REVIEW ARTICLE

THE RIGHT TO HEALTH CARE IN THE CONTEXT OF PUBLIC AND PRIVATE INTERESTS

DOI: 10.36740/WLek202312123

Olena G. Rohova, Olena G. Ostapenko, Oleksandr I. Lysiak
SIMON KUZNETS KHARKIV NATIONAL UNIVERSITY OF ECONOMICS, KHARKIV, UKRAINE

ABSTRACT

The aim: To review of existing approaches regarding the ratio of private and public interests in the content of the right to health care.

Materials and methods: In this paper, a systemic approach was used, which made it possible to analyze public-law and private-law interests as part of the content of the right to health care in their systemic unity. The application of the comparative research method and the dialectical method made it possible to investigate the dynamic relationship between public legal and private legal interests as part of the right to health care.

Conclusions: In the context of the analysis of the content of the right to health care, it was determined that private and public interests find their form in the institutions of individual and public health. In conditions of economic stability and the absence of threats to the realization of the right to health care, the state of realization of the right to individual health and public health can be described by the categories of «binary» or «synergy», when public health and individual health strengthen each other one. Private and public interests in the content of the right to health care can be in a state of conflict in conditions of limited resources. Taking into account the need to legitimately regulate the conflict between private and public interests in the content of the right to health care, states establish legal norms, which we defined as «axiological collisions».

KEY WORDS: right to health care, public interest, private interest, health care system

Wiad Lek. 2023;76(12):2714-2720

INTRODUCTION

In our multifaceted world, the right to health care is considered one of the fundamental legal values, as a prerequisite for the existence and development of a person, a key to the functioning of an efficient economy and the progressive development of society as a whole. Despite the long historical path of humanity to the recognition of this right and its consolidation in national legal systems and acts of international law, the debate about the content of the right to health care, its «polyvalence» from the point of view of private and public interests, has not lost its relevance at the present time.

As we know, since the days of Roman law, the main criterion for distinguishing between private and public law – legal interest – has been considered the most important «engine» of human actions, the motive for any legally significant behavior. Currently, the division of law into private and publicis considered one of the features of continental European (Romano-Germanic Legal System) law [1]; the legal systems of many civilized countries are based on the principle of dividing law into private and public (Germany, France, Italy, Spain, and others) [2].

A wide range of researchers have paid a lot of attention to the study of various aspects of legal interest, the dichotomy of public and private interests in various doctrines and legal systems [3-7]. As should be clear by now, the position one takes on the distinction between private law and public law is both theoretically and practically important [7]. From both a theoretical and a practical point of view, it is important to trace the connection between legal interests and the formation of conceptual approaches to the right to health care.

After the World War II the most important trend in the development of national legal systems and international law was the desire to create a global «legal infrastructure» of human rights. The mutual process of development of global human rights law and the implementation of the concept of human rights in national legal systems took place against the background of a powerful scientific discourse, the issues of which were related to the justification of the universal nature of human rights against determinism, the search for a certain balance of public and private interests in determining the content of human rights. Joseph Raz describes the specified problems regarding the right to health care in categories «compromise between concern for health and the pursuit of other values» [8].

Even a superficial overview of the existing multifaceted approaches to the concept of the right to health

care allows us to identify a certain «conflict potential» in the content of this right: 1) how widely we are ready to understand the content of this right and the interests related to it, in order to provide it with effective guarantees implementation; 2) how widely we are ready to recognize the subject field of this right, realizing that this field may overlap with other individual rights and interests (for example, with the right to choose one's behavior, including the self-destructive one); 3) to what extent we are ready to protect this individual right, including in the situation of its conflict with certain public interests and values, primarily with the interests of public health.The solutions to these issues lie at the intersection of philosophy, politics, bioethics, law in general and legal axiology in particular.

The above mentioned determines the relevance of right to health care research from the point of view of the ratio of private and public interests in its content.

THE AIM

The aim is to review of existing approaches regarding the ratio of private and public interests in the content of the right to health care.

MATERIALS AND METHODS

In this paper, a systemic approach was used, which made it possible to analyze public-law and private-law interests as part of the content of the right to health care in their systemic unity. The research process was carried out on the basis of the principles of historicism, objectivity, complexity and reasonableness, which created a methodological basis for the analysis of the research subject. The application of the dialectical method made it possible to investigate the dynamic relationship between public legal and private legal interests as part of the right to health care. In addition, the research used such methods as an abstract logical method for theoretical generalization and conclusions, a method of analyzes and synthesis for the determination of the relationship between public and private interests. The conclusions obtained in the course of the work would not be sufficiently substantiated without the use of the comparative research method.

