect of the project is difficult to reconcile with the social policy and rights of the European Union. E.Levits emphasized that the plan contradicts the highest principle (überprinzip) of a socially responsible state provided in the Preamble and in Article 1 of the Constitution, which states that a state's policy has to focus on the social equity. A social equity means distribution of material (and partly immaterial) benefits from the wealthy representatives of the society to the poor ones. Although the intensity of applying this principle is left in the hands of the government (however, setting certain minimum limits so that the state may not ignore it), it certainly does not permit distribution of benefits from the poor inhabitants to the wealthy ones so that the wealthy ones possess even more.[143]

Regardless of the critical polemics in the public, the bill „Health Care Financing Law" was passed to the Parliament in November 2013.

The purpose of the law provided in Article 1 of the bill is to promote attraction of the financing necessary to ensure health care service. Practically it provides for introduction of a compulsory health insurance, by binding it to personal income tax payments. Thirteen out of seventeen Articles are dedicated to this regulation, leaving the remaining three Articles to other health care issues the regulation of which would be particularly important. The remaining three Articles cover: the sources and amount of financing of health care (Article 2), state reimbursed basic health care services (Article 3), and the group of persons entitled to the state reimbursed basic health care services (Article 4). An attempt to define in Article 2 the state reimbursed basic health care services or the basic level of medical assistance

[142] E.Levits, "Constitutional law problems from a socially responsible state "überprinzip" standpoint", Proceedings of the IX Bīriņu Seminar of the Constitutional Law policy, organised by the Public Law Institute, Bīriņi, 25.-27.July 2012.
[143] Ibid.

provided in Article 111 of the Constitution on the level of the legislator (the Primary legislation) for the first time is regarded positively. According to the bill, the state guaranteed services that would be available to everyone regardless of whether taxes are paid (and the amount of the taxes paid) are 1) emergency medical care; 2) planned health care to patients for diagnosing and treating certain diseases or conditions; 3) reimbursing costs incurred from buying medicines and medical equipment intended for out-patient treatment. Further it delegates establishment of the types and levels of the medical treatment services funded from the state budget to the Cabinet of Ministers.

Almost at the same time the bill was passed to the Parliament, the Ombudsman created the Advisory Council in the field of health care and on 22 October 2013 its first meeting was convened. The main tasks for the Advisory Council were to identify the state-guaranteed minimum of medical assistance and to propose necessary amendments to the legislation.[144]

During the meeting, the doctors and legal experts working in the field of health care pointed out to the fact that the respective Article of the bill was incomplete in terms of listing all the diagnosis. The list is incomplete, there are equally severe and life-threatening diagnosis and conditions, that are not listed in the Article, for example, cardiovascular diseases, that are the most common cause of death in Latvia (arrhythmia, heart valves' conditions); severe rheumatological conditions, patients with gastroenterological diseases, genetic diseases, not to mention rare diseases. Such imperfection would open an opportunity for ungrounded discrimination with respect to ensuring health care services, concluded the Ombudsman.[145]

In the beginning of year 2014, the Ombudsman opposed to pushing the bill „Health Care Financing Law" forward and having a view that the offered regulation is not in accordance with Article 91 of the Constitution, because it leaves out persons with irregular, seasonal income from the state guaranteed health care.[146]

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[144] Meeting Minutes of the Advisory Council No.1, 22 October 2013 (in Latvian). Available at: http://www.tiesibsargs.lv/par-mums/konsultativas-padomes/veselibas-aprupes-joma (24.05.2015).
[145] Meeting Minutes of the Advisory Council No.2, 5 November 2013 (in Latvian). Available at: http://www.tiesibsargs.lv/files/content/konsultativa_padome_Veselibas_aprupe_Protokols_05112013.pdf (24.05.2015.)
[146] Letter of the Ombudsman to the Parliament "About the bill „Health Care Financing Law", No.1-8/2, 29 January 2014, p.3.

The Ombudsman stated that the goals and utility of such a reform were not clear. Also, the benefits are not clear given that the experts have admitted that the new regulation would not provide additional financing to the industry. The quality of health care may not be improved at the cost of completely denying this service to a certain group of people.[147]

With such legal regulation, a risk would be existent that any medical assistance, including emergency medical care, may be „quoted", patient's co-payment may be set, as a result of which the state's duty to guarantee the basic level of medical assistance to everybody, established in Article 111 of the Constitution, may be violated. Delegating establishment of the level of emergency medical assistance to the Cabinet of Ministers is not acceptable. On the level of principle, the basic health care service guaranteed by the state to everybody, should be clearly established by the Law, and the legislator may not fully delegate a value of the constitutional level to the Cabinet of Ministers without explicitly setting the level and accessibility of the services.[148]

Taking into account a realization that one of the health policy characteristics crucial to the public health is a comprehensive accessibility to services and low co-payments in the primary health care, in the opinion of the Ombudsman, the primary health care should be part of the basic health care services. According to the Ombudsman, the more vulnerable groups of people (children, people with low income, persons with disabilities, politically repressed persons etc.) that the state has committed to protecting in particular, should be included in a Law, not Regulations.[149] At present the categories of people exempt from the patient co-payments are established in the Regulations issued by the government (see subchapter 4.2.).

As the Ombudsman notes in his letter to Parliament: "the bill does not provide for a more legislative clarity, i.e., there is still no answer to questions like: what types of health care services in what level with how much of patient co-payment and for how long will they be available to a person having fallen ill? According to

[147] The Ombudsman's annual report 2014 (in Latvian), Rīga, 2015, p.102.
[148] Ibid.
[149] Starfield B., Primary care: an increasingly important contributor to effectiveness, equity and efficiency of health services. SESPAS report 2012., Gac Sanit. 2012. Doi:10. 1016/j.gaceta 2011.10.009, cited in the Letter of the Ombudsman to the Parliament "About the bill „Health Care Financing Law"", No.1-8/2, 29 January 2014, p.5.

forecasts, though, the state funded health care services will not be available to at least 100 thousand inhabitants of Latvia." [150] Therefore, the Ombudsman did not recommend the further progress of the bill.

Analyzing the current situation, Ombudsman concluded, that it is not acceptable that the state guarantees only the service of the ambulance and emergency medical assistance provided in the clinic is already restricted by a certain co-payment of a patient. The Cabinet of Ministers has already violated the limits of its delegation by setting a patient co-payment for emergency medical assistance provided in a clinic.[151]

During discussions in public, it was found out that almost all non-governmental organisations representing the helth care sector have expressed criticism of the bill and the usefulness of passing it further, pointing out to the following: adopting the law in the proposed wording poses a high risk of increase in the number of neglected diseases and consequently the rate of invalidity, the number of emergency calls that, in the long term, will incur much higher costs to the public.

