HEALTH AS AN INDICATOR OF CIVILISATION

Dumitru STAN [*]

Abstract

Among crises facing present-day societies, health crisis owns a distinct place. Its special ranking is due to the fact that health is a representing indicator for the quality of civilisation of the social bodies. This study approaches the boundaries between health and civilisation from the point of view of the relationship between the whole and its parts. Therefore all health indicators are also to be considered as indicators of civilisation while the overall qualitative condition of civilisation is to be understood as an essential source of influencing the health department. Understanding the concept of health from the point of view of the complex of its sizes requires neither to reduce our rehabilitation attempts to mere physical remedies nor to assign some capabilities and responsibilities to health that the latter might not be able to cope with. From examples presented here it would result that most of the critical health conditions could be restored only by making reference to civilisation and, similarly, health can be augmented in its three-dimensional feature only by the aid of the capital assets of civilisation.

Keywords: health condition, sustainable health, social health, physical health, psycho-mental health, health indicators, indicators of civilisation, health crisis, civilisation crisis, health ideology

Résumé

Parmi les crises de la société actuelle, la crise du domaine de la santé est tout a fait différente. Son importance est due au fait que la santé de la population est un indicateur de la qualité de la civilisation des sociétés. Les frontières entre la santé et la civilisation sont abordés dans cette étude dans les termes de la relation entre tout et partie. En tant que tel, tous les indicateurs pertinents pour la santé sont supposés être indicateurs de la civilisation, et l'état de la civilisation est considérée comme la principale source d'influencer le domaine de la santé. La compréhension du concept de la santé par ses dimensions complexes nous oblige à ne réduire pas les démarches de refaire la santé à de remèdes naturels, ni d'attribuer au domaine de la santé des capacités et des responsabilités qui ne peut pas les finaliser. Les exemples présentés dans cet article montrent que seulement par référence à la civilisation peuvent être surmontées la majorité d'états critiques de la santé et avec l'aide des capitaux de la civilisation peut être augmentée la santé dans sa tridimensionnalité.

Mots-clés. santé, santé durable, santé sociale, santé physique, indicateurs de santé mentale, indicateurs de civilisation, crise sanitaire, crise de la civilisation, idéologie de la santé

Rezumat

Între crizele cu care se confruntă societăţile actuale, un loc aparte îl ocupă criza din domeniul sănătăţii. Poziţionarea specială a acesteia este urmarea faptului că starea de sănătate a populaţiei este un indicator reprezentativ al calităţii civilizaţiei corpurilor sociale.

[*] Assoc.prof.Ph.D., Department of Sociology and Social Work, Faculty of Philosophy and Social-Political Sciences, Alexandru Ioan Cuza University of Iaşi, Carol I 11, 700506, Iaşi, Romania; e-mail: dtrustan@yahoo.com.

Frontierele dintre domeniul sănătăţii şi cel al civilizaţiei sunt abordate în studiul de faţă din perspectiva relaţiei dintre parte şi întreg. Ca atare, toţi indicatorii relevanţi pentru starea de sănătate sunt asumaţi şi ca indicatori de civilizaţie, iar starea calitativă de ansamblu a civilizaţiei este înţeleasă ca sursă esenţială de influenţare a departamentului sănătăţii. Înţelegerea conceptului de sănătate prin prisma complexului dimensiunilor lui ne obligă să nu reducem demersurile de refacere a stării de sănătate doar la diverse remedii fizice şi nici să atribuim domeniului sănătăţii capacităţi şi responsabilităţi pe care să nu le poată finaliza. Din exemplele prezentate rezultă că doar prin raportare la civilizaţie pot fi depăşite cele mai multe dintre stările critice de sănătate şi, de asemenea, doar cu ajutorul capitalurilor de civilizaţie poate fi augmentată sanătatea în tridimensionalitatea ei.

Cuvinte cheie: stare de sănătate, sănătate durabilă, sănătate socială, sănătate fizică, sănătate psiho-mintală, indicatori de sănătate, indicatori de civilizaţie, criza sănătăţii, criza civilizaţiei, ideologia sănătăţii.

