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Healthcare in a modern state

Keywords: health care, right to health care, modern state, quality of health care system

Summary. The article is devoted to health protection in the modern state. To this end, it analyzes selected international agreements in terms of the sources of the right to health care, which is inextricably linked to human dignity. The article also examines and compares data contained in reports assessing health care in various countries around the world. Based on the results presented in these reports, conclusions are made about the characteristics that should characterize health care in a modern country.

Ochrona zdrowia w nowoczesnym państwie

Słowa kluczowe: opieka zdrowotna, prawo do ochrony zdrowia, nowoczesne państwo, jakość systemu ochrony zdrowia

Streszczenie. Artykuł poświęcony jest ochronie zdrowia w nowoczesnym państwie. W tym celu analizuje wybrane umowy międzynarodowe pod kątem źródeł prawa do ochrony zdrowia, które jest nierozerwalnie związane z godnością ludzką. W artykule badane i porównywane są także dane zawarte w raportach oceniających ochronę zdrowia w różnych krajach na świecie. W oparciu o wyniki prezentowane w tych raportach sformułowane zostały wnioski dotyczące cech, jakimi powinna charakteryzować się opieka zdrowotna w nowoczesnym państwie.

Introduction

Health is a fundamental human right. It is inextricably linked to human dignity and guaranteed by various acts of international and national law of individual states. In an organized structure such as a modern state, the preservation of health requires the involvement of citizens and public authorities. What, then, should be the characteristics of health care in a modern state? What factors determine that health care in one state is at a higher level than in others? Does a modern, safe, and effective health care service require significant financial resources, or, however, does proper management of the system, appropriate legislation, and quality

standards play a key role? Within the framework of this article, the author will try to provide answers to the above questions.

Right to health care

The second of the nine principles formulated in the preamble to the **Constitution of the World Health Organization**[1] was adopted at the International Health Conference held in New York from June 19 to July 22, 1946, and signed on July 22, 1946, by representatives of 61 countries, ratified on April 7, 1948, reads: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social situation". The author does not doubt that these words are stronger and more relevant than ever. So, what does the right to health mean for all people? It means that everyone should have access to the health services they need, when and where they need them, without financial hardship and regardless of background, social status, gender, or age. It also means the ability to control one's health, to take an active role in taking care of oneself, the right to informed consent, and access to services free from violence and discrimination, respect for the right to privacy, and to be treated with respect and dignity. According to the author, all of the above are standards of modern health care.

The human right to health care is also addressed in the **Universal Declaration of Human**[2] **Rights** proclaimed by the United Nations General Assembly in Paris on December 10, 1948, in General Assembly Resolution 217/III-A. Although the Declaration was not binding and was not a source of international law, it became a common standard for all nations. It was a landmark document in the history of human rights, as it defined for the first time basic human rights subject to universal protection. Its text has been translated into more than 500 languages. The issue of health protection is regulated in Article 25 (1) of the Declaration[3]. According to its wording, every person is entitled to a level of well-being that ensures the preservation of this personal good for him and his family, in particular through access to medical care. The Declaration does not indicate specific systemic solutions through which this entitlement is to be realized. As Jaskólska rightly notes: "For

[1] Constitution of the World Health Organization, World Health Organization, 1946, https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1 (accesssed on 30.09.2022).

[2] *Universal Declaration of Human Rights*, United Nations 1947, https://www.un.org/en/about-us/universal-declaration-of-human-rights (accessed on 30.09.2022).

[3] Article 25 (1) of Universal Declaration of Human Rights reads:
1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

these are already issues of concrete policy, which can only be resolved in individual regimes, through the formulation and implementation of specific legislation. The role of the Declaration here essentially boils down to raising awareness that such rights exist and should be realized"[4].