For example in its statement, the Family Doctor Association of Latvia strongly criticised the new bill by pointing out that it will not solve the problem of lack of health care financing and will deny state reimbursed health care to part of the society and needlessly burden the medical practitioners with having to check their patients' belonging to certain groups that are exempt from patient co-payments.[152]

Also in view of the Latvian Medical Association, the law proposed by the Ministry of Health does not provide for the procedures of spending the health care funding, does not solved the funding issues of emergency medical assistance, primary health care and prevention. In view of the President of the Latvian Medical Association, Dr. P.Apinis, the law was intentionally developed so imperfect so that it would not be possible to adopt it. He indicates that working on the bill, in his view, was an imitation of effort. The proposals for structuring and improving the bill were rejected. In July 2014 he predicted that before the coming parliamentary elections in

[150] Supra note 144.
[151] Ibid. p.p.5-6.
[152] Statement of the Family Doctor Association of Latvia to the Prime Minister and the Ministry of Health, No.155, 5 November 2013 (in Latvian). Available at: http://www.lgaa.lv/?q=node/113 (04.06.2015).

autumn 2014 the governing party, a member of which was the Minister of the Health, will not pass a bill heavily criticized by the industry, and after elections the party will most likely avoid the responsibility of running the Ministry of Health.[153] His predictions entirely came true and running the Ministry of Health became the responsibility of another party. Since autumn 2014, the government has proceeded with some, nevertheless of little significance, steps to make the health care service more available.

The Latvian Medical Association has many times insisted on adjusting the laws on health care, by having a view that two framework laws – the already existing Medical Treatment Law and the Public Health Law – are necessary. As admitted by the President of the Association, the procedure of funding medical treatment could be incorporated in the Medical Treatment Law or could be a separate Law.[154]

The Advisor to the President of the Latvian Medical Association, L. Cipule admits – in order to solve the exacerbated problems in the field of health care, the Ministry of the Health should commence a serious work on developing the Public Health Law, but politicians – on developing respective amendments to the Constitution by establishing a new paradigm in health care – the public health as the ultimate goal, and getting rid of the incomprehensible guarantee – a basic level of medical assistance.[155] Here, one could object to Ms. Cipule that first part of Article 111 of the Constitution already covers this ultimate goal of the public health protection in a broader sense, providing that „the State shall protect human health" (see Chapter 2.1.). Meanwhile, one should agree that the statement „a basic level of medical assistance" is quite down to earth and lacks ambition. It is important to note here that in the international standards such as ICESCR or Revised European Social Charter the definition is concise but carries a different message. It also provides that the state has to act within the limits of its resources, nevertheless the ultimate goal with respect to an individual is „the right of everyone to the enjoyment of the highest attainable standard of health."

[153] P.Apinis "Health financing law is dead, long live the Law!" (in Latvian), 11 June 2014.
[154] Ibid.
[155] L.Cipule, "Aimless wandering in the field of health", IR, 17 July 2014,

4.4.3. From words to deeds

In December 2014, the Latvian society was shaken by yet another desperate cry for help. This time medical assistance was needed to a child, despite the fact that children belong to the group to which the state provides everything needed for their health. Dāvis – a nine years old boy – was diagnosed with a severe combined pathology. Treatment was possible only in Philadelphia, U.S. Dāvis was the first patient with a need to receive treatment outside of the European Union and European Economic Area – outside of these territories, the state does not reimburse treatments even for children. The citizens once again collected 317'173 EUR for the treatment of Dāvis. Thanks to the great public pressure the state alloted additional 100'000 EUR. After the citizens had collected money, several ministers announced that they would work on making sure that such cases will not repeat.

The Minister of Health said that the Ministry of Health has a vision of the necessary amendments to regulations in order to extend the range of countries where the citizens of Latvia may receive the necessary treatments, should such treatments be unavailable in Latvia. Funding for covering the costs of such rare cases would be in a separate fund, to which the money could be transferred from the state budget and by attracting donations. I see it as a satisfactory solution to any exceptional circumstance when human life is endangered and when, according to the ultimate goal of a socially responsible state established in the Constitution, help should be ensured.

One of the most comforting news lately is the fact that in June 2015 the government supported the conception of the Ministry of Health to fund 50%, or up to 150'000 EUR, from the costs of treating children outside the European Union, European Economic Area and Switzerland. In the future, a child will be able to receive a partly state-funded medical assistance outside the EU, EEA and Switzerland, too. The Ministry of Health indicates, however, that the National Health Service may refuse such help, in case it can be received in the EU, EEA or Switzerland. Since no additional funds are allotted to this goal in the health budget of the state and usually the costs of treatment have to be covered even before the process of medical treatment has been started, in the future 450'000 EUR a year from the state budget should be allotted to circumstances of exceptional medical treatment in order to cover extraordinary medical treatment costs.

Although the above decision provides for only half of the funds necessary for every exceptional circumstance, it serves as a signal that the Minister of Health has a serious intention to seek solutions to adjust the health care sector instead of making vague promises.

The question remains open – what will be the ambition of the Latvian government to support the Minister of Health in allotting the necessary funding to the industry which, according to the Guidelines, should reach 205 million euros in year 2016.

Chapter 5. A comparative analysis based on the Estonian experience by providing rights to health protection

The conclusions drawn about the constitutional guarantees in Latvia in the previous chapters invite to inspect the situation in this area in other countries, in order to find out if developments in the health care of Latvia are regularities or other scenarios of development are available. With the similarities of the historical as well as the current economic and political development of the three Baltic States in mind, it is convenient to choose one or both of the neighbouring countries for comparative research. By paying attention to both, the statistical data (see Subchapter 5.1.) and notes taken during discussions with colleagues in Ombudsman institutions,[156] a conclusion is drawn that Estonia may currently be viewed as a certain example of the good practice in the Baltics. For this reason, this particular neighbouring country is chosen for a close comparative research. The aim of this Chapter is not a profound analysis of the health care system of Estonia, which would be neither possible nor necessary within the framework of this Master's Thesis. The attention will be paid mainly to the previously discussed aspects concerning the constitutional guarantees of the health care system in Latvia and that are significant in the context of this research as reflects weak points of the system.

[156] Interview with Ineta Rezevska, Ombudsman Office of Latvia, Head of Division of Social, Economical and Cultural Rights, Rīga, 01 June 2015 and with Kristjan Ots, Senior Adviser to the Chancellor of Justice.

5.1. A General overview of the health care system in Estonia

Estonia is the fourth smallest country of the European Union. According to the statistics, 1,313,271 persons lived in Estonia on 1 January 2015.[157] Estonia became independent in 1920, and exactly like Latvia was occupied by the Soviet Union in 1940 but regained independence in 1991. Fundamental reforms of the early 1990s aimed to move the health system away from a centrally funded and managed system to a decentralized model funded through social insurance in the same way as in Latvia. This process of the decentralization in the 1990s did not result in efficient and accessible health services. Therefore, there was once again a trend towards centralizing planning and regulation after reforms in 2001-2003.[158]

The Ministry of Social Affairs is the central administrator of the Estonian health care system. The ministry has to develop the relevant regulations and strategies. There are several agencies within the area of administration of the Ministry of Social Affairs such as the State Agency of Medicines and the Health Board, which handle health care matters.[159] The key components of the health system are shown in Fig.2.[160]