1. Complementarity of the relationship between health and civilisation.

Societies from all times have been ranked either civilised or less civilised according especially to the way in which they succeeded to provide for health to its members. A brief evaluation of this statement might find it rather reductionist and forced. As a matter of fact, the degree of civilisation of a society is rather measured and certified not by "x-raying" the health of its inhabitants but by a tremendous number of some fan-shaped and incoherently scattered indicators: from the quality of dwellings and durability of the building materials used for civil buildings to the quantity of telecommunication services offered to population; from the multitude of food available for consumption to social attractiveness of political regimes; from the raw materials used for current clothing of individuals to the water and sanitary sewer networks they are using; from the pastime services for the elderly to constructive inventiveness of strategies for solving interpersonal conflicts; from prompt reaction of social care services to happiness of the members of the society under evaluation.

It is true that, on a first sight, no one-to-one relationship seems to exist between these indicators and people's health; one cannot establish unquestionable correspondences between materials being used for building structure, government performances, infrastructure facilities, personal happiness, ways of solving social clashes, on the one hand, and quality of people's health, on the other hand. Nevertheless, due to a more persistent analytical approach we realise that behind unrefined realities behind these indicators are being functionally correlated and are eventually to be found in the amplitude of the real health of people making up that society. That is why *population's health* is considered to be the most relevant indicator to quality standards for the life of the society members, but also as a synthesis indicator in defining the level of civilisation of that society. While judging things from this point of view, all elements having been immediately and

obviously or indirectly and disguisedly involved in generating health should be considered as *civilisation determinants*.

Anytime these determinants produce some pain and people suffer from one or several diseases there should be identical individual and social responses to recover health. Otherwise, insufficient health on the individual level could be extended with different dysfunctions on the level of small or middle-sized groups or even with crises having repercussions on the entire society. And more, some ailments could get so big extensions that they may even cross the boundaries of one state to turn into an epidemic, pandemic or *threats to human race* no matter where it lives. To avoid such situations, societies from the archaic to post-modern societies, have established and perfected the *field of health* within them – a structure with a functional individuality whose authority has proved to be at least as powerful as *governance, economics, politics, kinship, education* etc. As an objective part of the social systems, the field of health mobilises internal or external, personal and group resources, it makes use of formal and informal strategies, it relies on traditional and current means, it de-structures and re-structures periodically, etc., and all these acting options are being permanently connected to the imperatives of health rehabilitation or health re-launch.

To stop catastrophic migration of diseases, several institutions and organisations have been established, especially in the contemporary period, to follow the evolution of regional and global health-related problems. Due to it, location of disease risk determinants can be rapidly made and transfer of effective, civilised remedies among societies is being stimulated. The essential objective of fight against crises through cooperation with both intra-society and supranational, civilisation structures still remains to obtain health, respectively “a complete physical, mental and social well-being” (Grosu, 1999, p. 150), for all categories of people. In other words, humankind should oppose hostilely to any disease and act favourably to any victim, including when it anticipates that the victim, once recovered from the disease, may turn into an executioner (Ruffin, 1991) or, paradoxically and without any practical reason, may be forced to comply with an older death penalty.

Surprisingly, *the right to health, in this context, is seemingly stronger than the right to life.* According to laws of societies (still) applying the death penalty, the latter may be lost under extreme circumstances, when offences have been proven to be crimes and therefore radically punished since they are being perceived as an attempt on life; in exchange, the first type of right having been mentioned here should never disappear: one’s health should be provided for the entire life and it should also be regained by that person even when decaying has been a result of a legally and correctly established penalty.

