



A Few Words about Health Care Law

Siniša Franjić^{1*}

¹Independent Researcher, Croatia

Corresponding Author: Siniša Franjić [ORCID ID](#)

Address: Independent Researcher, Croatia; Email: sinisa.franjic@gmail.com

Received date: 19 April 2021; **Accepted date:** 07 July 2021; **Published date:** 15 July 2021

Citation: Franjić S. A Few Words about Health Care Law. J Health Care and Research. 2021 Jul 15;2(2):126-32.

Copyright © 2021 Franjić S. This is an open-access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium provided the original work is properly cited.

Abstract

Every person has the right to health care and the opportunity to achieve the highest possible level of health. Every person is obliged to take care of their health. No one should endanger the health of other people. Every person is obliged to provide first aid to an injured or sick person in accordance with their knowledge and abilities and to provide them with access to the nearest medical institution. Every citizen has the right to health care while respecting the highest possible standard of human rights and values, i.e. the right to physical and mental integrity and security of his personality, as well as respect for his moral, cultural, religious and philosophical beliefs.

Keywords

Health, Health Care, Policy, Health Care Law

Introduction

Health care is an activity with a primary intention to improve health, as opposed to other activities which have indirect health effects (such as education or housing) [1]. Health care comprises a wide spectrum of activities including, for example, health promotion, disease prevention, curative care, rehabilitation, long-term and palliative care. Health care also expands beyond the formal sector into the informal sector, and also includes lay care. The availability of health care from lay people may determine how much health care by professionals is needed. A working definition of health care for the purposes of health care evaluation might be 'any activity that is intended to improve the state of physical, mental or social function for one or more people'.

Considering the definition, it is clear that there are many different groups of people providing health care. Professional careers (doctors, nurses, physiotherapists,

for example) are easily recognized, but throughout the world most health care is performed by lay people. Parents care for sick children. Children care for elderly parents. Many voluntary organizations care for the ill, the homeless and the disabled. In many countries, social services provide care for many groups of people. This care is intended to improve the well-being of the recipients. As such, it may be considered to be health care.

Health care constitutes an essential element in a typical European welfare state [2]. A welfare state in Europe is originally a nation-state, where contributions to a national health care system normally are provided through taxation or by payments of premiums into an insurance scheme. Although differing in many ways, all health care systems in the Member States of the EU provide near universal coverage based on solidarity. However, generally there is an increasingly blurred line between such states and EU law as part of

a more comprehensive multi-level legal system, where EU law and the national law of its Member States are mutually embedded. Regarding more specifically healthcare, the same situation seems to have developed. Health care law used to be a nation-state matter, but, inter alia, the EU has altered this point of departure. Also, the market as such is having an increasing influence on the organisation of health care. Thus, there is a wave of liberalisation and privatisation, including the fact that cross-border health care has become a reality, which is changing the traditional way of setting up such systems. Also, certain basic values and principles, for example, non-discrimination, equality, social inclusion, and access to essential services, are becoming increasingly influential. These changes are largely, but not only, due to the influence of the EU.

Competences

The issue of the distribution of competences is a concrete way of examining which direction European health law moves [2]. By including this dimension, it is possible to see at which level of governance the legislative competences in the area are placed, and in fact thereby also obtaining an indication of how much economic and/or social integration may be expected. On the one hand, if the legislative competences primarily are vested at the Member State level, they are more likely to be free to go ahead the way they so wish. On the other hand, if competences primarily are vested at the level of the EU, interference in this regard may be expected with an increased economic and social integration as the result.

Discrimination

At first glance, providing a definition of the concept of discrimination seems simple [3]. A closer look, however, reveals that this is far from the truth. In effect, discrimination and its interpretations come in all forms and shapes. One might even say that the scope and thus purpose of the concept is in the eye of the beholder.

Equality is the state in which equal situations are treated equally. The difficulty with this definition is that no two situations are ever wholly the same. Absolute equality is impossible. In a legal context,

‘equal’ means ‘equal in all ways that are legally accepted to be legitimately relevant to the decision in question’. Discrimination means that differential treatment has taken place without a legally accepted ground, for example, race or nationality. In order to reach a state of equality in which equal situations are treated equally, the prohibition of discrimination is imperative. Without it, there would be no means to achieve equality. In other words: the one cannot exist without the other.

Certain forms of discrimination are widely perceived to be morally and ethically unacceptable, such as discrimination on the ground of race or sex. Others are unacceptable for a combination of reasons, in which practical and political goals play a role. Discrimination on grounds of nationality is an example of the latter. The condemnation of this type of discrimination is by no means as self-evident as other types of discrimination that are clearly morally abject. In a civil society, (direct) discrimination on the highly suspect ground ‘race’ will not be approved of under any circumstances. Discrimination on nationality, however, has long been a means to form and unite a nation and protect the interests of these sovereign states. Up to this day, it functions as a shield to ensure that civilians of states have privileges in their home state. Part of this system is that enjoyment of these same rights and privileges in host states is absent, or at best limited.