An example of an act of international law with global reach is the International **Covenant on Economic, Social and Cultural Rights**[5] at the core of which is the Universal Declaration of Human Rights mentioned above. This treaty was adopted by the General Assembly of the United Nations on December 16, 1966 and entered into force on January 3, 1976. It commits its parties to work for the granting of economic, social, and cultural rights, including the right to health. As of July 2020, it has been adopted by 171 States Parties. Another four countries, including the United States, have signed but not ratified the Pact. The issue of health has been devoted to Article 12[6]. The first paragraph of the article in question defines the right to health. In turn, the next one lists examples of obligations by which States Parties are to enable the full realization of this right. The right to health should not be understood solely as the right to be healthy. The right to health includes both freedoms and entitlements, including the right to control one's health and body, sexual and reproductive freedom, and the right to be free from interference (the right to be free from torture, the right to consensual medical treatment). It also includes the right to a health care system that provides equal opportunities for people to enjoy the highest attainable standard of health. The concept of "the highest attainable standard of health" referred to in Article 12(1) of the Covenant takes into account both the biological and socioeconomic conditions of the individual and the available resources of the state. Many aspects cannot be considered

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[4] J. Jaskólska, *Treść Powszechnej Deklaracji Praw Człowieka*, „Człowiek w Kulturze" 1998, vol. 11, p. 81, https://bazhum.muzhp.pl/media/files/Czlowiek_w_Kulturze/Czlowiek_w_Kulturze-r1998--t11/Czlowiek_w_Kulturze-r1998-t11-s49-97/Czlowiek_w_Kulturze-r1998-t11-s49-97.pdf (accessed on: 30.09.2022).

[5] International Covenant on Economic, Social and Cultural Rights, General Assembly resolution 2200A (XXI), United Nations General Assembly 1966, https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights (accessed on 30.09.2022).

[6] Article 12 of Covenant on Economic, Social and Cultural Rights reads:
1. 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.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
b) The improvement of all aspects of environmental and industrial hygiene;
c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

solely within the framework of the relationship between States and individuals; in particular, a State cannot ensure good health, nor can it protect every possible cause of human ill health. Accordingly, variables such as genetic factors, individual susceptibility to ill health, and the adoption of unhealthy or risky lifestyles can play an important role in an individual's health. Thus, as rightly noted in the commentary to Article 12 of the Covenant in question, "the right to health must be understood as the right to enjoy the various facilities, goods, services, and conditions necessary to realize the highest attainable standard of health"[7].

Among the sources of European international law, two agreements should be singled out. The first is the **European Social Charter**[8], opened for signature on October 18, 1961, in Turin, effective February 26, 1965. This basic agreement of the Council of Europe on socio-economic rights is a guarantee of both civil and political rights and freedoms. It is based on equality based on race, color, and gender, religion, political opinion, national or social origin. The Charter guarantees several rights and freedoms of the social sphere, including the right to health protection, outlined in Article 11 of the Charter[9], and the right to social and medical assistance, found in Article 13 of the document[10]. Inherent in the norm flowing from Article 11 is human dignity, which is the source of all human rights and freedoms.

[7] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4, https://www.refworld.org/docid/4538838d0.html (accessed on 30.09.2022).

[8] *European Social Charter*, Council of Europe, Turin 1961, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168048b059 (accessed on 30.09.2022).

[9] Article 11 of European Social Charter reads: With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed *inter alia*:
1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases.

[10] Article 13 of European Social Charter reads: With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake:
1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;
2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;
4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Contracting Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11th December 1953.

