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Protection of the Right to Health through Legal Means and Marketing Studies

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Abstract: Guaranteeing the right to health care requires a positive obligation on the part of the state to take measures to ensure hygiene and public health. Viewed through European law, in the jurisprudence of the CJEU the right to health care has been the subject of several approaches, even if under a different title, including the right to administer pharmacies, the right to market medicines in conditions of quality and patient safety, etc. In conclusion, it can be seen that the provisions of international documents do not limit the right to health only to the provision of health care. The right to health is portrayed by the incorporation of economic and social factors with a role in creating the conditions for a healthy life, including: nutrition, access to drinking water, food security, access to public health services, etc. International legal documents give priority to public health measures, although sometimes the imposition of such measures may conflict with certain individual rights and freedoms relating to quarantine, vaccination or individual freedoms.

Keywords: the right to public health; public health services; public health standards; malpractice; free movement in the field of health care; environmental hygiene

1. Introduction

The current social and economic context determines us more than ever to be interested in health and the protection of the right to health has become a major concern, moving to the forefront of the professional goals of many institutions and a routine challenge for central and local public administration.

The right to health must be ensured and organized to the highest quality standards, in contrast to the traditional approach of providing medical services with minimal interest to ensure patient satisfaction.

The constitutional right to health has been portrayed as a prerogative that encompasses a number of economic factors, including an interdependent relationship between the whole party, including nutrition, access to drinking water, food security, access to public health services, etc.

In some respects, the ambivalence of health refers to the matter of human rights, where the right to physical and mental integrity is treated as a civil right, while from the point of view of the organization and enforcement of the law the right to health is approached as a public right, administrative, social and economic nature as the obligation to protect public health and hygiene rests with the state.

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The obligation to ensure the organization of a social, medical and human resources infrastructure is incumbent on the state so as to ensure the physical and mental health of any person in a non-discriminatory manner, because the protection of health is part of the intrinsic values of the human being.

2. The International Legal Perspective on the Right to Health Care

From the perspective of international legal documents, guaranteeing the right to health care presupposes a positive obligation on the part of the state to take measures to ensure hygiene and public health.

In the mentioned documents, the right to public health protection is one of the most important socio-economic rights, being regulated in multiple legal norms, such as: art. 25 of the Universal Declaration of Human Rights, according to which *"every person has the right to a standard of living adequate for the health and well-being of his family, and the mother and child shall be entitled to special assistance and protection*"; in Article 12 of the International Covenant on Economic, Social and Cultural Rights, referring to "*the right of every person to the enjoyment of the highest attainable standard of physical and mental health and to the measures that States Parties must take to ensure the exercise of that right*"; art. 13 of the revised European Social Charter, which sets out the principles aimed at ensuring the realization of the right to health for all persons with special applicability for persons who do not have the necessary material or financial resources.

Correlating those previously stated with the provisions of art. 35 of the Charter of Fundamental Rights of the European Union according to which "*everyone has the right to preventive care, but also to receive medical care under the conditions established by national law and practice*" shows that the right to health is a fundamental right of every citizen.

Viewed through European law, in the jurisprudence of the CJEU the right to health care has been the subject of several approaches, even if under a different title, including the right to administer pharmacies, the right to market medicines in conditions of quality and patient safety (Gheorghe, 2015, p. 23), etc.

The Court concluded that art. 49 and 54 of the TFEU cannot affect the competence of the state to organize health services, with reference to the social security system. At the same time, it ruled that according to the provisions of art. 49 and 54 TFEU that "*Member States may not impose or maintain unjustified restrictions on the free movement*" of healthcare. On the contrary, the Court has ruled that states must give priority to the life and health of individuals. This presupposes ensuring the freedom of European nationals to settle in the territory of the Member States, with validity also for legal persons providing medical services.

It is interesting to note that although the Court recognized their margin of appreciation of the freedom in the field of movement of persons and capital, the decision for art. 49 of the THB was that the provisions prohibit the taking of measures at national level that would make it more difficult for people to settle in a state, in a non-discriminatory manner, by reference to the criterion of citizenship.