The view on unconditioned medical care emphasises *in the first place the social importance of health* as if it were the primary existential condition according to which all content of individual and group life should be designed. At the same

time, the deepness to meet this condition would represent a rather highly precise anticipation both of successes and failures of society functioning. *In the second place*, the same view is able to persuade us on the priority position that health indicators should have: hospitalisation capacity with reference to the number of population, eradication of social diseases, positive effects generated by primary and tertiary medicine, life span, fertility rate, frequency of medical examinations and medical analyses, sanitary education of population, public and private medical funding, providing for required medication, preventive medical and post-trauma care, providing for health under special conditions, ability to provide for immediate medical intervention, etc. The level to achieve these performance indicators reveals not only the *potential in the field of health*, but also the advantages or, on the contrary, the *precariousness of civilisation* within social environment where such measures are being made.

Due to their being recognised as barometric units to health and civilisation consistency, indicators of health are hierarchically placed before indicators of the other fields of the society. Social rationalisation imposing this favourable place is based on two extremely simple arguments (Becker, 1997): **a.** if people are healthy then their health will contribute to functional optimisation of all fields of their activities and increased social benefits; **b.** if people are not healthy, then negative effects are being diversified and they become source of a long series of shortcomings: quality of activities decreases in all fields of the social system, including those which may not have been directly affected by it but which functionally rely on what they get from the relationship with outer environments marked by diseases; expenses increase in the field of health at the same time with decreased funding to other fields; persons suffering from diseases are either tempted or forced to act minimally and that results in delaying the rhythm of personal and social development; the field of health becomes overloaded and the crisis occurs inside it precisely the moment when it is required to be most effective; social mistrust in the abilities of health formal institutions is getting amplified and people resort to informal alternative means to recover their health; health of the ill people is continuously decaying since diseases associate one another and they are being inter-determined due to lack or delay of medical interventions and so on.

The most powerful reactivity expressed by the health department in any modern society is firstly materialised in the organisation of the institution called *medicine*. It is through it that civilised human environments see that they have necessary means to train specialised middle level or high level staff to counteract sufferings and diseases, could define and manage medical care services for current and prospective beneficiaries, have rules for specific medical intervention and professional ethics at their disposal, there is a patient-centred strategy of the medical act. When manifestations of this department occur only after suffering and disease have extremely disturbed the quality of life in a society and seriously threatened its stability, one can say that the *level of civilisation which characterises*

it is mediocre. On the other hand, when a society is able not only to maintain and promptly rehabilitate the health of its members but also to prevent and systematically control degradation of this state, one can say about that society that it has a *high level of civilisation*.

All societies included in the last category obtain notable performances in preventive healthcare since they separate the three (social, mental and physical) dimensions required by the population health. At the same time, prestigious societies due to their civilisation standards keep on insisting on specialised treatment for each and every dimension and they acknowledge their freedom to have their own objectives and methodologies and separate statutory and professional positions: to provide for *social health*, social care institutions are activated, social inquiries are made with the aid of specific scientific instruments and social worker are trained to become professionals; to provide for an optimal *mental health* (Enăchescu, 2004), the effects of the determinants of mental health management and mental morbidness are detected and explained, scientific assessment methods and methods to influence the psychological state of the subjects (children, old people, alcoholics, drug addicts, etc.) are applied, roles of the people involved in patient treatment (educators, members of the nuclear family of origin, members of the extended family, educational advisors, psychologists, psychiatrists, etc) are delimited as clearly as possible, patients are treated with concrete medical and/or psychological rehabilitation measures, as well as preventive educational measures within residential environment threatened by the disease.

As for the *physical health*, it is considered to be the most important dimension of the health condition, and the aspects on anatomic integrity and physiological normality are considered to be medical priorities and prerequisites for the accomplishment of the other two dimensions by the collective mentality. Therefore, in compliance with human needs for fighting against diseases, to treat the physical body represents the most beneficial approach the medicine can take and the professionals involved in it would worth to the highest extend the status of a doctor. Moreover, people with jobs or interests in social health are not given the professional name of doctor, while those involved in promoting psychological and mental health are rather acknowledged as psychologists than doctor (psychiatrist). Furthermore, the process of obtaining a three-dimensional health follows a way that reflects obvious privileged consideration to physical health with reference to social and psycho-mental health: indicators relevant to physical health, although numerous and not very easily understandable, given their specialised terminology, are given much consideration and are labelled as being decisive or preliminary by actors involved in social and psychological and mental health of individuals and groups; yet, those concerned with the physical dimension of health need much less social and psychological information on patients, they can even totally ignore them especially in cases of emergency care.