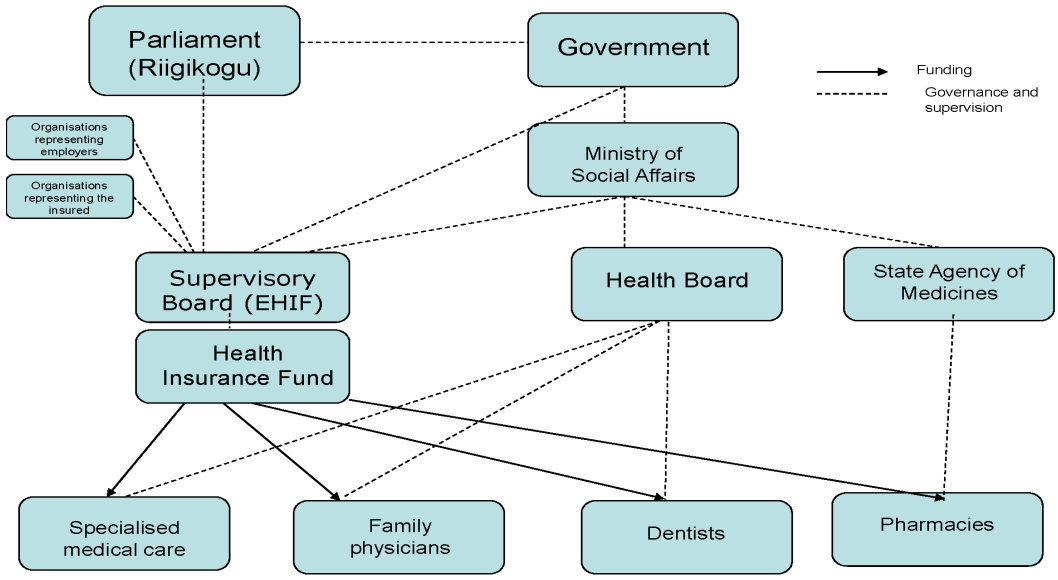

Figure 2

[157] Statistics Estonia. Available at http://www.stat.ee/90643
[158] T. Lai, T. Habicht, K. Kahur, M. Reinap, R. Kiivet, E. van Ginneken. Estonia: health system review. Health Systems in Transition, 2013; 15(6), p.xvii.
[159] Eesti Haigekassa. Available at: https://www.haigekassa.ee
[160] Overview of health care system in Estonia,

The Estonian health care system is based on separation of the provision of health services and funding thereof, the relative independence of health care providers in operational decision-making and the organization of the health care system around family health centers. Separation of the health care providers and funding is achieved via the independent Health Insurance Fund (EHIF),[161] which plays no direct role in managing medical institutions (e.g. representatives of the Health Insurance Fund are not represented in the hospitals' supervisory boards). Such separation of the health care providers and the funders guarantees unbiased funding decisions, aimed only at meeting the treatment needs of the insured and ensuring the use of health insurance moneys for the designated purpose.[162]

The funding of Estonian health care system is mainly through solidarity-based mandatory health insurance contributions in the form of an earmarked social payroll tax, which amounts to about two-thirds of total health care expenditure.[163] Health insurance system provides that 13% from the social tax of 33% are allotted to health care, and in case of necessity it is supplemented from the budget of a municipality or the state.[164] The Ministry of Social Affairs handles financing emergency care for uninsured people, as well as for ambulance services and public health programs, drawing on general tax revenue. Private expenditure comprises approximately 20% of all health expenditure, mostly in the form of co-payments for medicines and dental care.[165]

Taken as a whole, the health insurance system covers about 95% of the population. Contributions are related to employment. The share of non-contributing individuals (children, pensioners, etc.) represents almost 50% of the insured.[166]

According the later WHO Health System Review on Estonia (2013) overall health expenditure in Estonia is relatively low at 5.9% of GDP in 2011 (the EU average was 9.59%), and lower than the other Baltic states. However, the proportion of publicly funded health expenditure is relatively high (only the Czech Republic and Croatia are higher, among central and eastern European countries), and the national

[161] Estonian Health Insurance Fund Act (2009); Statutes of the Estonian Health Insurance Fund (2009).
[162] Eesti Haigekassa. Available at: https://www.haigekassa.ee
[163] Health Insurance Act (2008).
[164] Supra note 15.
[165] Supra note 157, p.xix.
[166] Ibid.

health plan includes the specific objective of holding out-of-pocket contributions at less than 25% of total health expenditure.[167] It may be recalled that this indicator grew up to the 38% in 2010 in Latvia, but in planning documents is fixed 27,9% limit to which these payments should be reduced until 2020.[168] As can be seen, the estimated percentage there in Latvia in 2020 still will be higher than in Estonia has been achieved already. The current Latvian Government Action Plan includes also the task for the Ministry of Health to decrease co-payments for medicines and hospitals, for example, reduce payments for the hospitalization from 13.52 EUR to 7.00 EUR per day until December 31, 2017.[169] Here should be noted that there exist already now fixed in-patient fee for the hospitalization of up to 2.50 EUR per day (for up to 10 days per hospitalization) in Estonia.[170] As can be seen, the differences between these payments in the two countries are considerable.

For some time ago there has been discussion in Estonia that the constitutional right to health protection does not allow for co-payments by the insured patients. Such payments could put a heavy burden on those people with a lower income. Estonian legal experts L.L.M. T.Annus and Mag.iur. A.Nõmper point out several arguments why this practice is necessary and constitutional, however: "first of all, there is a systematic argument that contrary to the first paragraph of Article 37 of the Constitution, which sets forth the right to education for juveniles free of charge, the first paragraph of Article 28 of the Constitution does not state that health protection has to be completely free of charge to inhabitants. Secondly, the complete responsibility of the state does not motivate people to protect their health by abandoning unhealthy practices, for example. Patients' contributions may be considered as a kind of self-liability. Thirdly, the financial burden might be unbearable for the state and prevent the state from engaging in other necessary policies".[171]

[167] Ibid.
[168] Supra note 137, p.93.
[169] Latvian Government Action Plan 2015-2018, the Cabinet of Ministers, 11.02.2015, the Step of action 299/F.
[170] Supra note 143.
[171] A.Nõmper, T.Annus, The Right to Health Protection in the Estonian Constitution, Juridica International, VII/2002, p.124.

5.2. Estonia and the European Social Charter

Estonia just like Latvia is a Contracting Party of the ESC. Estonia ratified the Revised European Social Charter on 11 September 2000 and accepted additional provisions of the Charter on 27 June 2012.

The last report concerned the accepted provisions of the thematic group "Health, social security and social protection" was submitted by Estonia on 6 May 2013. The Committee came up with its Conclusions 2013 in January 2014.

The report of the State confirms that foreign nationals residing or working lawfully in the country have access to health care on equal conditions to nationals. As regards vulnerable groups that are covered by the public health insurance system, the report indicates that the following categories have equal rights to insured persons: pregnant women, persons under 19 years of age, persons receiving a state pension or those with 5 years left on reaching pensionable age, and students up to 24 years.[172]

Health care for other uninsured persons is provided as emergency care and funded from the state budget. A family physician is obliged to provide emergency care to a non-resident or to any another person living in his/her service area that is not included in the practice list.[173]

As regards waiting times, the report acknowledged that despite additional financing, waiting times have not improved during the reference period. Moreover, the maximum length of waiting time, established by a decision of the Health Insurance Fund on 6 March 2009, was extended to 6 weeks for out-patient specialized medical care (previously four weeks). The report states that the shortening of waiting times does not depend on financial considerations, as much as it does on the number and labour organisation of doctors and nurses. The Committee considered that waiting times continue being an area of concern.[174]

The report indicated that there are high rates of population satisfaction with access and quality of healthcare services (see subchapter 5.5.1.).

[172] ECSR Conclusions 2013, Estonia, January 2014, p.19.
[173] 10th National Report on the implementation of the Revised European Social Charter, the Government of Estonia (Articles 3, 11, 12, 13 and 14 for the period of 01/01/2008 – 31/12/2011), 06.05.2013.
[174] Supra note 171, p.20.