Consequently, the right to health care is a condition for the inviolability of human dignity. The legal provision in question imposes an obligation on member states to eliminate as far as possible the causes of disease, to provide a system of guidance and education on health matters and prevention, by making the public aware of its individual responsibility and the need to improve health and to prevent, as far as possible, epidemic, endemic and other diseases, as well as accidents. All of the responsibilities listed above should be carried out by member states at both the central and local government levels. The task of eliminating (as much as possible) the causes of diseases and providing a system of guidance can be carried out by the authorities of member states, through the organization of a universal and effective health care system involving the public and private sectors. Great emphasis should be placed on preventive and educational measures. Related to the latter is the goal of building public awareness of and responsibility for health security in the broadest sense, which can be achieved through information and education campaigns using a variety of tools, in places such as schools, workplaces, and public spaces. When evaluating the effectiveness of the public authority's activities in carrying out the above tasks, attention should be paid to the extent to which the intended goals have been achieved in society as a whole and in particular groups, including among those at risk of social exclusion.Concerning persons who lack sufficient resources and are unable to provide for themselves from other sources, Article 13 of the Charter establishes the right to social and medical assistance. In terms of the right to medical assistance, these persons, in the event of illness or deterioration of their health, have gained a guarantee of access to necessary medical care. At this point, it should be emphasized that the question support should also include counseling at an appropriate level[11]. As in the case of the previously presented acts, the duty to create an adequate health care system lies with the authorities of the Council of Europe member states.

The second act of international law limited to the EU area is the **Charter of Fundamental Rights of the European Union**[12]. In its original form, it was enacted and signed on behalf of the three Community bodies: Parliament, the Council, and the European Commission. This took place on December 7, 2000, in Nice during the European Council summit. The agreement eventually became binding

[11] For more on Articles 11 and 13 of the European Social Charter, see A. M. Świątkowski, M. Wujczyk, *Karta Praw Społecznych Rady Europy Jako Szansa Ustanowienia Jednolitej Koncepcji Obywatelstwa Unii Europejskiej*, "Roczniki Administracji i Prawa. Wyższa Szkoła Humanitas" 2016, no. 16(2), p. 415, http://cejsh.icm.edu.pl/cejsh/element/bwmeta1.element.desklight-f847bd20-3aff-4a65-8de4-a11fa6747b78 (accessed on 30.09.2022).

[12] Charter of Fundamental Rights of the European Union, European Convention, 2000, https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A12012P%2FTXT (accessed on 30.09.2022).

through the Lisbon Treaty, signed on December 13, 2007, and which entered into force on December 1, 2009. The Charter establishes political, social, and economic rights in EU law for both citizens and residents of the area. The issue of health care is regulated in Article 35 of the Charter of Fundamental Rights[13]. The principles outlined in this article are based on repealed Article 152 of the EC Treaty[14], now replaced by Article 168 of the Treaty on the Functioning of the European Union[15], and Articles 11 and 13 of the European Social Charter, discussed earlier.

[13] Article 35 of Charter of Fundamental Rights of the European Union reads: Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.

[14] Article 152 of the UC Treaty read:
1. A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education. The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.
2. The Community shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.
3. The Community and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.
4. The Council, acting in accordance with the procedure referred to in Article 251 and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this article through adopting:
a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;
b) by way of derogation from Article 37, measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;
c) incentive measures designed to protect and improve human health, excluding any harmonisation of the laws and regulations of the Member States. The Council, acting by a qualified majority on a proposal from the Commission, may also adopt recommendations for the purposes set out in this article.
5. Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

[15] Article 168 of Treaty on the Functioning of the European Union (ex Article 152 TEC) reads:
1. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities. Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and comba-

Juxtaposing Article 35 of the Charter of Fundamental Rights with Article 168 of the EU Treaty, it should be noted that the former defines the powers of the European Community in a very general way, while the latter already in the first paragraph contains an extensive catalog of more concrete powers such as: defining and implementing all Union policies and activities, the duty to ensure a high level of human health protection, activities directed at improving public health, preventing human diseases and ailments, removing sources of danger to physical and mental health, combating epidemics by developing research focused on determining their causes and ways of spreading and preventing them, promoting health information

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ting serious cross-border threats to health. The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.
2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas. Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.
3. The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.
4. By way of derogation from Article 2(5) and Article 6(a) and in accordance with Article 4(2)(k) the European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting in order to meet common safety concerns:
a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;
b) measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;
c) measures setting high standards of quality and safety for medicinal products and devices for medical use.
5. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.
6. The Council, on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.
7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

and education, monitoring and early warning of serious cross-border health threats and combating such threats, as well as measures to reduce the harmful effects of drug addiction involving information and prevention. In this regard, it should be understood that Article 35 of the Charter of Fundamental Rights establishes two general principles. First, member states must ensure equal access to health services. Second, in defining and implementing all Union policies and activities, it is an obligation to ensure a high level of human health protection.