In conclusion, it can be seen that the provisions of international documents do not limit the right to health only to the provision of health care. The right to health is portrayed by the incorporation of economic and social factors with a role in creating the conditions for a healthy life, including: *nutrition, access to drinking water, food security, access to public health services, etc.*

International legal documents give priority to public health measures, although sometimes the imposition of such measures may conflict with certain individual rights and freedoms relating to quarantine, vaccination or individual freedoms (Diaconu, 2010, p. 156).

Romania, through art. 34 of the Romanian Constitution received the right to health care (similar to the right to education, etc.) in the form of a "right of claim", being mentioned in the text of the regulation that the state has a general positive obligation to effectively guarantee it.

3. Ensuring Public Health and Hygiene by Fulfilling the Positive Obligation by the State

The state of health has been defined by the international body WHO - the World Health Organization in relation to the right to health of any person, the correlative obligation of the state thereon: "*the right of every human being to a living environment with minimal health risks, the right of access to medical services, the right to be supported for the maintenance and promotion of health throughout one's life*" (Muraru & Tănăsescu, 2008, p. 319).

By referring to the definition provided by the WHO, it can be seen that the recognition of the right to health is not enough, the state being obliged to compete to ensure the highest level of health that can be achieved for its citizens.

According to art. 34 para. 2 of the Romanian Constitution, the state has distinct obligations regarding the measures to achieve the right to health, firstly those for ensuring public health and secondly for ensuring public hygiene (Gheorghe, 2015, p. 272).

The category of public health insurance measures includes efforts to reduce new-born mortality, infant mortality, harmonious child development, prophylaxis and treatment of endemic and occupational diseases. From the second category of measures, this refers to ensuring public hygiene, in close connection with human health, the status of the obligation to improve the hygiene of the environment, especially of the industrial environment.

The right to health care guaranteed by art. 34 of the Constitution is also received by art. 58 paragraph (1) and art. 61 paragraph (1) of the Civil Code, being approached by the legislator together with the right to life and the right to physical and mental integrity, the recognition of which is equally achieved.

The intrinsic link between the two rights is obvious, as the right to life is the basis for upholding the other rights, and the right to physical and mental integrity presupposes both the existence and maintenance of good health.

In the field of human rights**, the right to physical and mental integrity is treated as a civil right**, while **the right to health is treated as a public, administrative**, social and economic right as the obligation to protect public health and hygiene rests with the state.

The Civil Code through art. 252 provided that every natural person has the right to the protection of the values intrinsic to the human being, where we find the health and physical integrity, subsequently to art. 253 describing the means of defending these values. The injured person in the form of injury to the state of health may request compensations or a patrimonial reparation, even if the prejudice was a

When the injured person has suffered an impairment of his health or bodily integrity through the loss or diminution of work capacity, he has at his disposal the provisions of art. 1387 Civil Code. For the situation in which the injury of the physical integrity or of the health has as a consequence the restriction of the possibility of family and social life, based on art. 1871 the victim can claim compensation for this non-patrimonial damage.

If the injury or deterioration of the health condition occurred as a result of a medical error (malpractice), the legislator provided by Law 95/2006 to engage the medical liability for: **error, negligence, recklessness and insufficient medical knowledge.**

The state thus has the obligation to ensure the organization of a social, medical, human resources infrastructure, etc. so as to ensure the physical and mental health of any person in a non-discriminatory manner, because the protection of health is part of the intrinsic values of the human being.

4. The Correlative Obligations of the State to Ensure the Right to Health

The health insurance of the population belongs to the specialized public services, having in the centre the Ministry of Health, as the central authority in the field of public health care.

The non-discriminatory and equal accessibility of citizens to the public health service is *in extensio* a translation of the principle of equality before the law, expressed both by the Universal Declaration of Human Rights and enshrined in art. 16 paragraph (1), which states the equality "before the law and the public authority, without privileges and discrimination".