The Committee concluded that the situation in Estonia is in conformity with Article 11 paragraph 1 and also in conformity with Article 13 paragraph 3 of the Charter while Latvia was not in conformity with them.[175]

5.3. The Constitutional guarantees and justiciability of the right to health

The present (fourth) Constitution of Estonia was enacted after a referendum on 28 June 1992.[176] Its second chapter sets out the people's rights, liberties, and duties. Similarly to Article 111 of the Constitution of Latvia Article 28 of the Estonian Constitution provides that "everyone has the right to health protection".[177] However, as can be seen, the wording in the Estonian Constitution is even more concise.

Historically Estonian Constitutions of 1920 and 1938 contained some provisions related to social rights, although their general application and enforceability in the courts was doubtful. In this respect, the provisions of the Constitution of the Soviet Union were radically different, providing for the maintenance of a net of health care facilities (Article 24) and for the right to health care (Article 42). This right was assured in practice in several ways, including the provision of qualified health care services for free in state-owned health care facilities, implementation of comprehensive disease prevention programs, etc.[178]

Three major framework laws regulating the health care in are: the Health Insurance Act (2002), the Health Services Organization Act (2002) and the Public Health Act (1995).

When comparing the provisions of these laws with the previously discussed Latvian regulatory framework, one should conclude that the Estonian regulatory framework has a much more successful structure. The general guaranteed medical care services are regulated by the Health Services Organization Act (2001). It clearly defines the organization of providing medical care on three levels – the General Medical Care, the Emergency Medical Care and the Specialised Medical Care.[179] Also, the contents, sources of financing, persons in charge and their duties on each of

[175] Ibid.
[176] Estonica, Encyclopedia about Estonia.
[177] The Constitution of the Republic of Estonia, 28.06.1992.
[178] Supra note 157, p.120.
[179] Health Services Organization Act (2001), Divisions 2., 3., 4.

the levels are regulated. The functions of each person involved in medical care are also systemically distinguished. Furthermore, Article 4 of the Law provides a general framework of financing medical care, providing in detail the available resources and indicating the source of the funding within the framework of the system. This principal law is complemented by the Public Health Act, which regulates the public health aspects, whereas the Health Insurance Act regulates the specific aspects of financing concerning health insurance.

As previously mentioned, there is only one law – the Medical Treatment Law – in Latvia, which, unfortunately, fails to provide such an extensive regulation. The Medical Treatment Law, similar to the Health Services Organization Act of Estonia, has survived several reforms. As a result, it has been many times amended and supplemented. About one fourth of the Sections of the Law have ceased to apply, and the Law is supplemented with new Sections, e.g., with norms of the health information system (e-health)[180]. The many supplements may be one of the reasons the Latvian Law has lost its logical structure, and its regulation has become difficult to apprehend. It is important to note here, that in terms of the number of amendments the Estonian Law has undergone more of them, nevertheless its inherent logical structure has not been disconcerted. Separate norms of a general character and mutually unrelated Sections can be found in the Medical Treatment Law, many of them providing a delegation to the government to regulate a particular area without even specifying the level of such delegation[181]. An example has already been mentioned before when, as a result of such an approach of the legislator, the whole regulation of organization and financing of the medical care has shifted to a secondary legislation – the Regulations of the Cabinet of Ministers. Thus, the competency of the legislator is currently regulated on the government level, consequently losing the institutional equilibrium between the power of the legislator and the executive branch established by the Constitution. As a kind of paradox an example of providing a detailed special regulation on Mental Illness in the Medical Treatment Law (Chapter XI) in an effort to compensate for a lack of regulation concerning mental health can be mentioned. In terms of volume, this regulation dedicated to one specific area of medical care

[180] The Medical Treatment Law, Chapter XIV. The Health information system.
[181] According to the Law, the Cabinet of Ministers has a delegation in at least 40 areas.

currently takes up about one-third of the Law, whereas regulation of the emergency medical care is provided in one sentence. Such principal questions related to medical care as a family doctor and primary or secondary medical care are not covered in the Law at all. Without disputing the importance of the questions regarding mental health, one should conclude that such a detailed special regulation does not fit in a regulation of a general character and turns the already fragmented structure of the Medical Treatment Law more incomprehensible and unbalanced. For a comparison, in Estonia the mental health issues are regulated by a separate Mental Health Act (1997), thus pointing out the importance of the issue and, together with other laws of the sector, forming a mutually related and structured system of legislative acts of one sector.

The medical care system in Estonia differs from that in Latvia, which is the reason why such a legislative regulation would not be possible to use directly as a model. Nevertheless, the example of Estonia with a well-considered legislative regulation of a sector as a basis for a successful alignment of the sector is a good incentive for Latvia to align its legislative regulation primarily. A systemic approach and goal-oriented effort of the ministry in charge and the Members of the Parliament are needed to achieve it.

Moreover, in addition to the problems dealt with the legislative framework, the question about the enforceability of health rights in the courts (justiciability) remains rather controversial as in Latvia (see subchapter 2.4), so in Estonia.

As noticed by Estonian legal experts T.Annus and A.Nõmper "the court system and court procedures are usually designed to protect the interests represented before it. Health care financing decisions are called "polycentric", which means that they involve a number of different competitive and antagonistic interests and in a common legal procedure, where a single plaintiff faces a single defendant it would be difficult to ensure that all these interests were adequately represented before the court. The most important consideration behind not recognizing justiciability of the right to health protection is the financial one. The level of protection might depend on the availability of resources. "[182]

Furthermore they detected through the decision of the German Constitutional Court that it is accepted that the legislator has considerable margin of appreciation in

[182] Ibid.

determining the adequate measures for protecting social rights and that the courts must not excessively interfere with social policy making.[183] In this regard, we can to draw parallels with the conclusions of Latvian Constitutional Court as well.

However, as shown by comparative experiences the justiciability is possible. First of all courts have a long tradition of indirectly guaranteeing social rights, by interpreting civil and political rights as encompassing certain aspects of social rights. A study carried out by the International Commission of Jurists concludes that judicial protection of the right to health has been achieved in different legal systems through: the right to life, the right to be free from torture or cruel, inhuman and degrading treatment and the right to respect for the private and family life. It also gives examples of the Indian Supreme Court, the Colombian Constitutional Court and the Inter-American Court of Human Rights.[184]

In Europe, the ECtHR stressed the connection between the maintenance of health care services and the prohibition on cruel, inhuman and degrading treatment. So, in the case D v. the United Kingdom, the Court held that deportation of the prison inmate who was benefiting from an HIV treatment to a country where such treatment was not available amounted to a violation of the right to be free from inhuman or degrading treatment or punishment under the ECHR.[185]

Besides T.Annus and A.Nõmper also note whenever the social rights provisions are clear enough and enable the courts to apply them to concrete cases, they are fully entitled to do so. The ECSR has taken a similar position and demanded that states provide for a justiciable right to health protection.[186]

Regarding the Estonian Constitution they emphasize that it "does not explicitly provide for the dynamic or progressive character of social rights, but it allows for restrictions on the fundamental rights as long as they are necessary for the democratic society (paragraph 11). Long-term economic stability and the balance of economic development might certainly be goals that justify the limitations for providing free health care to everyone. Also, the social rights must not mean that some

[183] Ibid.
[184] For details see: International Commission of Jurists, Courts and the Legal Enforcement of Economic, Social, and Cultural Rights: Comparative experiences of justiciability, Geneva, 2008, p.65-66.
[185] See European Court of Human Rights, D. v. the United Kingdom, May 2, 1997, paras. 51-53.
[186] Supra note 171, p.120.