Policy

Almost all developed health systems have set up mechanisms for planning health care resources, aiming to ensure access to health care for the whole population, preserve its quality, avoid wastage of resources and guarantee its longterm financial sustainability [4]. The basic objective of health care capacity planning is to tune health care supply to the national populations’ needs, by defining the availability and distribution of health care services and the health care work-force. Planning policies do not necessarily mean to restrict or limit supply.

Health care capacity planning can take many forms and realise several functions. Planning measures can be taken at the level of training, the entrance into the profession, the authorisation to set up practice or to

build or open facilities. But also by reserving certain interventions to providers of a certain type or with a certain activity level or through selectively contracting with providers, authorities can effectively plan the capacity of health systems to provide health care. By setting a quantitative and territorial quota of care providers, policy makers generally aim to ensure accessibility to care for the whole population, including remote areas; to ensure quality of care provision, for example, through the preservation of a sufficient concentration of experience and to cater for the rational use of the limited public budgets. Information asymmetry between the producers and recipients of health care is generally considered as one of the root causes for market failures in the health sector by which competition does not necessarily lead to optimal allocation of resources nor to balanced price setting. In addition, payment systems often provide financial incentives to increase the volume of services and to provide the whole spectrum of services, leading to overcapacity, supply-side imbalances, wastage through provider-induced demand and loss of investments in underused capacity. Without regulatory intervention, provider-induced demand can lead to a high density of sophisticated diagnostic equipment while basic needs remain unmet. Quantitative and geographical planning norms defining the number of health care providers can avoid a situation where care providers only select the 'easiest to treat' patients or exclusively provide treatments that are well-remunerated and for which income is predictable. It can also avoid the situation where health care provision is concentrated only in the most profitable areas, ensuring that health care services are available for all groups and geographical areas.

The extent and nature of capacity planning varies greatly between countries, reflecting the health systems institutional and regulatory framework. Quantitative and territorial planning norms in principle include health care providers that provide publicly funded care and have an agreement or contract with the health authorities with regard to the price, quality, effectiveness and quantity of the health provision.

Health care is instantaneous: the individual

consumes the operation in the real time that the surgeon produces it [5]. Health care is active: the patient must supply some input into making himself well. Health care, most of all, is unbalanced. The doctor knows best. Every patient knows that.

The temptation to palm off a 'lemon' is a fact of life. Yet the doctor at the same time has a professional ethic which pulls him in the opposite direction. Asymmetrical information may in that sense be a greater threat when the consumer is buying a car or trying to decide if a chicken is fresh. The doctor's role as a carer makes him see himself as the agent of a purposive teleology that is more than crass money-making alone. Like an emergency clinic, he will not turn away a desperate client since his ultimate maximand is survival and health. He is often accredited to a non-profit supplier, either a private clinic or a British-type National Health Service. He works in highly regulated markets that circumscribe what he can and cannot do. Morality restricts flexibility and licensing filters entry. Competitive pricing, commercial advertising and entrepreneurial innovation can get a professional struck off. The butcher may have an instinct of workmanship but no one would say he had sworn a Hippocratic Oath that complements the law of contract. Health care, however, is different.

Society, meanwhile, has values and objectives of its own which it wishes to impose upon the dyad of market exchange. Health care involves other people. Other people want contagious externalities and third-party spillovers to be contained by collective action. As well as You and Me, there is also an Us which has a vision, a consensus and a baseline that is a common bond. Other people want absolute values like social justice, collective responsibility and respect for persons to complement the economist's maximand of input-output efficiency. Our common value system is what makes us fellow citizens, team-mates and integrated cooperators rather than isolated perfect competitors whose only purpose is to turn a penny whenever a gull is to be twisted. The market is about wants. Health care is about wants and about needs. Health care, in other words, is not the same.

Business Arrangement

Healthcare reform, rising costs, and an increased number of health management organizations have led healthcare providers to seek new and more profitable business relationships [6]. These relationships include, among others, hospital mergers, hospital-physician joint ventures, and other types of hospital-affiliated physician networks. These types of arrangements often raise legal issues surrounding possible kickbacks, self-referrals, false claims, and even antitrust violations. Therefore, it is important that all applicable legal issues be understood, and that potential business relations be analyzed, not only from a financial perspective, but also from a legal and regulatory perspective. Taking such matters into account during the planning stage will help businesses and individuals structure organizations in a manner that avoids potential civil and criminal consequences of violating the law.