Health insurance, like any public service, has a number of features (Negruț, 2020, p. 5), including:

- Meets needs related to a general public interest;
- It has a legal regime of public law;
- It is performed continuously, without interruption, assuming its uninterrupted existence and its perpetual functioning;
- The equality of all persons is recognized, which implies both equal and non-discriminatory treatment and similar requirements for beneficiaries;
- The way of realization can be done by specialized public agents or by authorized private agents;
- Dispute resolution is the responsibility of administrative litigation courts.

By virtue of ensuring a high standard of quality regarding medical services, the legislator has a number of constitutional obligations and derived laws: the obligation to organize social health and the social insurance system for illness, accidents, maternity and recovery; the obligation to adopt measures to protect the physical and mental health of the person, etc.

The international community has been concerned about the adoption in 1994 of the "Patients' Code", with the aim of establishing principles and strategies in the field of health, containing obligations for all healthcare providers in Europe (Popescu, 2007, p. 38).

A large part of the provisions of the Patients Code was received by Law no. 46/2003 which establishes and portrays a principle regarding the patient-doctor relationship: the patient's rights must be designed in such a way that the patient-doctor relationship is respected both by the dignity of the caregiver and the caregiver, because between them there is no relationship of subordination, but an equality in rights and responsibilities (Popescu, 2007, p. 39).

Through it's over 850 articles, Law 65/2006 on health care reform, establishes a true health code, which regulates the constitutional obligations of the state regarding the guarantee of art. 34 of the Constitution. At the very beginning of the law, at art. 3, it is explained that public health care is subject to organized social effort achievable through a set of legislative and policy measures, strategies and programs for

those in charge of health, in conjunction with the organization of institutions specializing in providing the full range of services needed.

The legal definition of public health can be found in art. 4 para. (1) according to which it represents "the state of health of the population in relation to the factors of its configuration and determination: socio-economic, biological, environmental or lifestyle".

Analysing the text of the law we will find that the state of health is both an obligation of the central and local public administration authorities, but it is also of natural and legal persons, as shown in art. 3.

The issue of public health continues to be of undeniable importance in the current context generated by the pandemic health crisis, with reverberations in terms of financial resources for health and related legal and administrative efforts.

The European Court of Human Rights has ruled on the positive obligation of states to ensure the effective realization of the right to health, (Panaitescu v. Romania) in the sense that states cannot invoke in the form of a legal pretext the lack of resources to pursue a obligations resulting from a court decision aimed at protecting a person's rights to access free treatment. In addition, the Strasbourg court also considered that on the basis of the relevant national legislation, in this case Law 189/2000 on the approval of Government Ordinance no. 105/1999 for the amendment and completion of the Decree-law no. 118/1990 on granting rights to persons persecuted for political reasons by the dictatorship established from March 6, 1945, as well as to those deported abroad or imprisoned, republished, with subsequent amendments, the applicant had priority and free access to care specific to the disease he was suffering from.

Thus, in the case of Ștefan Panaitescu v. Romania[1] of 10 April 2012, the applicant, suffering from cancer, addressed the Oncological Institute of Cluj-Napoca and the Cluj-Napoca Health Insurance House in May 2005 to offer him the very expensive medicines needed for treatment. In view of the refusal of these authorities to grant him free access to the medicinal products he needed, the applicant brought an action before the national courts in November 2005 and the ECHR appealed to the ECHR. Because he died during the trial, continued by his son, the ECHR concluded that ROMANIA had violated the applicant's right to life, given that he had not been able to receive the correct treatment free of charge, even though he was in an advanced stage of the disease.

As can be seen, the state has an obligation to regulate measures to ensure the physical integrity of patients and protect them from the serious consequences that medical intervention can generate.

In this way, patients should be informed in advance about the foreseeable risks of the medical intervention, and they should give their informed consent, and if the patient has suffered a bodily injury caused by the medical intervention, it is appropriate for them an appropriate compensation.