groups in the society become privileged at the expense of others by demanding certain free services from the state. Under limited resources, all public welfare services need sufficient attention."[187]

Considering the opportunities and costs of modern medicine, it is clear that the state cannot provide for free all health care services anyone wants or needs. It would, therefore, be more appropriate to speak about the responsibility of the state to guarantee the availability of health care services. This includes the question of financial availability, concerning both regular health care as well as a treatment in extraordinary or emergency situations, where the right to life plays an important role in interpreting the constitutional guarantees.[188]

For those not covered by compulsory or voluntary insurance in Estonia, the right to receive emergency care for free is granted by the Health Care Services Organisation Act. Therefore, it might be considered that the state has a system, which guarantees the financial availability of basic health care services for all. However Estonian legal experts see the controversial issue while debating to what extent must the state provides the services for the poor or uninsured; and to what extent must the state provide for care involving extraordinary costs for treatment. The Health Care Services Organisation Act in Estonia understands under emergency care such services "which are provided by health care professionals in situations where postponement of care or failure to provide care may cause the death or permanent damage to the health of the person requiring care".[189] Such measures start from a simple injection of insulin and end with a hearth-lung transplantation and gene therapy. Considering the life-preserving nature of the essential services, the rights seem to be protected by the right to life instead of the right to health protection, and T.Annus and A.Nõmper notes that "the human life has a very high value in the Estonian society, and it does not seem to be justified simply to refer to tight resources when refusing potentially life-saving care. It seems unavoidable that a rational decision-making procedure has to exist, together with rules for making the decision. The right to life must be given enough attention and reasons for refusing treatment have to be well founded, e.g. the

[187] Supra note 171, p.121.
[188] Supra note 171, p.123.
[189] Supra note 171, p.125.

probability of the treatment to cure the disease might not be high enough to justify the costs (so called principle of cost-effectiveness)."[190]

T.Annus and A.Nõmper have figured that the comparative law demonstrates that the rights to high-cost health care in specific cases are in fact rarely enforceable in the courts. They pointed, "under the English or Scottish law the patients do not have a legal right to receive treatment or any particular standard of health care services. The health care rights are not justiciable. In Canada and the United States the right to receive health care services has not been approved as a constitutional right at all, while in Russia, despite the fact that the Russian Constitution of 1993 states that health care is provided free-of-charge in public and municipal health care facilities, the state is de facto giving up its commitments."[191]

As it can be seen from the examples discussed in Subchapter 4.3.1. of this study, there is a different approach to implementing rights to health care in Latvia than in Estonia and the human life not always has a high value in the eyes of the Latvian law appliers. The Latvian Constitutional Court, as it is apparent from its previous judgments, supports rather a conservative approach to the issue of justiciability of the right to health protection (see subchapter 2.4).

5.4. Comparison of the three particular aspects of the access to the rights to health

Following are some particular aspects chosen for comparative analysis, which are particularly relevant for a discussion within the framework of this research. They highlight contrasts developed over the time between both health care systems under study, as well as unfold the similar problems small countries encounter in the field of rare diseases.

5.4.1. Satisfaction with health services delivered and waiting times

According to the WHO Health System Review on Estonia (2013), 67% of people were satisfied with the Estonian health care system and rated it as "good" or

[190] Ibid.
[191] Ibid.

"reasonably good" in 2012, while the proportion of this group ranged from 61% to 63% in 2008–2011. More than half (55%) of the people were satisfied with access to health care in 2012, while 79% were satisfied with the quality of care in Estonia in the same year. The level of satisfaction with care access has been stable since 2003 without a clear trend, while the overall trend for satisfaction with care quality and the health care system has been positive, even during the economic downturn. Clearly, the area in need of improvement is access to care, which was highlighted by 45% of respondents of the satisfaction survey as the most negative aspect of the health care system (EHIF and Ministry of Social Affairs, 2013). The Estonian NHP has the target of 68% of the population satisfied with access to care by 2020 (Ministry of Social Affairs, 2008).[192]

Meanwhile According to the WHO Health System Review on Latvia (2012), 66% of citizens evaluate the overall quality of health care as bad (European Commission, 2011) and 65% think that the quality of care in Latvia is worse than in the other EU member states (European Commission, 2010).[193]

According to the provided data, one may conclude that about two thirds of the population in Latvia have a reason for dissatisfaction with the medical care provided to them, whereas in Estonia, on the contrary, two thirds of the population are satisfied with the provided medical care. The reasons for dissatisfaction are reflected in the data collected by the European Commission for the year 2015. The following Fig.3 shows self-reported unmet needs for medical examination by reason in EU Member States.[194]

As can be seen from Fig.3 unmet needs for medical care for reasons of costs in Latvia are the highest among EU Member States, while in Estonia they are significantly lower.

The comparatively high costs of the medical care in Latvia have already been indicated before (see subchapter 4.2.) and it is also depicted in the statistics provided in Figure 3. Meanwhile Estonia positively surprises that its inhabitants have significantly less frequently indicated that medical examinations are too expensive, even compared to such „old" members of the EU as Italy and France.

[192] Supra note 157, p.163.
[193] Supra note 3, p.169.
[194] European Commission, Country report Latvia 2015, {COM (2015) 85 final}, Brussels, 26.2.2015, p.74.