It should be noted that although all of the aforementioned acts referred to the issue of health care in their content, only two of them, namely the International Covenant on Economic, Social and Cultural Rights in Article 12 and the Charter of Fundamental Rights of the European Union in Article 35, specify the level of quality that the health care system should meet. The former of the aforementioned acts refers to the right of everyone to enjoy the highest attainable level of physical and mental health protection, while the latter refers to a high level of human health protection. According to the author, the health care system in a modern state should be of the highest possible level. With this in mind, it is worth looking at the results of selected studies on the quality of health care in individual countries.

Quality of health care around the world

A WHO report published in January 2000, entitled „**Measuring Overall Health System Performance for 191 Countries**"[16], shows that at the time the top ten health care rankings were: France, Italy, San Marino, Andorra, Malta, Singapore, Spain, Oman, Austria, and Japan. Given that medicine is one of the fastest growing sciences, the above ranking has lost its relevance. Subsequent research in this area has produced new, updated lists.

The result of the Ipsos[17] international survey on healthcare was a report published in October 2018 entitled "Global Views On Healthcare – 2018"[18]. It presented results related to topic areas such as Personal Health Perceptions, Evaluating the Healthcare System, Patient Experience, Expected Changes in Healthcare, Adoption

[16] A. Tandon, C.JL. Murray, J.A. Lauer, D.B. Evans, *Measuring Overall Health System Performance for 191 Countries*, GPE Discussion Paper Series, World Health Organization 2000, no. 30, https://www.researchgate.net/publication/255624050_Measuring_Overall_Health_System_Performance_for_191_Countries (accessed on 30.09.2022).

[17] Ipsos is an independent research company controlled and managed by research professionals. Founded in France in 1975, Ipsos has developed into a global research group with a strong presence in all key markets. Ipsos ranks third in the global research industry. With offices in 89 countries, Ipsos provides reliable knowledge in six research specialties: advertising, customer loyalty, marketing, marketing, media, public affairs research, and research management.

[18] *Global Views On Healthcare – 2018*, Ipsos, 2018, https://www.ipsos.com/pl-pl/global-views-healthcare (accessed on 30.09.2022).

of Healthcare Technology, and Healthcare Information[19]. The information in the Personal Health Perceptions section shows that more than half of all adults surveyed worldwide (56%) enjoyed good health. Among the countries surveyed, those with the highest levels of reported good health were India (70%), Serbia (68%), and Saudi Arabia (67%), while the lowest levels were recorded by Hungary (47%), Poland (48%) and Russia (49%). It should be noted here that the entire survey was conducted using the Ipsos Global Advisor platform, which required Internet access[20]. In terms of access to necessary medical care, globally, half (49%) confirmed that they have such access, while as many as 24% said they do not. The countries where the highest percentage of adults disagreed that they receive needed medical care were Russia (44%), Peru (44%), Poland (42%), and Chile (40%). On the other side of the scale were Germans (11%), as well as Belgians, Australians, and Britons (12% each). Compared to medical care, a slightly smaller percentage of people worldwide (46%) confirmed that they receive necessary dental care, while 28% of respondents answered in the negative.

The Evaluating the Healthcare System section presents consumers' assessment of the quality of healthcare. The results varied widely from country to country. Globally, 45% of respondents rated it well, while 23% expressed dissatisfaction with their country's healthcare quality. In 14 of the 28 countries, the majority rated it as good, with the highest in the UK (73%), Malaysia (72%), and Australia (71%). The lowest ratings were in Brazil (39%), Poland (31%), and Russia (29%). In the ranking based on this data, the top ten places are held by the UK, Malaysia, Australia, Belgium, the US, Canada, Spain, Argentina, Germany, and France.