Cognitive details about social and psycho-mental situation are rather invoked after it has been physically cured and their being mentioned aims at reaching two

goals of highest importance to society: **a.** to help patient to avoid becoming physically ill again and to implicitly provide for a *sustainable health*, reliable for the patient due to the fact that it is able to request for complementary interventions to be made by those who could help him to consolidate his recovered health or to support him to value advantages of his body health in his psycho-social life. In other words, once the doctor has succeeded in recovering or improving the body health of his patient, he should call for intervention of professionals specialised on social and psycho-mental dimension of health. In doing so, the doctor does not only get his own efforts on the patient optimised or fortified, but he also obliges society to take responsibilities which are related not only to physical health. Ultimately, *the regain of normality and social-cultural restitution of the person* who benefited from medical care represent finalities to certify for social power of the field of health. **b.** to found all medical approach on the *absolute right to health* of each and every human being and to reject discriminatory medical practices since they allow to unequally treat patients because their religious or political options are different from the majority of the population, or they belong to ethnic minority, or they are said to be socially or intellectually inferior to the others, etc.

Since these goals are so significant, accomplishment of their contents requires concrete deeds such as periodical improvement of health legislation, constructively severe sanction of malpractice situations, cooperation between medical and socio-cultural institutions in their fight against effects of diseases, change of social attitudes to disease and health, interpretation of all medical successes as derivatives of civilisation, assumption of specialised health training despite its being is a long and costly process, desideologisation of the field of health and especially of medical practices, etc. Nevertheless the most relevant events to be associated to the two goals still remains: **a.** the dialogues having been initiated by the doctor involved in the treatment of the physical trauma of the disease with specialists dealing with social and psycho-mental health of the patient, starting from the premise that the *weaknesses of the physical health can be compensated by the strengths of the psycho-mental and social health* and that successes in the treatment of physical diseases may devolve to chronic failures if they are not accompanied by the complementary effects of social and psycho-mental health; **b.** recognition of the defining health indicators as being also representative indicators of the civilisation level of a society, as well as of the fact that frontiers between health and civilisation are being activated and maintained as a flexible relationship between whole and part more from theoretical and methodological reasons. In other words, the field of health is also to be found among the structural constituents of a civilised social system, and the functioning of the latter may be considered as decisive since it reverberates both on the level of the performances of the other constituent fields and on the quality of the civilisation of the whole social system.

Deterministic consequences occur not only with regard to the state of civilisation being conditioned by the field of health, but also in relation with the

action of the civilisation forces on the population health. For example, if society owns a comfortable level of civilisation and brings about satisfaction from air quality, water quality, food, dwelling, security, inter-human relationships and individual access to goods and services, or from regaining work capability, etc., there is big probability it influences the field of health through these offers. Practically, two are the effects that derive from optimal civilisation and all modern societies aim at it: to reach a convenient level of current individual health, on the one hand, and to own a huge potential of defeating diseases, on the other hand. Conclusions to be drawn from such examples ascertain the preconceptions according to which *society does not come to be certified as being civilised as long as it does not provide for a convenient level of health* to its members while individuals and groups possessing comfortable health at a given moment are not able to really enjoy its appropriate advantages if they cannot value it through the filter of the validated civilisation (Maliţa, 1998).