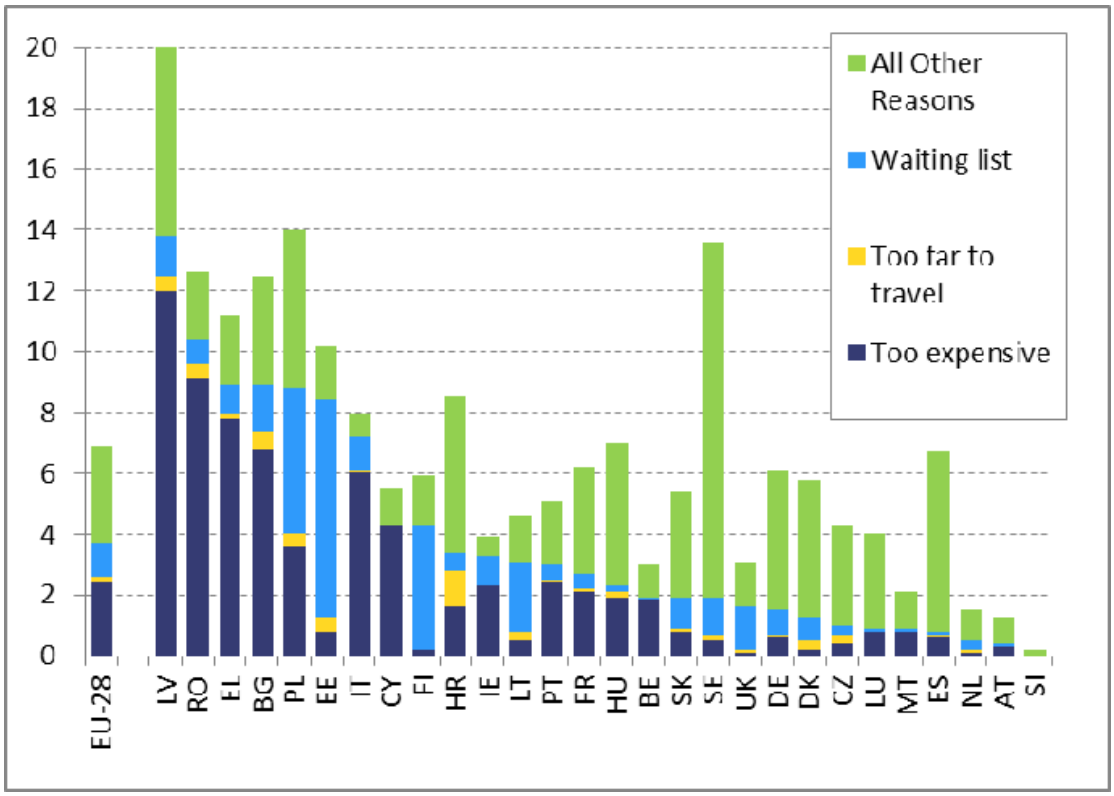

Figure 3

Particularly surprising with regard to reasons provided in Figure 3 is the indicated problem of waiting lists in Estonia, turning out to be the highest in the EU. Knowing from my own experience that problems with waiting lists in Latvia are at least as big as in Estonia, I am questioning the objectivity of such self-reported polls. The phenomenon of the long waiting time in Estonia may be explained by an active approach of the Estonian institutions in charge to diminish the problem and the public awareness of the rights to receive a state financed medical care service within a reasonable time. Hence, the waiting times are an identified problem in Estonia, and the awareness of it is depicted in the polls. Whereas the institutions in charge in Latvia view waiting times as normal, and not as a problem calling for a solution. It is at the citizens' own discretion to choose whether to wait for a state guaranteed service, probably unreasonably long, or immediately receive a self-paid service. In such a case, it is not necessary either to restrict the waiting time, or control if the established restrictions are followed. It is why in Latvia the maximum waiting periods are not set forth by any legislative document. This opinion prevailing in the medical care system

in Latvia has rooted in the public consciousness, too. Given that the health care system lacks financing and all requests to receive a health care service may not be met at the same time, a majority of patients hold an opinion that they have no right to receive a service more promptly. Thus, all those who cannot afford to wait, e.g., due to medical reasons, or can afford to pay, will choose services at a full price. As a result, a patient is content for having received a service promptly, whereas the system, including doctors, is twice as content due to an influx of additional resources. It appears to be a win-win situation. The problem shines through at the point when a patient is asked to assess the system – he/she admits unavailability of a service not because of the long waiting, but because the service was expensive, in effect, so expensive that he/she is not able to pay for it; for this reason a patient is often forced to borrow or ask for donations. This is the phenomenon in Latvia depicted in Figure 3.

In contrast to the Latvian practice, the Estonian legal experts have pointed out that "waiting lists are another mechanism for reducing availability of health care, which are commonly used to reduce the financial burden on the Estonian Health Insurance Fund's budget. This causes a clear constitutional problem — the availability of health care services is not guaranteed sufficiently well as the procedures for decision-making is not well elaborated".[195]

As recognized by the Karolinska Institute (Sweden) researchers within the wider study about waiting times in health care, long waiting times is an important health policy issue in many countries, and many have introduced some form of national waiting time guarantees. International comparison of waiting times are critical for countries to improve policy and for patients to be able to make informed choices, especially in Europe, where patients have the right to seek care in other countries if there is undue delay.[196]

As mentioned before in Estonia is being actively searched for solutions to the waiting time problem and it has been introduced the regulation. According to the WHO report on Estonia "Health systems in transition", the Supervisory Board approves the EHIF's maximum waiting times. There are also agreed maximum limits

[195] Supra note 171, p.124.
[196] Nina Viberg, Birger C.Forsberg, Michael Borowitz, Roger Molin, International comparisons of waiting times in health care – Limitations and prospects, Health Policy 112 (2013) 53-61.

for waiting times within the contracts: emergency care should be provided immediately, outpatient specialist care within six weeks and inpatient care within eight months. The waiting times are closely monitored by the EHIF, which will take preventive action, for example proposing changes in the financial appendices, in order to guarantee access to health care. Data on waiting times are monitored by the EHIF regional branches, and the contract volume is adjusted if there are insured individuals who have not been treated within the target limits.[197]

For comparison, the information available in the WHO report on Latvia is: "If waiting lists are substantial, and if providers have exceeded the number of patients to be treated (e.g.: towards the end of the month or year) according to their contracts with the NHS, patients have the option to pay directly (100% of costs) for the treatment at contracted or non-contracted providers." or "If patients do not have a referral, e.g. because they wish to avoid waiting times, all costs have to be covered out-of-pocket or through the voluntary health insurance."[198] From the conclusions of the report it is also clear that "it remains difficult for patients to be informed about the specific types of services to which they are entitled and to know whether they have the right to receive them without waiting. In particular, the existence of waiting lists and the possibility to access services in the public sector at full cost may expose patients to provider attempts at making them pay for services, which they are entitled to receive free. Furthermore, while conclusive evidence is limited, informal payments continue to be considered a problem in the Latvian health system."[199]

Although several years have passed since drawing up the report, no significant improvements regarding waiting times in Latvia are observed. Even with the information on waiting times for receiving planned in-patient service (data as of 1 July 2015) compiled and updated on the National Health Service website, it offers merely a rough idea. In order to find out the precise waiting time, one is advised to contact the respective health care institution. Oftentimes patients report that after contacting the health care institution, the actual situation is found to be different from that available on the NHS website. Here we arrive at another painful problem in Latvia

[197] See supra note 157, p.p.130-131.
[198] Supra note 2, p.p.62., 108.
[199] Supra note 2, p.178.

– availability and flow of information in the health care system. It is compared with the Estonian experience in the next Chapter.[200]

5.4.2. Using e-health solutions to improve efficiency

A nationwide e-health system was launched in Estonia in 2008. This and all other e-health solutions were seen as tools to improve efficient use of health resources by reducing paperwork and duplication, and to improve medical statistics. In essence, the Estonian e-health system today is a platform that incorporates a growing number of e-solutions such as electronic health records, e-prescriptions, digital image archive, patient portal, e-laboratory, e-emergency care solutions and statistics modules enabling information exchange with other e-systems. Patients can access their medical records and digital prescriptions through a patient portal and be better informed.[201] In Estonia has long time ago been recognized that investments in the e-health system play a crucial role here through better exchange of information and increasing accountability. Today in this area there can be observed significant progress.

The project *e-veselība* (e-health) has been discussed also in Latvia for over ten years, but the initial stage of its implementation is planned to be concluded only in December of this year.

According to the former State Secretary of the Ministry of Health, R. Muciņš, there have been problems in this area, both the overall decision making process of the government and different procedures have delayed the projects of *e-veselība*. He also points out that "the first document was drawn up in the year 2005 and it was planned to find solutions within a couple of years, it is now the year 2015 and we continue waiting".[202] Delaying the introduction of *e-veselība* makes one wonder why Estonia was able to introduce this project even before the economic crisis, when comparatively more funds for health care sector were available, whereas Latvia failed. Experts have already searched for the reasons within the framework of various projects researching corruption mechanisms[203], it is why I will not go into detail about them here. At the

[200] http://www.vmnvd.gov.lv/lv/469-veselibas-aprupes-pakalpojumi/gaidisanas-rindas-planveida-arstniecibai-slimnicas
[201] Supra note 157, p.154
[202] Sanita Igaune, "Muciņš will treat IKT sector", (in Latvian), Dienas Bizness, 04.03.2015.
[203] Indra Mangule, "Corruption in the health sector: challenges and examples of good practice in Latvia" (in Latvian), Rīga, 2015, KNAB "Risks of the corruption in health care system" Review, 2012.

same time, it is clear that the delay has supported and been an excuse for delaying solutions to other unresolved issues. One of such examples was already discussed in detail with regard to issues of rare diseases in Latvia, when delaying solutions is referred to a lack of respective registries, insufficient account and research of the statistical data and other suchlike formal excuses. Here I am knowingly focusing on rare diseases, as, in my opinion, this research would not be complete without also discussing the progress of the neighbouring country with regard to solutions to issues concerning rare diseases.