Physicians and medical groups forming and operating under legal entities must be aware of the tax and personal liability consequences that the various entity structures entail. Generally, the two broad categories of entity structure available, incorporated and unincorporated entities, will afford the physician different levels of protections in those crucial areas. Although no business structure will protect or afford the physician immunity from liability stemming from his own professional actions, some entities provide better personal protection than others in the event the actions of a partner, colleague, or employee of a physician were the cause of a suit. A closer examination of the advantages and drawbacks of each entity is required to provide physicians and medical groups with a better idea of how to structure their business. However, one should not solely rely on the following brief overview regarding the choice of optimal physician entity. Laws and tax regulations concerning the various entities can vary from state to state and it is therefore crucial that a physician consult a legal expert from his or her own state before making the ultimate decision of which entity to operate.

The first step in establishing an optimally functioning department of nursing is to ensure that the structure of the department is well defined. With the

ever-changing nature of health care in the 21st century, it is not uncommon that the structure of nursing services has evolved over the last several decades [7]. Traditional models—with a single-leader hierarchy and pyramid-type organizational structure, where members of the organization report to one supervisor and decisions flow typically from the leader down to members of the team—are no longer seen in the complex healthcare organizations and healthcare systems of the 21st century. Traditional models have been replaced with matrix models and service line models and often a combination of the two models.

Matrix models are based on having two supervisors, one being a functional supervisor of the specialty area in which the individual works; the other is the supervisor of the current work initiative. Though this model is frequently seen in engineering, the model is also seen in health care where care is structured to meet the needs of a particular population such as orthopedic, cardiovascular, or psychiatric services. Service line models have demonstrated increase in volume and market share and decreased costs in healthcare organizations.

Service line models are helpful in managing nursing services in an organization as financial indicators such as volume, market share, and costs are routinely a part of the nurse executive's financial dashboard and are reviewed routinely and acted upon as indicated to ensure appropriate levels of nursing services. Successful service lines have a clear definition of what comprises the service line so that the organization is able to stay focused on outcomes and benchmarks.

Medical Error

The concept of medical error fails to acknowledge that patients can contribute to, or avoid, errors both in and out of these settings [8]. Whereas the accepted view of medical error depersonalises error by attributing it to groups of professionals or health care organisations, a new focus on patient error would ascribe active errors to the actions of patients. Such a concept would need to distinguish between people and their settings, not only because the current concept of medical error is clinician centric, but because it does not clearly acknowledge that people, as autonomous

entities, produce active errors wherever they come in contact with the health system. Specific attributions of error – for example to patients acting outside a medical setting – would help to clarify the question of who contributes to such errors, whether directly or via systems deficiencies. And, despite debate about how to identify a patient, it might be more feasible to identify the errors made by patients than those made by the many types of interacting clinical providers. The different types of error are not mutually exclusive: an error such as refusal of clinical investigations, which originates in the process of patient-clinician interaction, could be attributed to both a patient and a clinician.

Quality of Health Care

The challenge of efficiently delivering individualized, effective care is one facing every health care provider [9]. Hospitals, nursing homes, community clinics, and emergency rooms are often crowded. Waiting rooms may be overflowing and emergency rooms flooded with insured and uninsured individuals seeking needed health care. The use of emergency rooms for routine care is the most expensive delivery modality but guarantees that care will be provided.

The United States, even with its excellent technology and highly educated providers, has yet to master the challenge to provide quality health care to the full population. The country's public health challenges are many and continue to evolve as health care professionals and communities work with our elected leaders and government agencies to meet these tremendous needs and to discover and implement new and successful strategies.

Such health care challenges can be both energizing and rewarding. The exciting opportunity of delivering health care in the United States is afforded by the wealth of technology, expert colleagues and specialists, and the continually developing medical research that constantly leads to revolutionary new treatments and cures. An emphasis on evidence-based practice is pushing new, effective practices to the bedside and into the clinicians' hands quickly upon discovery. Pharmacology options and new procedures are being released at remarkable rates. Opportunities exist for

interdisciplinary planning and development of collaborative new approaches for the delivery of quality health care. State-of-the-art technology combines with evidence-based practice delivery. Most work environments are energizing and exciting, with different patients and challenges every single day.

Emergency Management

A fundamental tenet of emergency management is that institutions must prepare for events that may rarely occur while taking protective actions to mitigate any likelihood that they will occur at all [10]. Due to the low frequency of events testing the health system's ability to respond to a disaster, an act of terrorism, or a public health emergency, the ability to evaluate the strengths and weaknesses of hospital emergency preparedness is limited. In addition, the public has strong expectations of the roles hospitals should play during times of disaster. Healthcare institutions are expected to provide both emergency care and continuance of the day-to-day healthcare responsibilities regardless of the volume and demand. Recently, they have also become sites of community refuge, bastions of safety in a threatening and dangerous environment. The public believes that hospitals will have light, heat, air conditioning, water, food, and communications capabilities, regardless of the fact that the institution may itself be affected by the calamity.