[19] According to the website www.ipsos.com, the results are from a survey conducted in 2018 on the Ipsos Global Advisor platform using the Ipsos Online Panel system. The first survey (questions A1-A5) was conducted between April 20 and May 4, 2018, with a sample of 20,767 adults in 27 countries: Argentina, Australia, Belgium, Brazil, Canada, Chile, China, France, Germany, Great Britain, Hungary, India, Italy, Japan, Malaysia, Mexico, Peru, Poland, Russia, Saudi Arabia, Serbia, South Africa, South Korea, Spain, Sweden, Turkey, and the United States. The second survey (covering questions B1-B13) was conducted between May 25 and June 8, 2018. With 23,249 adults in 28 countries (same as above plus Colombia). All survey respondents are 18-64 years old in Canada and the United States, and 16-64 years old in all other countries. Data are weighted according to population profile.

[20] In 17 countries, Internet access is high enough to consider the samples representative of the national population in the age ranges covered: Argentina, Australia, Belgium, Canada, France, Germany, Hungary, Italy, Japan, Poland, Serbia, South Korea, Spain, Sweden, the UK, and the US. Brazil, Chile, China, Colombia, India, Malaysia, Mexico, Russia, Peru, Saudi Arabia, South Africa, and Turkey have lower levels of Internet access. The samples from these countries should not be considered fully representative of the country, but rather represent a more affluent, connected population, representing an important and emerging middle class.

Table 1. Summary of top ten rankings by WHO (2000) and Ipsos (2018)

Ranking position	Country (2000 / WHO)	Country (2018 / Ipsos)
1	France	UK (#18 in 2000)
2	Italy	Malaysia (#49 in 2000)
3	San Marino	Australia (#32 in 2000)
4	Andorra	Belgium (#21 in 2000 r.)
5	Malta	USA (#37 in 2000)
6	Singapore	Canada (#30 2000)
7	Spain	Spain (#7 in 2000)
8	Oman	Argentina(#75 in 2000)
9	Austria	Germany (#25 in 2000)
10	Japan	France (#1 in 2000)

Only four in ten adults (41%) surveyed in 28 countries expressed confidence that their country's health care system would provide them with the best treatment, while nearly three in ten people (31%) did not trust their country's health care system. Spaniards (64%), Britons (63%), Malaysians (63%), and Australians (61%) expressed the highest appreciation. At the bottom of the table were Hungary (13%) and Russia (13%). In terms of waiting time to see a doctor, globally, 60% of respondents expressed their dissatisfaction, considering it too long. The exceptions were patients from Belgium, South Korea, the US, Australia, and Japan. At the same time, only 41% of people said they did not encounter difficulties in making a medical appointment in their area, while 32% disagreed with this statement. Countries, where more than 60% of people agreed with this statement, were Spain, Australia, and India. Countries, where residents encountered difficulties in this regard, included Brazil, Peru, Hungary, and Poland. As many as 55% of respondents felt that their country's health care system is overburdened. This opinion was most often expressed by the British (85%), Hungarians (80%), and Swedes (74%). Three in five (58%) respondents said that many people in their country cannot afford good health care. At the same time, only 32% of respondents said their country's health care system provides the same standard of care for everyone, while 40% had the opposite view. Only in Malaysia, the United Kingdom, Spain, and Canada did a majority of respondents give an affirmative response, while in Hungary, Poland, South Africa, and all four South American countries surveyed, the percentage of positive responses was less than 20%. Respondents also expressed concerns about the security of their data. Exactly half (50%) admitted that they feared their data would be shared with third parties without their consent. The countries with the highest percentage of such individuals were Mexico (67%) and Peru (65%).

The data presented in the Patient Experience section shows that although consumers in many countries had mixed opinions about their healthcare system, their views on interactions with individual healthcare professionals were generally positive. For the most part, adults participating in the survey in 28 countries were treated with dignity and respect (60%), seriousness (56%), acceptance (55%), felt safe (52%), and knew what to expect from their doctor (52%) during their last visit to a healthcare professional.