5.4.3. The situation in the field of rare diseases

First of all, it should be recognized that in terms of treatment of rare diseases patients in Estonia are confronted with similar problems to those in Latvia. The situation is lively characterized in an article, which won the EU Health Prize for Journalists in 2012. Dr. Kairit Joost, a medical geneticist, interviewed by the author of the article, says: "When a child who suffers from a rare disease is born in Estonia, it's not their fault that they were born in a small country […] However, when it does happen it is a real disaster, as treatment may not always be available here."[204]

The article also referred to an example where three children have been diagnosed with a rare disease in Estonia. Two of them had died before they received the treatment they needed. Family ties allow the third child to receive an enzyme replacement therapy in Italy, where the costs of this expensive treatment were covered for them.[205] These cases are in tune with the examples mentioned above talking about Latvia (see Subchapter 4.3.1.) when assistance is refused by a formal decision of the responsible institutions failing to adhere constitutional principles.

Another doctor Riina Zordania, Head of the Department of Medical Genetics at the University of Tartu Hospital, says: "Everyone has to be able to receive treatment in the European Union, […] but in a small country, doctors have to run an exhausting bureaucratic gauntlet when they treat a rare disease or need a rare drug – we have to do piles of paperwork." According to the information provided by the article, the doctors' efforts to get financing for a drug are not always successful – the Health Insurance

[204] Silja Paavle "Medical Geneticist: A rare disease is a real disaster in Estonia. People don't always get the treatment they need, as Estonia is such a small country", 2012
[205] Ibid.

Fund may decide that importing the drug is impossible, and that alternative options for treatment should be sought.[206]

From the brief description above, it can be concluded that in the field of rare diseases both patients and physicians in Estonia are challenged by similar problems to those in Latvia. Interestingly, by observing the Estonian approach to these problems, Latvia may find a useful experience for itself.

So in September 2012, a working group was set up to discuss the activities in the field of rare diseases, which should be added to the implementation plan of the Estonian National Health Plan 2009-2020 (ENHP): the working group had professionals in the field of rare diseases (doctors, medical geneticists, representatives of patient organisations, representatives of the Estonian Board of Disabled People, etc.).[207] A Rare Diseases Development Plan was adopted on 20 February 2014. The plan provides concrete steps to improve the situation in the field of rare diseases, namely, ensuring the funding required for supplementing and processing a rare diseases database and linking it to various other registers, where appropriate; establishment of a rare diseases centre of expertise with a committee of experts on rare diseases, operating at the rare diseases centre; development of a scientific research in the sphere of rare diseases, and strengthening the patients' organisations.[208]

According to the State report 2013, Estonia does not plan for rare disease-specific registries. In Estonia, all health-related information is collected in the Health Information System (Tervise Infosüsteem). Rather, an overview and statistical data on diseases, including rare diseases can be extracted from the electronic health information system. [209] The Genetic Centre of Joint Laboratory of Tartu University Hospital has a database including information on patients having consulted with medical genetics since 1990. The database belongs to the Genetic Centre; however, information can be supplied on request. Experts agreed that it would be highly reasonable to continue developing the current database. The database will contribute to a better organisation of supervision over the occurrence of rare diseases and their

[206] Ibid.
[207] Aymé S., Rodwell C., eds., "2013 Report on the State of the Art of Rare Disease Activities in Europe", July 2013.
[208] The Ministry of Social Affairs, Rare diseases development plan, Tallinn, 20 February 2014.
[209] Ibid. p.5.

prevalence/spread. The experts also agreed that the centre of expertise will fulfil both the role of the activity coordinator and the distributor of information, therefore creating the database, and a centre should be given due consideration. Similarly to Latvia, there is currently no official information centre for rare diseases in Estonia other than Orphanet, and there is no help line for rare diseases.[210]

Estonia, just like Latvia is among the countries with a poor neonatal screening coverage. Neonatal screening programs are currently implemented only for phenylketonuria and congenital hypothyroidism. A newborn screening for only two rare disorders is certainly not sufficient, that resulted in discussions concerning the expansion of the types of screening by using the tandem mass spectrometry method. The situation appears to be similar in both Baltic States.[211]

Despite the difficulties, organisations of patients play an extremely important role in supporting the patients who suffer from rare diseases and their family members, and increasing the awareness of such diseases in the society in general. Significantly, the Estonian Chamber of Disabled People and the Estonian Patient Advocacy Association (EPAA) provide support for patient organisations in Estonia. The activity of EPAA is financed by earmarked grants from the state budget while the Latvian patient organizations do not receive any support from the state. Patient organisations are represented in the Council of the Estonian Health Insurance Fund, and grants are available for patient organisations to attend these meetings.[212]

Overall the development of the national plan for rare diseases seems to be an important initial step towards improving the situation in this field both in Estonia and Latvia. However, both countries currently lack officially designated centres of expertise, and an accurate register of rare diseases, making it impossible to collect and evaluate comprehensive information on rare diseases. Some centres are recognized by their reputation only. Latvia is planning to implement the e-health information system at first and after establish electronic platform-based disease registers (including rare diseases).[213]

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[210] Supra note 207.
[211] Konstantins Logviss, Dainis Krievins and Santa Purvina, Rare diseases and orphan drugs: Latvian story, Orphanet Journal of Rare Diseases, 2014, 9:147.
[212] Supra note 207, p.6.
[213] The Ministry of Health of the Republic of Latvia, National Plan for Rare Diseases for the period from 2013 to 2015, 20 June 2013.

In summary, this chapter discussing some specific health care issues in Estonia from different perspectives makes one conclude that overall, the Estonian health care system works better than that of Latvia. The significantly higher self-assessment of the health care system by its users in Estonia compared to Latvia is the evidence. Also, the e-health project is successfully implemented in Estonia, outperforming Latvia for at least seven years. At the same time, patients in Estonia are confronted with similar problems to those in Latvia in the field of rare diseases. Early detection and prevention of rare diseases, integrated health care of patients, timely access to orphan drugs and continuing education of health care professionals play a crucial role in improving quality of life of patients suffering from rare diseases. Many of these activities are incorporated in the national plan for rare diseases, which will hopefully soon ensure people's full rights to health.

Conclusions

The Constitution of the Republic of Latvia regulates the accessibility to health care in a rather abstract and concise way – Article 111 provides that „The State shall protect human health and guarantee a basic level of medical assistance for everyone". The constitutional norm does not provide any indication as to what a guaranteed minimum medical care encompasses. The decision on what exactly stands for this basic level is left at the discretion of the legislator and the executive branch.

Without questioning the close relevance of the realization of the social rights with each state's capabilities, it is nevertheless worth taking into account the following realization – if any social rights are included in a state's constitution then the state may not abdicate them. These rights are not of a declarative nature only. The Latvian legislator and executive branch may not refuse to provide health services, as the rights to receive them are included in the Constitution. It is therefore particularly important to clarify the quantitative and qualitative value of the term „minimum medical care" provided in Article 111 of the Constitution with regard to the rights of each person to ask for and to receive medical care paid by the state.