REVIEW AND DISCUSSION

The criterion of the nature of the dominant interest, allows to distinguish public law, which protects the general, state, public interests, public goods, important not for the individual but for the society, country as a whole. Instead, in private law, the personality interests of the individual (persons) are dominant [9]. In the context of the analysis of the right to health care, it is appropriate to distinguish between individual health and public health, which, in our opinion, are institutionalized forms of private and public interests in the field of health care.

As we know, Constitution of the World Health Organization (WHO), signed at New York on 22 July 1946, declares the value of the individual right to health care (one of the fundamental rights of every human being), as well as the value of the world legal order – «the health of all peoples». As stated in the WHO Constitution: «Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures» [10]. That implied the provision of basic preventive and curative medical services and the provision of medicines, the creation of the necessary system of medical institutions located in places accessible to the people, as well as the availability of qualified medical specialists. Thus, the approach defined by the WHO emphasized the associative relationship between the human right and the obligation of the states in the field of health care.

The human right to health appears in Article 12(1) of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR): The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health [11].

Attainability connotes duties being relative to the economic, social and political circumstances of different countries [8].Thus, the widest list of restrictions related to the practical implementation of the individual right to health care lies in the plane of the real capabilities of each state to ensure the implementation of the researched right. It will not be news to claim that each sovereign state is looking for its own way of implementing social policy and achieving a balance of private and public interests. In our opinion, the amount of social obligations guaranteed by the state in the field of health care is directly proportional to the recognized public interests in this field. Taking this into account, each state also establishes certain restrictions for the exercise of the right to health care.

For example, the Constitution of Ukraine (articles 35, 39) defines restrictions on the exercise of human rights may be established «in accordance with the law and only in the interests of national security and public order, with the purpose of preventing disturbances or crimes, protecting the health of the population, or protecting the rights and freedoms of other persons» [12]. It is not difficult to notice that public interests are really «weighty» limitations of individual rights (private interest).

The development of the theoretical and law enforcement potential of the concept of human rights, which took place during the second half of the 20 th century, led to a misleading global confidence that «The international community must treat human rights on a global, equitable and equal basis» [13]. It was in such a paradigm – equal access to versatile legal opportunities – that scientific research of right to health care were mostly carried out.

It seems that we are unlikely to find reliable information about the date in historical time when the justification and implementation of the concepts of the individual right to health care began. «The right to health … is a product of the Industrial Revolution in 19th-century Britain, in circumstances analogous to those in less developed countries today» [14].

As we know, the individual right to health care is relatively conditionally classified as a second generation of human rights (socio-economic and cultural rights), which gained recognition and consolidation during the days of socialist revolutions. Traditionally, the theory of the division of human rights, which was developed by the French lawyer Karel Vasak, is used to classify human rights. The basis of this concept is the generational approach, namely, the division of rights into three generations [15].

Since the recognition and proclamation of the individual right to health care, many conceptual approaches to understanding health and the content of the right to health care have been developed. «…it is well known that health is subject to conflicting meanings, from narrow biomedical definitions based on the statistically normal functioning of the human organism, through to very broad accounts of positive well-being and human flourishing, such as the World Health Organization's concept of «complete physical, mental and social well-being» [16]. There is not a linear spectrum of concepts of health. Rather, there is a plurality of accounts, with a notable added dimension when we contrast individual and population-level understandings [17].

It can be argued that concepts of public health are equally multifaceted. As Encyclopedia Britannica states, «Are view of the historical development of public health, which began in ancient times, emphasize show various public health concepts have evolved» [*18*]. It is important to emphasize that in the scientific discourse, the concept of «public health» is very often identified with the concept of «population health», using these terms as synonyms.

The field of public health is closely related to population health, so much so that the two terms are sometimes used interchangeably. A key distinction: Population health tends to focus on a narrow group, usually determined by geographic boundaries. Public health often addresses larger communities, including those determined not by geography but by race, gender, immigration status, disability level, or other factors [19]. If these definitions are causing more confusion than clarity, take a step back and consider that «public» and «population» are synonyms and in most cases, so too are «public health» and «population health» [20].