In healthcare delivery, we attempt to meet the health and medical needs of the community by providing a place for individuals to seek preventative medicine, care for chronic medical conditions, emergency medical treatment, and rehabilitation from injury or illness. While a healthcare institution serves the community, this responsibility occurs at the level of the individual. Each individual expects a thorough assessment and treatment if needed, regardless of the needs of others. This approach is different than that practiced by emergency managers, whose goal is to assist the largest number of people with the limited resources that are available. As such, emergency management principles are focused on the needs of the population rather than the individual.

The healthcare delivery system is vast and

comprised of multiple entry points at primary care providers, clinics, urgent care centers, hospitals, rehabilitation facilities, and long-term care facilities. The point of entry for many individuals into the acute healthcare system is through the emergency department (ED). Since the late 1970s, the emergency medical services (EMS) system has allowed victims of acute illness and injury to receive initial stabilization of life-threatening medical conditions on the way to the emergency department. Among the many strengths of the ED is the ability to integrate two major components of the healthcare system: prehospital and definitive care. The emergency department maintains constant communications with the EMS system and serves as the direct point of entry for prehospital providers into the hospital or trauma center. Emergency physicians represent a critical link in this process by anticipating the resources that ill and injured patients will need upon arrival at the ED, and initiating appropriate life-saving medical care until specialty resources become available. In this context, the healthcare system is an emergency response entity.

Conclusion

Health care includes a system of social, group and individual measures, services and activities for preserving and improving health, disease prevention, early detection of disease, timely treatment, and health care and rehabilitation, as well as the application of health technologies. Health care, within health institutions and private practices, is provided by health workers and health associates by applying modern medical procedures and technologies, and by monitoring the achievements in the development of medical science. Within the framework of social health care, health care is provided which includes: - preservation and improvement of health, detection and suppression of risk factors for the occurrence of diseases, acquisition of knowledge and habits about a healthy lifestyle; - promotion of healthy lifestyles; - prevention, control and early detection of diseases; - timely diagnosis and timely treatment, rehabilitation of the sick and injured; - information that is necessary for the population or an individual to act responsibly and to exercise the right to health.

Conflict of Interest

The author has read and approved the final version of the manuscript. The author has no conflicts of interest to declare.

References

- [1] Smith S, Sinclair D, Raine R. Health care evaluation. McGraw-Hill Education (UK); 2005 Nov 1.
- [2] Neergaard U. EU health care law in a constitutional light: Distribution of competences, notions of 'solidarity', and 'social Europe'. In *Health Care and EU Law 2011* (pp. 19-58). TMC Asser Press, The Hague. van de Gronden JW, Szyszczyk E, Neergaard U, Krajewski M, editors. Health care and EU law. Springer Science & Business Media; 2011 May 18.
- [3] Drijber BJ, Cadenau H. Discrimination and beyond. In *Health Care and EU Law 2011* (pp. 59-76). TMC Asser Press. van de Gronden JW, Szyszczyk E, Neergaard U, Krajewski M. Health care and EU law. Springer Science & Business Media; 2011 May 18.
- [4] Baeten R, Palm W. The compatibility of health care capacity planning policies with EU internal market rules. In *Health Care and EU law 2011* (pp. 389-411). TMC Asser Press. van de Gronden JW, Szyszczyk E, Neergaard U, Krajewski M. Health care and EU law. Springer Science & Business Media; 2011 May 18.
- [5] Reisman DA. Health care and public policy. Edward Elgar Publishing; 2009.
- [6] Imperato GL, Perling LJ, Segal M. Legal Implications of Business Arrangements in the Healthcare Industry. *Health Care Administration: Managing Organized Delivery Systems*. 2010 Apr 12:107.
- [7] Wolper LF. Health care administration: managing organized delivery systems. Jones & Bartlett Publishers; 2010 Apr 12.
- [8] Buetow S, Elwyn G. Patient safety and patient error. *Health Care Errors and Patient Safety*. 2009 Mar 12:48-55.
- [9] Whitehouse DMN, Gale DD. "Introduction" in Whitehouse DMN, Gale DD, Lubinsky J, Doig KM, McPhee S, Sanders B, Buck G, Gara N, Higdon CW. "Health Care Professional Practice in the United States" in Nichols BL, Davis CR (eds). "What You Need to Know about Health Care and the Allied Health Professions in the United States". New York, USA: Springer Publishing Company, LLC; 2010. p. 150-151.

[10] Reilly MJ, Markenson DS. Introduction to hospital and healthcare emergency management. Health Care Emergency Management Principles and Practice. Burlington, MA: Jones and Bartlett Learning; 2011. p. 3-19.