Meanwhile, one should agree that the statement „a basic level of medical assistance" is quite down to earth and lacks ambition when compared to the international standards such as CESCR or Revised European Social Charter. The definition given there is concise, too, but carries a different message. It also provides that the state has to act within the limits of its resources, nevertheless the ultimate goal with respect to an individual is „the right of everyone to the enjoyment of the highest attainable standard of health."

There have been a number of discussions of the above question among lawyers, medical professionals and the public. The Ombudsman endeavoured to solve it in the annual conference in 2013 organized by the Ombudsman's Office, as well as within the framework of the Advisory Council of Ombudsman, by seeking for an answer to the question – what does a basic level of medical assistance mean in the 21st century. The conclusions of the serious and extensive working group failed to provide the expected result.

However, the Ombudsman highlighted opinion that on the level of principle, the basic health care service guaranteed by the state to everyone, should be clearly established by the Law, and the legislator may not fully delegate a value of the constitutional level to the Cabinet of Ministers without explicitly setting the level and accessibility of the services in the Primary legislation.

At present, the Medical Treatment Law provides that it is the duty of the state to provide emergency medical care, but clear criteria for defining the contents of such care are missing. Although it should be in the competence of the Parliament, the level of the state-funded emergency medical care is currently defined by the Regulation No 1529 „Procedures on Organizing and Financing Health Care" of the Cabinet of Ministers (17.12.2013), in which the state-financed services, as well as services not financed by the state, are enlisted. A problem arises when a person has a life threatening pathology not included in the regulation mentioned above.

For example, the case closely discussed in this research on the NHS refusing to finance a lung transplantation – the only solution to saving life – to a young woman with a rare, life threatening disease. The reasoning behind the refusal was simple – financing a lung transplantation is not provided in the regulations, but the reason why organ transplantation is needed at all and the reason the state should finance it was ignored.

In Latvia, a state-financed kidney, liver (for children) and heart transplantations are possible, which are costly operations. These operations are needed in cases when all other treatment options have been exhausted, and a patient's life has to be saved. Why does the state finance organ transplantation in many cases, but financing lung transplantation is omitted, even if it is the only way to save a life? Here the principle of legal equality established in Article 91 of the Constitution is concerned. With the Constitution providing that the state has to ensure certain guarantees (including financial) in the field of health care, the goal of the legislator is to avoid a threat to human health and life. If, from the point of view of medicine, one cannot live without lung transplantation, it is a fallacy from the side of the state to refuse financing this service. In the given case the patient could go to the court and contest the decision of the NHS, but this process is not easy, takes time and other resources, which in case of a severe disease may be cumbersome or even entirely

impossible. Furthermore, with several conclusions of the Constitutional Court regarding the state's duties to realize the social rights in mind, it is difficult to predict the outcome of such litigation process. In the given case, it is also problematic to dispute a regulation not providing financing to lung transplantation in the Constitutional Court, since the Court's principal task is to verify compliance of regulations with the Constitution and it does not take part in the process of adjusting the legislation. It is a function of the legislator and, in this particular case, according to the delegation provided by law – that of the executive branch.

Although the legal regulation of health care accessibility in Latvia is quite detailed overall, problems arise from interpretation of the rules and its application according to its purport and goals. A person lacks guarantees that in case of complicated health issues the ambiguous rules will be interpreted in his/her favour. The Latvian society is aware of it, the proof of which is the high level of public support by donating to people in need of solving health issues. The great activity of donors points to the fact that the public is well aware of the necessity to allocate more financing to health care, and it is possible to help by donating to those who need it most. Meanwhile, it shows that the public administration has not been able to develop an efficient health care financing system until now, both by motivating the public to pay taxes and ensuring reasonable and transparent administration of the state budget, as well as by ensuring a just spending of these financial resources.

As can be seen in the example of Latvia and Estonia, it is of particular importance that in the countries in transition the constitutional principles (such as social responsibility, the rule of law, human rights etc.) firmly take root in the consciousness of the public administration and the developers of its policy, as well as become the guiding landmark of their work. The statement that Latvia is a socially responsible state may not be hollow words only. This legal principle has to be filled with a specific content, and it imposes certain obligations on the state. Unfortunately, it is still not like that in Latvia. In emergency situations, when the Constitution provides for a basic level of medical health care and this basic level is specified only by regulations of the government that it may easily change, the constitutional health care guarantees turn into a myth.

From the comparative analysis, it is obvious that the medical care system in Estonia differs from that in Latvia, which is the reason why such a legislative regulation would not be possible to use directly as a model. Nevertheless, the example of Estonia with a well-considered legislative regulation of a sector as a basis for a successful alignment of the sector is a good incentive for Latvia to align its legislative regulation primarily. A systemic approach and goal-oriented effort of the ministry in charge and the Members of the Parliament are needed to achieve it.

The attempt to regulate the state guaranteed basic level of medical assistance on the level of the legislator has been currently suspended. The treatment of rare diseases in some cases does not fit at" this basic level. An active involvement of the government and legislator in adjusting the regulatory framework is not observed.

The examples discussed and the general problems in treating rare diseases and organ transplantation demonstrate that even when it is a matter of life or death, the attitude of people in charge of the state policy to solving such issues is simplified – the law does not provide help, therefore – one is not entitled to it. The answer to the question – why does the law not provide it? – is simple, too – there is no financing, whereas the existing resources are directed "to ensure the interests of a broader public". What are these interests? In my opinion, it is revealed by the generous response of the public when someone's health and life is threatened. The missing money is promptly donated without undue delay. The public's interest is that, in each case, one receives the necessary help. It is the conviction for which they are ready to pay twice – first, by paying taxes, and second, in each individual case when the government has failed to provide it in its regulations. This is quite a controversial situation. On the one hand, the Constitution provides that the government should ensure at least the minimum health care to everyone, on the other hand, the solution offered by the government is leaving complicated situations on the individuals' own or public terms. This controversy assures that the constitutional guarantees of health care in Latvia, at least for now, are a myth, not a reality.

It must be noted here that the UN Committee (CESCR) concludes in the General Comments 14 that a State, which is unwilling to use the maximum of its available resources for the realisation of the right to health, is in violation of its obligation under Article 12.

With regard to the state's duties to protect health, the Constitutional Court indicated that "arising from the state's duties to protect health is the state's duty to perform measures aiming at people's health protection, including provision of health care services and ensuring their availability. Nevertheless, it does not imply that any person would always have the right to receive any medical services for free. The state holds a broad discretion in choosing the way people may exercise their rights of receiving health care services."[214]

One has to conclude with regret that the Constitutional Court having the task to supervise the compliance of the existing regulation in the country with the constitutional principles, is following the same path as the government. In the cases where health care issues are related to restriction of civil and political rights (mainly related to prisoners rights to health care), the Court has consistently admitted that the regulation does not comply with the human rights norms. In the rest of the cases, concerning issues of the rights to health, the court decision has rendered the regulation appropriate and indicated that the government acts solely within the limits of its financial resources.

One should agree with a number of experts – lawyers, doctors and NGOs, who admit that Latvia with the statement „a basic level of medical assistance" provided by the Constitution, without its broader explanation by laws, is currently failing to ensure reaching the goal of the World Health Organization – „the attainment by all peoples of the highest possible level of health".

[214] Supra note 54.

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