European Research Studies Journal
Volume XXIV, Special Issue 1, 2021

pp. 414-420

Interactive Governance in Health Care as the Determinant of Safety for Respecting Patients' Rights

Submitted 12/01/21, 1st revision 16/02/21, 2nd revision 07/03/21, accepted 20/03/21

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Abstract:

Purpose: *The purpose of this research was to demonstrate a new model of interactive governance as an innovative tool in health care management in crisis situations.*
Project/Methodology/Approach: *The analysis of the new model of interactive governance in the context of health care is based, among other things, on a descriptive model and certain elements of economic analysis of law, expressed in the pursuit of optimal efficiency from legal and social points of view.*
Findings: *It was determined that there exists a correlation between health care and the public administration system. These interconnections comprise various elements reflecting a specific whole, which is relatively permanent and discernible among other parts of social reality. Those elements give rise to a specific network of various interconnections: legal, financial, economic, and trade. This results in a new model of governance based on a multi-level partnership of all public and non-public entities participating in governance.*
Practical implications: *The presented results are important for all public authorities since they facilitate a more effective change design in the field of management related to health care. This is especially important in respect of organising and administering legally protected goods in the health care system, which should successfully protect public health and the health of individual patients in each state.*
Originality/value: *This article presents the possible directions for change in health care management, which can contribute to improved effectiveness of activities undertaken by public authorities and the implementation of effective administration.*

Keywords: *Patient's Rights, healthcare systems, effective administration, interactive governance.*

JEL codes: *I1, I3, K38*

Paper type: *Research study.*

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1. Introduction

The issues of public health, patient safety, and responsible and rational management in the context of the growing crisis in health care caused by COVID-19, have become crucial contemporary topics. These are found interesting from the point of view of doctrine, especially by lawyers specialising in medical law, as well as health professionals, political scientists, economists, and health care managers. It is worth noting that patients, protection of their rights, and the doctor-patient relationship, in which legal and state institutions have lately tried to interfere to an increasing extent, all play a vital role in this context.

The crisis, which has been affecting the whole world for several months now, is a diverse space with multifaceted issues, where the gravity of the issues at hand far exceeds the traditional approach to health crises. The discussed issues include those related to duty of care and standard of care in medical services, which is inextricably connected with the correct depiction of the doctor-patient relationship, which brings the most sensitive legal and ethical dilemmas. Therefore, one can hear questions about the very foundations and objectives of specific fields of law and appropriate management in health care. There is a paradigm shift in the doctor-patient relationship, a change in the organisation of treatment facilities, and notable complexity of hospital and medical teams. The organisation of the health care system is facing the challenge of the correct allocation of medical goods, which means a search for the appropriate health care management model.

2. The Structure of a Health Care Crisis

The COVID-19 pandemic, in addition to an economic crisis, has highlighted a crisis related to the doctor-patient relationship – a crisis in trust, care, and duty. Traditionally, medicine is understood as a relationship between the doctor and the patient, which is based on trust, development of medical technology, communication, and wide access to information, including socialisation systems. Each of the aforementioned factors is intended to stabilise the doctor-patient relationship, first and foremost developing mutual trust. This trust is often the axis of disputes. It is shaken on numerous occasions, especially when not all patient's expectations towards the physicians have been met. This problem is developing and growing in the context of social globalisation. The flow of information is much faster than in previous decades, which in effect makes it easier for patients to analyse and file complaints against doctors.

It is worth noting that patients themselves demand a Hippocratic model and a paternalistic vision of medicine[5]. Today, such a model uses modern means of communication and dialogue within the framework of medical, medical, and caring

[5]*G. Gillett, Bioethics in the Clinic: Hippocratic Reflections, London 2004, pp. 134-135; H.T. Engelhardt, Bioethics Critically Reconsidered: Having Second Thoughts, Texas 2011, p. 146.*

activities. This makes it possible to analyse not only the physical aspects of the disease, but also defines a wider field in which it occurs and develops, i.e. psychological, social, family, and existential domains.