Population health is a relatively new term that has not yet been precisely defined. We propose that the definition be "the health outcomes of a group of individuals, including the distribution of such outcomes within the group," and we argue that the field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link these two [21].

«Population health is an opportunity for health care systems, agencies, and organizations to work together in order to improve the health outcomes of the communities they serve». «…at the core of public health lies the principle of social justice: making sure that we are providing people the right to be healthy and to live in conditions that will support their health». Broadly thinking about it, you could say public health is about what we're doing as a society and population health is about what a system is doing for their community [22]. For the purpose of our research, it is important to emphasize that the terms «public health» and «population health» (regardless of their substantive differences) appeal to public interests, the carriers of which are certain communities – social groups, the population of a certain state or, even humanity as a whole.

These global public interests, the subject of which is humanityas a whole, are based on universal values (for example, the value of public health is universally recognized). That is, the recognition of such a large-scale public interest is based on the presumption that this interest corresponds to the will of the world community and concerns every member of this community. But can it be argued that the public interest of the highest attainable level of health is the sum of the private interests of all people?

«… the health right cannot entail a set of individual contracts to ensure a healthy state for each person. Instead, a societal contract is involved.The societal commitment necessarily entails equity between groups as a fundamental principle» [14].

This recognized fundamental principle of social justice is constantly tested by time and law enforcement practice. Arguably, the strength of the general consensus on «highest attainable health» is maximal precisely at the theoretical level that forms the center of this vicious circle. The further from this center, the

more tests stand on the way to achieving the specified formula – such tests are related to cultural characteristics (in contrast to the universal, impeccable value of the right to health care), private interests, moral and ethical choices.

In practically seeking to make health public, ethical practice requires three important considerations to remain in view. First, the particular public health goal requires a clear ethical mandate. Second, the means used to reach that goal needs to be justified; we cannot just defend a policy or intervention because its outcomes are well-intended. And finally, we must not lose sight of the fact that our public health ethics must ultimately sit within a wholesale public and social ethics [16].

Presumably to smooth over this immanent conflict (between declaration and enforcement practice, between public and private interests), a significant number of researchers insist on the integration of «individual health» and «public health» efforts, arguing that this is a win-win situation: «Public health needs clinical partners, and the path to meeting this need is through integrated training. Medicine needs the power of population health» [23]; «Public health and medicine approach the challenge of health and health care from distinct, complementary perspectives» [24].

The WMA insists that public health should not be seen in isolation, as it is intrinsically linked to individual health, health care and medical care. The WMA advocates for the development of integrated health care systems in which both public health and individual health can be addressed [25].

Arah OA. argues that neither individual nor population health is *identifiable* or even definable without *informative contextualization* within the other [26].

Researchers point to the objectively existing process of convergence of private and public interests. «...the dynamics of public and private interests currently show a tendency towards convergence, mutual penetration. The interaction of public and private law reflects the dynamic balance of the interests of political forces, the state system, management mechanisms, the degree of freedom and independence of citizens in the modern world, etc.» [27]. The use of the term «binary» to denote actions that are carried out «simultaneously in the interests of the whole society and in the interests of an individual seems to be successful» [28].

Realization of public interests is often a condition for realization of private interests. The opposite situationis also possible, when the realization of a private interest leads to the realization of a public interest [29], «...any private interest can be summed up, considered, presented as a public interest, because a separate, private interest is very often important for the social whole. And vice versa: public interest without bringing it to any separate private interest becomes meaningless» [29].

Borrowing terminology from epidemiologic methodology, Arah OA. classifies the individual-versus-population health relationship into four categories [26]:

1. Immune: individual health remains good irrespective of the population health or context.
2. Causative: individual health is boosted in favorable population health or context.
3. Preventive: individual health is compromised when population health or context is unfavorable.
4. Doomed: individual health is compromised irrespective of the population health or context.

In our opinion, the dialectic of public-law and private-law interests is manifested in the fact that they can strengthen each other if they are synergistic (aimed a the same goal), or weaken each other if they are in conflict. Conflicts between public and private interests are activated in situations of choice in conditions of limited resources. Such resources can be all kinds of social and individual benefits, access to which directly or indirectly affects the real state of the realization of the right to health care (health care facilities, qualified doctors, medicines, medical technologies, information on effective clinical treatment protocols etc).