Relationship between the health department and civilisation as an inclusion relation between the whole and the part betrays a slightly changed balance of power as compared to what is regularly encountered in such given situations. Here there are some examples to justify the truthfulness of this statement: **a.** if the field of health is considered to be the quintessence of civilisation then exaggerate evaluation of the roles of the former naturally occur, *as if the other performances of civilisation were useless or even harmful* since population health does not reach the same performance rate, decays or remains on a poor level; **b.** if the part (the field of health) eclipses the social importance of all the other parts or fields of society, *the social whole tends to function as if it were subordinated to the dominant part*, and civilisation expresses itself as if it were obliged to sacrifice everything to reach planned health; **c.** if aspects related to health own vital positions within the whole civilisation, then *the field of health tends to be autonomously controlled* and to organise internally so that it depend as little as possible on what it happens outside it. The propensity to this autonomous control by no means should denote egocentric display of the health department or self-isolation to protect itself from the crises weakening the strength of the social body; on the contrary, the inner organisational pulse we are making references to suggests that this department assumes the responsibility of the physical, social and psycho-mental healing of the population, including when the rest of the society compartments may not significantly contribute to this target.

Sociological understanding of health cannot be correctly accomplished without correlating the all three inner dimensions. Starting from the three-dimensionality of health we can obtain an extended series of conceptual clarifications, useful especially to explaining health crises **a.** health is a real state to human body and a field of optimal functioning of the social body of such a complexity that the interdependence and complementarity of its constituent dimensions confers it the aura of system; **b.** the health system designates, *on a very large scale*, the

functional unit of social, mental and physical determinants within a given society and, *on a restricted scale*, the name of the health system is only given to fields involved in thorough management of the physical and anatomic and physiological health of the human being; **c.** *the physician* is the main character of this health system, he benefits from undisguised idealisation and he is often described as a "figure of support and self-denial, of the power of science and personal experience to relief from sufferings" (Hours, 2010, p. 39), although in many cases they "do consider man nothing but a biological animal whose existence should be preserved" (Hours, 2010, p. 43); **d.** *the network of the social care services* available to population, *the multitude of resources* usable in different elimination of diseases and the *patient healing rates* represent the most significant indicators for measurement of the capability of the health systems; **e.** desirable values of health indicators are not only a proof of man's opposition against physical disorder through use of cultural resources (Bauman, May, 2008, pp. 179-180), but they are also *civilisation indicators* or quality indicators of individual or group life; **f.** *the state of crisis in the field of health* is most often an effect of civilisation crisis within a given society while deviation of health indicators from the supportability or normality limits means that society has entered the *imminent stage of civilisation crisis*; **g.** the health indicators, although they are referential for the society, they define but partially its quality and consequently they should be correlated to aggravating or safeguarding values resulted from indicators outside health, to be able to indicate the real state of civilisation.

2. Health crisis de factor

It would be a utopia to think that societies could be made up of healthy people only. In exchange, it would not be any exaggeration to believe that they might be able to vigorously and rapidly respond the pathological situations they are facing. Unfortunately, with time passing, causes of human misfortunes have so diversified and become so acute that pessimism and mistrust clearly dominate social mentalities. This consequence is also valid for current conceptions of health. People find it easier to describe apocalyptic perspectives of societies and continuous health decaying of their race than to identify chances they have to defeat crises (Godin, 2005).

Desolate visions, regardless their scope, are not so much expressions of lucid thinking, but they are rather signs of the "spiritual meanness" (Grenier, 1995, p. 135) of their authors. Abandoning the force of positive thinking is easily converted into destructive social predictions or in long-term dissatisfaction sources. Moreover, the large density of such explanations reveals that individuals indulge morally in this deadlock as if they wish to have one or more justifications for their failures. "The more mediocre a man is, the more he believes in the evil" the famous Fr. Nietzsche stated, and not surprisingly at all he would also suggest a tonic

positioning of the human being with reference to what it compromises its existence: “either I contemplate man with benevolence or with an evil eye, I always find them concerned with a single task: to do what is good for the preservation of the human race. Not from any feeling of love for the race, but merely because nothing in them is older, stronger, more inexorable and unconquerable that this instinct – because this instinct constitutes the essence of our species, our herd (Nietzsche, 1994, p. 31). Consequently, if not from admiration for human intelligence, than at least from the perspective of the impact of successes having been obtained so far in their approach to preserve our species, the health superlatives should be therefore mentioned: *transplant, genetic engineering, minimally invasive surgery, use of artificial organs, aesthetic surgery, organ reconstruction, prosthesis, medication, unconditioned humanitarianism, vaccination, abolishment of some diseases, artificial insemination, medical approach of terminal patients, construction of the relationship between doctor and patient based on ethics and trust, etc.*