In the light of bioethical concepts referring to the principle of charity, it is patient autonomy which comes to the foreground. Lack thereof can currently manifest in different forms: incomplete information on patient's health and the treatment options for a given disease entity, and subsequent care. As noted by many authors, physicians now lack reference to the fundamental ethical, moral, bioethical, and axiological principles[6]. In addition to the principle of autonomy, it is the principle of equality which is often being overlooked[7]. The essence of this problem lies in the issues of managing goods in health care not being taken into consideration due to the absence of systemic standards to be implemented to appropriately distribute and allocate those goods which are pivotal from the patient's point of view, as well as the point of view of protecting their life and health safety. Thus, to uphold the principle of equality in health care management, a more humanistic and ethical approach to patients is needed, which would not be driven solely by the rule of profits, losses, and costs.

According to many analysts who research the issue at hand, physicians should use the latest knowledge in medical practice, provide patients with care, and be driven by the humanistic principle of respect. Also, the best way to avoid crisis situations while building positive doctor-patient relationships is to follow ethical and humanistic procedures.

The doctrine lists four skills in free medical practice. These include knowledge of health protection regulations and the resulting obligations; development of one's communication skills so that the doctor-patient relationships followed humanistic values; knowledge of law, including of patients' rights, since only then the doctor can demand these be upheld by the patients themselves, their relatives and institutional and administrative authorities; providing the patients with the sense of security; striving to improve verbal and non-verbal communication strategies as early as at the level of medical education[8].

The crisis depicted above has resulted in new challenges in terms of improving management in health care in modern states. Management in a time of crisis has become a complex process based on a multi-segment design where every segment is

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[6]*Cf. N. Summerton, J. Graham, Effects of the medical liability system in Australia, UK and USA, "Lancet" 2006, No. 368, pp. 240-246.*

[7]*Cf. B. Maier, W.A. Shibles, The Philosophy and Practice of Medicine and Bioethics: A Naturalistic – Huamnistic Approach, New York 2011, pp. 281-284; B.H. Levi, Respecting Patient Autonomy, Chicago 1999, pp. 176-179; S.S. Sanbar, Legal Medicine, Philadelphia 2007, p. 362; M.B. Mengel, W.H. Scott, A. Fields, Fundamentals of Clinical Practice, New York 2002, p. 88.*

[8]*N. Summerton, Positive and negative factors in defensive medicine: a questionnaire study of general practitioners, BMJ 1995, Vol. 312, p. 1308.*

responsible for a specific part of the public sphere. This fragmentation can be noted on two planes – vertical one where authority is divided between departments and ministries, and a horizontal one where it is implemented at local and regional levels (Czaputowicz, 2008). A new mechanism referred to as *governance* is being developed. Changes in the model of public administration result from the evolution of the functions of the state which thus far have been construed traditionally and assumed the superiority of state structures over other decision-making bodies.

In the present struggle against the pandemic, the traditional *government* model can be replaced by *governance*, thus creating a new public space where authority is collectively owned by all systems of co-operating actors as well as of spaces for social relations in which they are rooted (Scott, 2006).

2.1 Health Care Models – in Search of New Solutions

The functioning of the health care sector is one of the most crucial problems faced by modern states. Its organisation is conditional mainly on the individual economic condition of the state and the adopted health policy. We can distinguish the following health care models, Bismarck, Beveridge, residual (free-market), and Siemaszko Models. In the Bismarck Model, the health sector is financed by mandatory health contributions paid by employers and employees, and the scope of the provided benefits is determined by the exclusion of certain services, such as plastic surgery (Bieńkowska, 2017). In this model, there are many entities which compete with one another by offering competitive contributions to be paid by the policyholders for the same scope of services. States which use the Bismarck Model include, among others, Austria, the Netherlands, and Switzerland (Lewandowski, 2010).