We consider as an example another case from the jurisprudence of the European Court, namely the case of Elvira Codarcea against Romania[2] of June 2, 2009, in which the plaintiff, following some maxillofacial plastic surgeries, was left with a paresis on the right side. The applicant's attempts to enforce her application by a final judgment were unsuccessful, and the trial for compensation for malpractice lasted 9 years. The Court in Strasbourg found that the applicant's right to compensation for

[1] Application no. 30909/06, Case of Ștefan Panaitescu v. Romania, Strasbourg, Final 10.07. 2012, http://ier.gov.ro/wp-content/uploads/cedo/Cauza-Panaitescu-impotriva-Romaniei.pdf

[2] Application no. 31675/04, Codarcea case against Romania, Strasbourg, 02.06.2009. http://ier.gov.ro/wp-content/uploads/cedo/Cauza-Codarcea-impotriva-Romaniei.pdf

the damage suffered had been violated, and the length of proceedings before the national courts was excessive, forcing Romania to pay her EUR 20,000 for the damage suffered.

5. Satisfaction Level and Consumer Behaviour Implications for Health care Services Providers

Measuring customer satisfaction is important to because of it has a significant impact on organizations' long-term performance and it also has influence of the purchasing behaviour of individuals (Vu, 2015, pp. 1638-1655). Because in the modern competitive market the consumer satisfaction has been recognized as playing an essential role not only for the success, but for the survival itself of enterprises, considerable research keeps being conducted on that concept (Sheau & Kew, 2007, pp. 59-73). Given the framework of globalization, there is a huge potential customer base for services providers, but, at the same time, given that many organizations now have the opportunity to address market segments and to better customize their offers, the market has become increasingly heterogeneous, making success is more difficult because of stronger competition (Arenas-Gaitán, Sanz-Altamira & Ramirez-Correa, 2019). In that context, the health care markets are also becoming increasingly competitive for he providers and demanding in terms of quality.

In order to strategically improve the loyalty of their target consumers, health care organizations have to keep improving the satisfaction they are generating because patient satisfaction is the precursor of loyalty, as supported by some authors (Clark, 2006, pp. 1-7). Even if some of the patients that are satisfied may be not at the same time loyal, this author also concludes that the satisfaction surveys provide the necessary details to determine the predictors of patient loyalty, based on episodes of patient experience on which the efforts can be concentrated for the best results. Supplementary to the increasing need on better satisfying the patients in terms of core medicine, the health care is also subject to the improvement of hotel-like amenities and support services (Reich, 2014, pp. 1576-1628), in order to address the ever-developing needs of the present-day consumers. The importance of medical and non-medical elements for patients' satisfaction is also supported by different authors (Young, 2020, pp. 504-531) who shows for the customers the more visible accomplishments of room and board care can become a proxy for quality the medical treatment, that is intrinsically harder to observe, and that the hospitality of the medical unit has a halo effect. In turn, by concentrating resources for improving the halo effect may strategically influence the way medical units are being run as business.

5.1. Research Methodology

In terms of consumer behaviour implications for health care services providers, the main objectives are (1) the studying of the level of post-purchase concern among the patient whether their choice was the best or not, as an expression of the tendency for cognitive dissonance, (2) the evaluation of the main reasons for patients who had unsatisfactory experiences with a medical unit to choose it again and (3) the evaluation of the main reasons for patients who had satisfactory experiences with a medical unit not to choose it again. Addressing those objectives, it was hypothesised that (H_1) the socio-demographical variables age, gender, occupation, education and income influence the level of post-purchase concern, (H_2) the patients are mainly motivated to repeat or reject the choosing of a health care provider based on both internal factors and external factors, (H_3) some factors may motivate with different intensity the repeating and the rejecting of the choosing of a medical unit.

In order to address the present research paper's objectives, the support for the analysis and synthesis of information was provided by the data collected in a quantitative direct study, author statistical survey with the extensive scope of investigating consumer behaviour regarding health care services.