Successes mentioned in the list above would not have been possible but if discovered by chance if societies hadn’t been constrained to find answers to “necessary requirements to provide for public goods and services, … the need for insurance that production and consumption would not have side effects on the current wealth of the public and .. the need for insurance that production and consumption would not have side effects on the life and wealth of the generations to come” (Galbraith, 1997, p. 77). Deficits in finding satisfying solutions to these needs have turned into and keep being metamorphosized into causes of different diseases, health crises, civilisation crises, etc. but also into positive effects under the form of opposing reactions against critical consequences having been experienced.

Dysfunctions, crises and diseases have been therefore experiences that have proceeded most of successes in the field of health, and they obliged societies to own medical organisations, with special medical training, proper point of view on preventive healthcare, specific medical treatment and intervention, records on disease prevalence and incidence, etc. Finally, social system is said to face bigger or less troubles in terms of population health but it does not remain passive or submit to them and it builds anti-crisis strategies and recipes.

Crisis in the field of health occur when societies do not take advantages by the aforementioned constituents on a secured level for their members, proceed chaotically in fighting the disease and do not know remedies for a significant number of disease. Such a crisis become even more obvious when the social impact of some diseases is simply devastating or when both the causes of diseases the treatment to fight against them are very well known, but the existing information cannot be valued because resources to be used are either too little, and/or too costly.

Statistic knowledge of the evolutionary tendency on the de facto health does not turn, within this explanatory context, either into a new confirmation form of the incapability of the field of health, or a new pessimistic variant of the health crisis.

On the contrary, statistic records turn into condensed cognitive capitals, extremely useful to measure health capability, to establish priorities of health recovery acts, to use civilisation opportunities in reaching sanitary optimal point, etc. When statistic data are being used, all qualified societies, governments, organisations and institutions are able to construct *rational health policies* with a view to avoid or to stop crisis or escape it. Here there are some examples to demonstrate de facto health crisis, on the one hand, and action directions to be followed, on the other hand:

a. *Insufficient medical staff* (Oprea, Gavrilovici, Manea, Astărăstoae, 2013, pp. 30-38): almost 60 million professionals operate in the health system in the world, but their distribution is still slightly different from one continent to another and from one state to another. According to the indicator registering the number of doctors for one thousand of inhabitants, in Europe, in 2010, there were 3.18 doctors, while in Africa there were only 0.32 for the same year. The disparities become even larger in the case of doctors' distribution on countries: Cuba-6,72; Belarus-5,18; Austria-4,85; Russia-4,31; Switzerland-4,07;...Burkina Fasso-0,06; Togo-0,05; Somalia-0,04; Mozambic-0,03; Bhutan-0,02; Liberia and Tanzania-0,01. Even states being considered developed according to the most of social-economic indicators face the lack of doctors and they should therefore review their strategy of medical staff. From the point of view of this statistics, medicine "without borders" becomes a world objective and believing that problems of health crisis can be stopped at the borders is naivety. Critical unbalances also exists in Romania: on the level of 2012, 89% of the doctors had their jobs in urban area and only 11% in rural area, while 100 localities had no doctor, in the southern region there were 773 inhabitants to one doctor, in the south-east region there were 655 inhabitants while in the north-east region there were approximately no more that 2778 inhabitants to one doctor.