Trying to substantiate the formula of coexistence and mutual limitation of private and public interests, we will not find universal legal norms that determine the legitimate potential perspective of limiting public interests by private ones. At the same time, the limitation of private interests by public interests has a systemic nature, subject to compliance with certain legal conditions (determination of grounds, terms and elimination of collisions). «We define norm collisions as instances in which actors claim that two or more norms provide conflicting or incompatible expectations about appropriate behaviour in a specific situation» [30].

As we know, legal norm collisions serve as certain guideposts insituations of choosing between different legal prescriptions and eliminate legal uncertainty. Such norm collisions are used to regulate the choice between private and public interests. In our opinion, it will be correct to define them as «axiological collisions». In any case, the legislator must take responsibility for eliminating the axiological conflict on the basis of a certain moral choice, which is positioned for society as fair. «A system that distributes healthcare unevenly, on the basis of any determining factor other than necessity, raises numerous questions about how ethical that system is. In a society where disparity in the level of care or access to care exists, inevitably there will be individuals who fail to receive the care for which they desperately need» [31].

This is exactly the situation – the impossibility of access to medical care as a component of the individual right to health care – which has arisen as a result of the spread of the global pandemic for a significant number of people in different countries of the world. Presuming that the right to health care of an individual is the basis for realizing the right to health care for society as a whole, we lived in love with the «symbol of faith» – «the claim that all people alive today have the same human rights» [8]. Since the success of mass vaccination convinced us to look leniently at the processes of the spread of infectious diseases, we were sure that the epidemic well-being of society does not threaten the rights of an individual, which means that the rights of an individual can not in any case be sacrificed for the common good. The global pandemic – among other impacts on society – has actualized the conflict between public-law and private-law interests, the values of the individual right to health care and public health, as old as the world itself, and forced us to once again rethink their relationship.

CONCLUSIONS

The conceptual approach to the content of the right to health care, recognized at the global level (UN, WHO) and at the level of national legal systems, carries the ambivalent potential of the value of health in its individual and social dimensions. In the context of the analysis of the content of the right to health care, it was determined that private and public interests find their form in the institutions of individual and public health. In developed countries with socially-oriented models of health care systems, the correlation between the recognized scope of the right to health care and the positive obligations of the state is direct. In the conditions of different political regimes, the fact that the right to health care includes private and public interests can be denied (when public interests are absolutized in totalitarian states), or can be used as a tool of political manipulation. Denying or ignoring private interests can cause the deformation of the entire legal system of society, lead to totalitarianism and nationalization of all social life. In this case, the value of individual health is leveled, and the right to individual health is absorbed by the right to public health.

In conditions of economic stability and the absence of threats to the realization of the right to health care, the state of realization of the right to individual health and public health can be described by the categories of «binary» or «synergy», when public health and individual health strengthen each other one. Private and public interests in the content of the right to health care can be in a state of conflict in conditions of limited resources, which are all kinds of social and individual goods, access to which directly or indirectly affects the real state of the realization of the right to health care.

Taking into account the need to legitimately regulate the conflict between private and public interests in the content of the right to health care, states establish legal norms, which we defined as «axiological collisions». In our opinion, «axiological collisions» should indicate the legal conditions and reasons, the range of subjects to which they apply, as well as be based on the principles of the rule of law, humanism, integrity, and comprehensiveness of the right to health care.

The theoretical and practical problems considered in our review article require a continuation of the scientific discussion in order to further justify the formula of the ratio of public and private interests in the content of the right to health care without threat to each of these components.

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ORCID and contributionship:
Olena G. Rohova: 0000-0003-4482-0847 [A,B,D-F]
Olena G. Ostapenko: 0000-0001-5795-4276 [A,B,D]
Oleksandr I. Lysiak: 0000-0002-1511-3847 [A,B,D]

Conflict of interest:
The Authors declare no conflict of interest.

CORRESPONDING AUTHOR

Olena G. Rohova
Simon Kuznets Kharkiv National University of Economics
9-A Nauki pr-t, 61166 Kharkiv, Ukraine
e-mail: rogova31@ukr.net

Received: 27.04.2023
Accepted: 03.10.2023

A - Work concept and design, **B** – Data collection and analysis, **C** – Responsibility for statistical analysis, **D** – Writing the article, **E** – Critical review, **F** – Final approval of the article