The survey sample consisted of 385 consumers that have utilised health care services at least one time during a period of 12 months, on free choice basis. The research localisation was the country's capital Bucharest and its Ilfov region. The minimum age for participation was 18 years, the legal full adulthood age of Romania. The sampling was proportional and the repartition of frequencies of age groups was consistent with the structure provided by the National Statistics Institute (www.insse.ro), making the data collected from the participants representative without the need for additional ponderation measures. Three waves of self-administered questionnaires were transmitted to different patients for self-completion, with the desideratum to dose the effort from respondents on the funnel principle of going from general to specific topics. The results benefited from a statistical probability of 95% and the error was contained in the interval of ±5%.

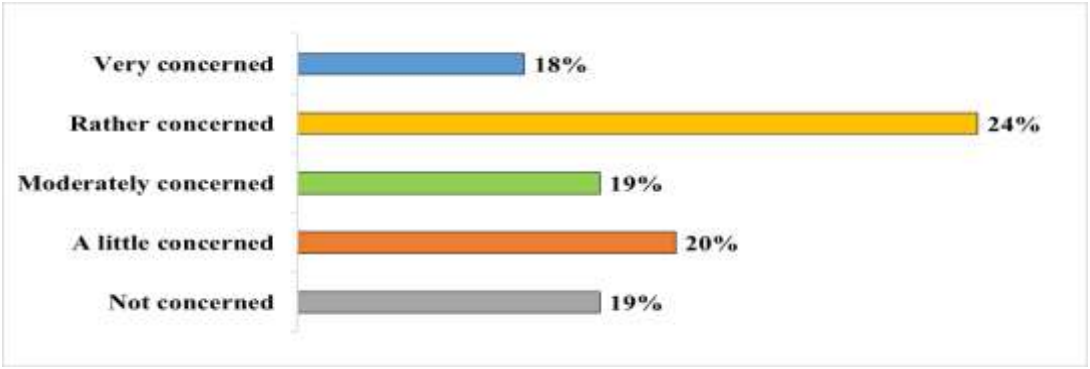

Figure 1. The Extent of Patients' Post-Purchase Concern if Their Choice Was the Best (%)

Source: Author Statistical Survey

Based on patients' answers, it was determined that the extent to which there is a concern if the choice made was the best expresses a tendency for the appearance of cognitive dissonance in the mind of the consumers. The intense concern area represents 18% of the cases, comprising the modal group of rather concerned patients (24%) as well as the group of those who declared themselves as being very concerned (18%). By taking into account the moderately concerned group of 19%, the total of patients whose interest to keep evaluating post-purchase whether their choice was the best or not adds up to a total of 61%. By contrast, the consumers manifesting little concerned represented 20% of cases and the group not concerned at all situated at 19%.

Among possible factors of influence on the degree of post-purchase concern for the patients, according to the ANOVA analysis (single factor, for α=0.05) the age (p=0.0039) and the occupation (p=0.0056) proved to be statistically relevant, while gender, education and income (p>0.0500) did not generate differentiations at a significant level.

When age is taken into account, the most concerned post-purchase are the young patients (31% of the 18 year cohort and 44% of the 19 year cohort), and also to a relevant degree the 60-64 year individuals (30% of them). The rather concerned consumers are, according to in-group percentage, the 30-34 year (32%), 55-59 year (30%), 65-69 year (38%), 70-74 year and 80-84 year (42% each) and the 85+year (an overwhelming proportion of 83% of them). The groups of moderately concerned patients had relevant internal proportions in the 25-29 year segment (31%), 35-39 year (33%), 50-54 year (29%) and 75-79 (30%). A degree of little concern was better represented in the 20-24 year consumers (50%), 45-49 year

(28%) and 70-74 year (42%). Finally, the patients that declared themselves as not showing any concern had relevant proportions in the 25-29 year cohort (31%), 40-44 year (43%) and 75-79 year (30%).