b. *Underfunding for the health system* (Dornescu, Manea, 2013, pp. 122-127): according to statistics spread by the World Health Organisation, the average percentage of health expenses in the decade 2000-2010, in the EU, was of 8.94 of the GDP. Allocations to Romania, for the same purpose and the same period, varied between 5.1 and 5.7 of the GDP, while the rich countries of the EU distributed annually more and more money to reach 9.5% and 11.9% in 2010. The level of health expenses in Romania is lower and lower as compared to the other states member of the EU and, furthermore their effectiveness is diminished since they are almost totally directed to hospitalisation, medication and salaries of the employees. "Half of total health expenses in Romania is assigned to hospital funding … The number of beds in hospitals per 100.000 inhabitants is bigger than the average in the EU, … the hospitalisation rate per 100 patients is bigger than the EU average, and so is the hospitalisation average time. There is also a relatively high rate of medication expenses (approximately 33%) from the total amount of health expenses" (Anton, 2013, pp. 103-105). Crisis in the field of the Romanian

health could be significantly attenuated not only by increased public funding, but also by covering great part of expenses through private funding (co-payment, private health insurances, informal payments by the patients, allocation of medication according to social principles).

c. *Unsatisfactory payment of the medical staff*. Statistics reveals salary levels which are too little motivating for the medical staff in many parts of the undeveloped or developing world. Paradoxically, although the symbolic prestige of the medical field is socially recognised in the whole world, it does not get materialised through salaries to measure doctors everywhere. For instance (Dornescu, Manea, 2013, p. 124), a doctor in the EU who gets a mean salary rate of 3500EUR if he worked in Romania, which is also a state member of the EU, would get ten times less than that. The rate between the gross income of a doctor and the national mean salary was in 2009: Hungary, 2.6 in France, 3.1 in the Netherlands, 3.3 in Germany, 3.7 in the USA, 4.3 in the UK, etc. In Romania, this relationship was 1.003 for primary care physician and only 0.53 for beginner resident physician. The situation of doctors in Romania is still critical: their salaries is still unattractive, they work under surviving sanitary conditions, they cannot enjoy decent living, they do not own economic capitals to invest in personal and family development, they are obliged to get professional retraining and to find other areas where to optimally valuate their cultural capital, etc.

d. *Migration of doctors and decapitalisation of the health system*. From the data centralised by the Romanian College of Physicians it results that no less than 20.000 Romanian doctors migrated especially to France, UK, Germany, Italy, Spain, Sweden, Ireland, the Netherlands, Canada, Belgium and Austria in the recent decades. Their leaving brought about a medical staff crisis in Romania, in the first place, and, in the second place, it resulted in huge economic deficits in the health systems through repayment of expenses made by the Romanian state in the process of professional training of doctors. For each doctor having been trained in Romania, some 51.000 lei have been consumed from formal resources which equals to some general loss of capital of 226 million EUR. This sum “could be considered to be little money if we didn’t know that Romania is currently a European country with the lowest level of the indicators for the *total health expenses in the GDP* and *public health expenses per capita*” (Oprea, Gavrilovici, Manea, Astărăstoae, 2013, pp. 38-40). Economic losses suffered by Romania in this way are being amplified by a considerably number of times if we consider all categories of expenses made by the society in all stages of training of a migrant doctor, as well as taxes and contributions that he should have paid to the Romanian state as an active person inside it. The amount of the economic losses might have been still amplified, having in view recent expenses engaged in the training of the doctors to replace those who have migrated, social collateral costs to compensate for the lower quality of medical care services, compulsory pecuniary sanctions for the health system, derived from malpractice, late and implicitly more costly appeal

to medical care as a result of mistrust in professional competence of the remaining doctors, etc.