The Beveridge Model is financed mainly from taxes imposed on citizens and from other public sources. It is governmental or local-governmental institutions which collect the funds and pay for services. Every citizen is entitled to services the scope of which is determined by the so-called range of reimbursed benefits. The Beveridge Model is employed in such states as Sweden, Norway, Denmark, and Ireland. 2

Next, the Siemaszko Model was used in the 1990s in Central and Eastern Europe (Poland, Hungary), and was based on health care services being funded from the state budget. The scope of provided benefits was based on reimbursement. Specific professional groups, such as police and military were able to benefit from an extended range of services paid for by the state.

The free marked (residual) system present in the United States of America is strikingly different when compared with the models above. In this system, health services are financed by individual patient fees and voluntary insurance, and the range of services available is limited by the funds available to the patient or the scope of the contract with the insurer. Patients who are unable to pay for their insurance (the elderly and poor people) are covered by government programmes (Lewandowski, 2010).

Technological and structural changes, especially at the social level, result in the necessity for modern states to search for new solutions in the operation of health care. The sphere of management is shifted from a field of economy to the area of activity of various non-state groups and actors. Therefore, a new type of state is being created, referred to as the *network state*. It is comprised of a network of state bodies and institutions and non-state entities, which share powers traditionally referred to as those of the state. A new model of rule referred to as *multi-level governance* is blurring the differences between internal and external functions of the state. In this model, the task of the state is to create appropriate conditions for cooperation, to facilitate interaction processes in public and non-public networks. This is to enable the effective implementation of tasks and problem-solving among all stakeholders, in the group that does not have its representation or where this representation is insufficient (Izdebski, 2012). In this context *multi-level governance* refers not to the state itself but rather to the activities of public administration, as governance in many aspects boils down to implementing various tasks and meeting social needs.

Network governance is a broader term that *multi-level governance*. This is because in addition to decentralising and deconcentrating the mechanisms of power, it is also based on internal coordination activities (Sroka, 2009). These are usually soft law regulations devised taking into consideration accepted cultural norms, guidelines, recommended indicators, or examples of best practice. This indicates that *network governance* is focused on the coordination of relations between the centres of power and their collaborators (Sroka, 2009). Cooperation and coordination take place when it is impossible to act based on traditional methods of management and control. For the health sector, this means that when searching for new solutions, states will need to focus not only on reforming the manner of funding benefits, but more importantly on promoting competition in treatment outcomes (Lewandowski, 2010).

2.2 Interactivity as the Determinant of New Solutions in Governance

Over the last several dozen years the traditional model of governance has changed. Globalisation and coexisting processes have resulted in power which was previously centralised in national decision-making bodies and specifically demarcated territorial borders, being dispersed to new entities which appeared in a supranational space. The public sphere has become a space for processes some of which are taking place faster than the other, where changes in the economy remain ahead of those in the political system (Rydlewski, 2009). The emergence of new actors in the domain of governance has forced all entities to cooperate and coordinate collective activities. The very meaning of coordination is not unambiguous, though. It can be interpreted in three ways (Jessop, 2007), as:

1. ex-post coordination through exchange,
2. ex-ante coordination through imperative top-down planning,
3. coordination as reflexive self-organisation.

Jessop regards this third type of coordination as the most fitting to describe governance, interpreted as a negotiated consent to resolve socially complex problems. In today's polycentric world, governance based on coordinating the activities of various entities and actors in the political and economic manoeuvring is the most optimal form of governance. It is necessary to coordinate activities and actions to solve and overcome specific problems and crises at the national, international, and global levels, in a way which is acceptable to all parties involved.

All stakeholders participate directly or indirectly in the process of developing optimal solutions. Their task is to find the most optimal mechanisms of cooperation to meet the civilisational and cultural aspirations of individuals, social groups, and large communities. In this process, the place and role of the management centre is being redefined. Its most important task is to activate participants in the social system to adapt to and create new solutions through social communication and negotiation (Hausner, 2008). This brings about a space for interactive governance, which considers the complexity, diversity, and dynamism of social, economic, and political systems of the modern world. According to Hausner (2008) interactive governance is composed of three institutional components:

- functionally diverse participants in the social system,
- network of coordination,
- recursive rationality, which means the ability to correct one's behaviour due to other actors being active in the same political area and the results of one's previous actions.