In regard to the occupational categories of patients which reported the highest degrees of concern if their choices were the best or not, the study indicated relevant in-group proportions of 33% in the case of medical/ sanitary, of 30% for IT&C and of 28% for engineering. Levels of concern above average were well represented in the pensioner's group (with 45% of them) and sociology/ public utility services (33%). Some moderately concerned categories were found to be the education and the legal fields (each with in-group proportions of 36%), similar to the case of business owners/ managers (35%). Showing a rather limited post-purchase concern were the economic/ administration domains and technicians/ specialists (with prevalence of 24% in both groups). The patients that stated a lack of concern and thus minimal tendency for cognitive dissonance were the students' group (all of the cases), a significant proportion of the medical/ sanitary group (mounting to 67%) and some of the education group (36%). Notably, the results are also indicating that the medical/ sanitary group's options were split about one third with highest concern and two thirds with minimum concern, without the intermediary options, which could reveal that a solidly informed choice about health care services (in this case, certainly based on the professional background) will either strongly reduce the post-choice worrying for most of the consumers, or, on the other end of the spectrum, will carry on intensely post-purchase for some of the patients.

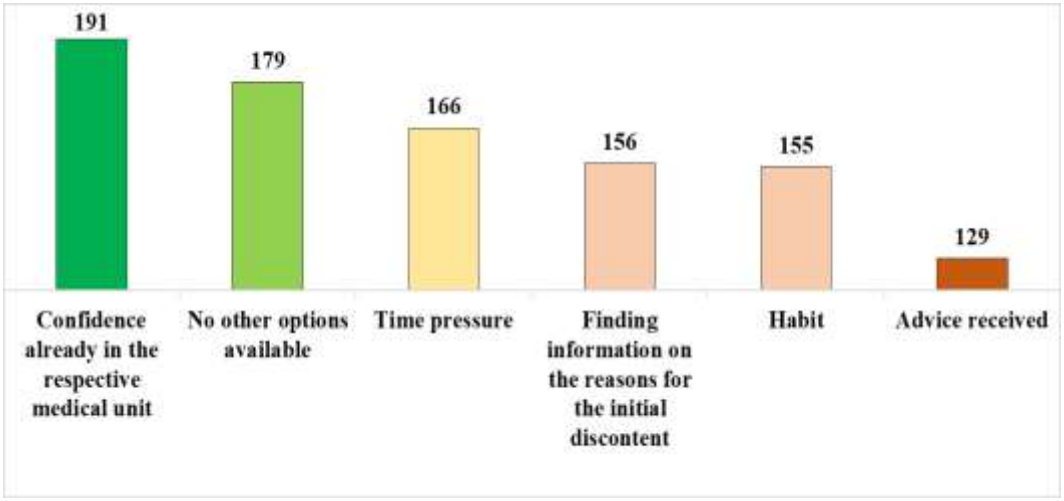

Figure 2. Main Reasons for Patients who had Unsatisfactory Experiences with a Medical Unit to choose it Again (Number of Mentions)

Source: Author Statistical Survey

Analysing the findings from the purposed scenario of patients being unsatisfied by the health care services received from a medical unit and still choosing it again, the results are showing that the strongest motivator for consumers is the confidence they already had placed on that provider (consumer internal factor totalling a number of 191 mentions). The lack of alternatives was also highly indicated (external factor with 179 mentions), followed by the pressure of time (internal factor, 166 mentions). Finding more information on the reason for the initial discontent (external factor indicated 156 times) and habit (internal factor, 155 times) proved to be important as well. To a lesser degree, the advice that patients receive post-purchase (eternal influence, 129 mentions) also has some potential to bringing them back to the initially poorly evaluated provider.