e. *Unequal access to health care services*. A great number of indicators useful in evaluation and comparison of societies has multiple significations. Most of these indicators are relevant both for the health system and for the definition of the civilisation level of the society. For instance, *life expectancy* is most often invoked to suggest that *effectiveness of all actions to fight against diseases depend on the quality of the society civilisation.* In the ideologised competition between the civilised and capitalist civilisations of some decades ago, this indicator could not put some makeup on the reality and demonstrate the superiority of the Western quality of life: "in communist countries, life expectancy marks time and even moves backward, while in the West it increases. Quite explainable otherwise if we consider hard working conditions, second-rate food, insufficient medical care … Today the discrepancy between the ex-communist space and the West has been for almost ten years … in favour of the latter" (Boia, 2006, p.163), the historian L. Boia claims. France has the highest life expectancy for women (84.4 years) while Romania is on the last place among all European states (76,2 years), and the percentage distance to separate these two countries is nothing else but a measure of their differences from the sanitary point of view. At the same time, the amount of such discrepancies among states represents incontestable proofs of unequal access to medical care services of their members and also a proof of socio-cultural differences between civilisations. Vulnerability of the current Romanian civilisation is also confirmed by its incapacity to cope with multiple critical health situations: *access of inhabitants to medical care services in rural area is clearly inferior to that of the inhabitants residing in cities; the medical insurance system does not succeed in gathering from the villagers all money required by complete medical care package; the number of tax payers to the health system reached a record figure: 8.7 million in 2011, but the number of those to benefit from medical care services is overwhelmingly higher*: *21.5 million people; Romanians are by far on the first place in Europe in terms of death rates for cardiovascular diseases and on the first place in the world for death rates for cardiovascular diseases associated with cerebrovascular disease (*Miftode, 2009, p. 257)*; if in the world, chronic diseases concerns public health in proportion of 46%, the same diseases count for 70% in the Romanian society* (Oprea, Gavrilovici, Vicol, Astărăstoae, 2013, p. 11)*; Romanians' consent for organ donation for transplantation after death is by one third lower than the European average value and only half of the American availability* (Ioan, Astărăstoae, 2013, pp. 169, 184) etc.

No matter how many examples we review on pathologies and dysfunctions in the field of health, we would reach the same conclusions: **a.** health crisis is the main consequence of the civilisation crisis. Whenever society does not provide for alimentary, residential, educational, relational, economic, moral, etc optimum having been socially constructed (Stan, 2003), and from this reason all health

dimensions are being disturbed for a period of time longer than normal, the mediocre state of civilisation triggers health crisis; **b.** Health crisis has not got important ampleness and has not triggered social manifestations to significantly question sanitary system, since theologically-nuanced and traditional ideas on the disease, getting older and death are still actual. At least in the Romanian area, it is thought that “health is our natural condition”, and disease “might have occurred only at a certain moment when an outer corruptibility principle succeeded, who knows how, to disturb the harmony of the creation” (Georgescu, 1978, p. 205). Generally speaking, the loss of health is assumed to be “heavens punishment, sent by God, as the people know that God does not beat one with a stick” (Candrea, 1999, p. 11), and also as an unavoidable consequence of time passing in the life of the individual.

Conduct of resigned acceptance of the disease and the end of one’s life still weighs much in the eastern area, so in Romania as well, but it has almost disappeared in the West; nevertheless everywhere around “getting familiar with” the death keeps on regressing with civilisation progress and these antithetic movements have been exemplarily proven by the way in which the West has evolved: “up to early 20th century, there has been much death in families: children, young people … Today this almost does not happen. Death is scarce and consequently we have lost the habit of dying. Familiar once, death has become a stranger. Form this point of view, the 20th century meant a turning point in the history of humankind” (Boia, 2006, p. 174).

Revolution it made in the last century was actually one of the civilisation but with almost miraculous effects on the health of the population. Here there are some randomly chosen examples of *civilisation facts which have saved people in many crisis moments*: extension of the water supply network and through it the improvement of the personal hygiene and residential conditions; discovery and use of state-of-the-art pharmaceutical products and some effective medical procedures which resulted in increased fertility, birth rate and life expectancy; review of the traditional cooking and food consumption which has got materialised into increased longevity; organisation of productive activities so that pastimes budget required by the recovery of the labour force increases; immense diversification of recreational and pastimes possibilities; change the mentality of the elderly and stimulate them to preserve their health and habits specific to younger ages; public information on the harmful effects of consumption of much salt, fats, alcohol, tobacco, etc., as well as on the positive effects of sports, labour, creativity, professional development, etc. Through such acts one could ultimately obtain *civilisation health, respectively physical health, social health, psycho-mental health, individual health, group health, environmental health,* etc. and implicitly a *powerful ideology of health* is being implemented.

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