Therefore, such defined interactivity in governance means the ability of all entities participating in coordination and cooperation to generate civilisational and cultural changes for the common good of all participants. Thus, interactive governance is strategic adaptation to changes in the social system environment. While it is not the perfect solution which guarantees success in solving modern, complex problems, it is an important point of reference in shaping a new order in social relations, including in health care and patients' rights (Hausner, 2008).

3. Conclusions

In the conducted critical analysis of the problem, it was demonstrated that the health care crisis revolving around the pandemic situation is determined by several factors. Among these, the most crucial, next legal and medical factors, is the appropriate governance factor closely correlated with the adoption of a management model specific to the health care sector, and the corresponding models of specific behaviour and standards in governance. The aforementioned determinants are complementary and intertwined. Private-law elements lose their private nature becoming purely

public-law parts – as in the appropriate allocation of goods that are of key importance to the protection of patients' rights and safety.

The challenges posed by the pandemic crisis highlighted the correlation between the health and public administration systems. They have become a sum of many parts, reflecting a specific whole, which is relatively permanent and discernible among other elements of social reality. Those elements give rise to a specific network of various interconnections: legal, institutional, financial, and economic. This results in a new model of governance based on a multi-level partnership of all public and non-public entities, which assume responsibility for meeting collective and individual needs. This depiction of the issue at hand facilitates the determination of appropriate relations in legal, axiological, and administrative terms.

References:

Bieńkowska, D. 2017. Medycyna defensywna. Nadużycia medyczne w systemie prawnym Stanów Zjednoczonych Ameryki, Poznań [in Polish].

Czaputowicz, J. 2008. Administracja publiczna. Wyzwania w dobie integracji europejskiej. Warszawa. [In Polish].

Engelhardt, H.T. 2011. Bioethics Critically Reconsidered: Having Second Thoughts, Texas.

Gillett, G. 2011. Bioethics in the Clinic. Hippocratic Reflections, London.

Hausner, J. 2008. Zarządzanie publiczne. Warszawa. [In Polish].

Izdebski, H. 2012. Doktryny polityczno-prawne. Warszawa. [In Polish].

Jessop, B. 2007. Promowanie „dobrego rządzenia" i ukrywanie jego słabości: refleksja nad politycznymi paradygmatami i politycznymi narracjami w sferze rządzenia. Przekład B. Kozina, Zarządzanie Publiczne, no. 2.

Lewandowski, R. 2010. Modele systemów opieki zdrowotnej na świecie. Narodowe Centrum Nauki, Projekt badawczy nr 2015/17/B/HS4/02747 pt: Model, typologia i metody pomiaru systemów kontroli publicznych w szpitalach. View Project. Warszawa [In Polish].

Levi, B.H. 1999. Respecting Patient Autonomy. Chicago.

Maier B., Shibles, W.A. 2011. The Philosophy and Practice of Medicine and Bioethics: A Naturalistic – Humanistic Approach, New York.

Mengel, M.B., Scott, W.H., Fields, A. 2002. Fundamentals of Clinical Practice. New York.

Rydlewski, G. 2009. Rządzenie w świecie mega zmian. Warszawa [In Polish].

Sanbar, S.S. 2007. Legal Medicine. Philadelphia.

Scott, J. 2006. Władza. Przekład S. Królak. Warszawa [In Polish].

Sroka, J. 2009. Deliberacja i rządzenie wielopasmowe. Wrocław [In Polish].

Summerton, N. 1995. Positive and negative factors in defensive medicine: a questionnaire study of general practitioners. BMJ, nr. 312.

Summerton, N., Graham, J. 2006. Effects of the medical liability system in Australia, UK and USA. Lancet, nr. 368.