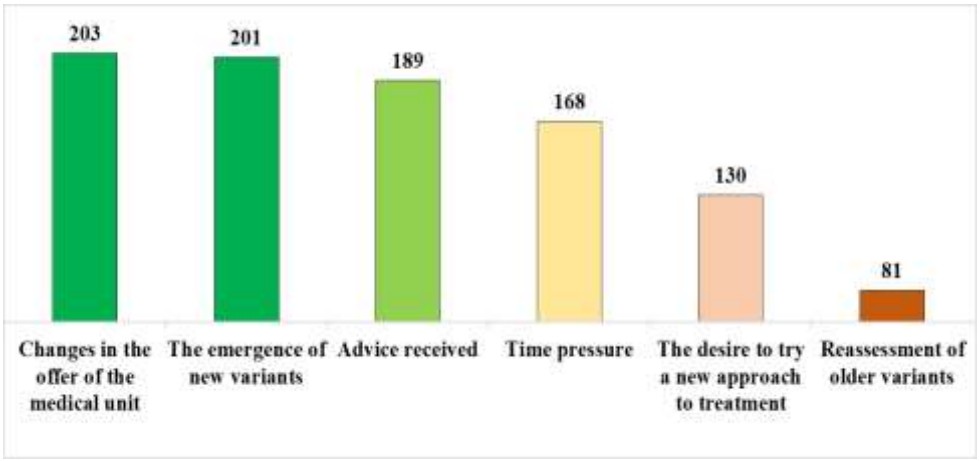

Figure 3. Main Reasons for Patients who had Satisfactory Experiences with a Medical Unit not to choose it again (Number of Mentions)

Source: Author statistical survey

The results for the next scenario, namely the further rejection of a health care provider although it previously performed well and the patients were satisfied, indicate that uninspired changes implemented in the offer of a medical unit might prove very dangerous in terms of consumer reaction (patient external factor with 203 mentions as reason for rejecting). Basically, if the patients perceive that they will not get the same content of services as when they were satisfied, they might abandon the medical unit next time. The emergence of new variants thus increasing the number of available competing options also shows a high potential to harm the business of a medical unit (external factor, 201 mentioned cases). The advice that patients are receiving places in a significantly higher position as a reason for rejection (external factor, 189 mentions) that it previously did as a reason for choosing again (129 mentions), marking it in this case as a significant risk factor for the future running of the medical unit. Time pressure (internal factor) is at a comparable level, with a relatively strong influence as a reason for not choosing despite good previous experience compared to the situation when it was a reason to choose despite bad previous experience (with 168 and respectively 166 mentions). Patients' desire to try a new treatment approach might also determine their rejection of a medical unit that provided them satisfaction in the past (internal factor, as indicated in 130 cases). Finally, to a lesser extent, but still occurring, consumers reassess some older variants (external factor addressed by an internal decision algorithm, 81 mentions) and that process sometimes makes the next choices to shift from a satisfactory health care provider to others.

Conclusions

The issue of public health will continue to be of undeniable importance in the current context generated by the pendemic health crisis, with reverberations in terms of financial resources for health and related legal and administrative efforts.

Viewed through European law, in the jurisprudence of the CJEU the right to health care has been the subject of several approaches, under different titles, such as: the right to administer pharmacies, the right to market medicines in conditions of quality and patient safety, etc.

Correlating the international legal statements found in art. 35 of the Charter of Fundamental Rights of the European Union ("everyone has the right to preventive care, but also to receive medical care under

the conditions established by national law and practice") with those of the Romanian Constitution, it follows that the right to health is a as a fundamental right of any citizen.

By virtue of ensuring a high standard of quality regarding medical services, the state has a number of constitutional obligations and derived laws: the obligation to organize social health and the social insurance system for illness, accidents, maternity and recovery; the obligation to adopt measures to protect the physical and mental health of the person, etc. It also has the obligation to organize a social, medical, human resources infrastructure, etc. so as to ensure the physical and mental health of any person in a non-discriminatory manner, because the protection of health is part of the intrinsic values of the human being.

A large part of the provisions, similar to the Patients 'Code of the law on patients' rights, establish and portray a principle regarding the patient-doctor relationship: the patient's rights must be designed in such a way that the patient-doctor relationship respects the dignity of both the caregiver and the which cares, because there is no relationship of subordination between them, but an equality in rights and responsibilities.

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