Another section titled Expected Changes in Healthcare focuses on issues related to expected changes in healthcare. It is noticeable that the vision of the future in emerging countries differed from that of already economically developed countries. Optimism prevailed in the first group (especially in China, India, Saudi Arabia, Malaysia, and all of Latin America), while pessimistic sentiment prevailed in many countries belonging to the second group (especially in Western Europe). Globally, more people believed that the availability of treatment for various conditions would improve (47%) rather than worsen (18%). The opposite trend was noticeable in Germany, Italy, France, and Sweden. Also, on the issue of the quality of health care and the availability of providers, optimists outnumbered pessimists (by 18 and 15%, respectively), while pessimists prevailed in most European countries. Regarding healthcare costs, more consumers in all countries surveyed expected them to be higher in a decade (34%). When it came to costs, pessimism prevailed in countries otherwise optimistic about the future of health care, including the US, Australia, South Africa, and Turkey.

The Adoption of Healthcare Technology section of the report presented findings in the area of technology adoption in healthcare, including telemedicine. According to the results presented, only 10% of all respondents had ever used telemedicine. There was a noticeable disparity between the use of telemedicine in Europe (2% in Belgium, 3% in Serbia, 4% in Russia, France, Spain, and Hungary) and the emerging countries of Asia and the Middle East (31% in Saudi Arabia, 27% in India, 24% in China, 15% in Malaysia) and the United States (15%). Among the 10% who had been exposed to the solution, about two-thirds said they would use it again, and one-third said they would not. In contrast, 44% of all respondents said they had not used telemedicine but would like to try it.

Data from Healthcare Information shows that medical personnel were then the primary source of information on healthcare, disease symptoms, and treatment options. For 58% of respondents, it was the only source of information. In all countries except Japan and Saudi Arabia, medical personnel were the primary source of information, followed by search engines (43%), family and friends (37%), pharmacists (34%), online encyclopedias (22%), and online medical information tools (22%). The availability of information about health services and how to take care

of one's health varied from country to country. Of all respondents, 47% said that information about health care services was readily available, while 50% said they encountered no difficulty in obtaining information on how to take care of their health. This attitude of respondents can be found in most English-speaking countries, as well as in Malaysia, Turkey, Sweden, Germany, Spain, and South Korea. In contrast, the lowest percentage of positive responses was recorded among respondents living in South America, Central Europe, Italy, and Japan.

In the report in question, among the key problems faced by each country's health care systems were access to treatment and long waiting times (40%), insufficient staff (36%), medical costs (32%), and excessive bureaucracy (26%). In the eight countries surveyed, access to treatment and waiting times to see a doctor was cited as the main problems. The greatest dissatisfaction among respondents was expressed by Poles (70%), Serbs (68%), Hungarians (65%), and Chileans (64%). In contrast, lack of staff was complained about by at least half of the respondents in six countries, including Sweden (68%), France (67%), Hungary (63%), and Germany (61%). Among the issues of serious concern in some countries were the high cost of access to treatment (64% in the US and 56% in Russia), poor quality of treatment (59% in Russia), an aging population (52% in Japan and 46% in China), lack of investment (more than 40% in Argentina, Brazil, the UK, and Spain), excessive bureaucracy (46% in Mexico), and low standards of cleanliness (30% in India and South Africa).

In turn, the report published on August 4, 2021, by The Commonwealth Fund[21], "Mirror, Mirror 2021 - Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries"[22] presents the results of a study that assessed the performance of the health care system in 11 high-income countries. Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States were selected as representative groups. Five indicators were used to assess them: Access to care, Care process, Administrative efficiency, Equity, and Health care outcomes.

[21] According to its website, https://www.commonwealthfund.org/about-us, The Commonwealth Fund is dedicated to promoting an efficient, equitable health care system that provides better access, better quality and greater efficiency, especially for the most vulnerable populations, including people of color, low-income people, and the uninsured. The Fund carries out this mandate by supporting independent research on health care issues and awarding grants to improve health care practice and policy. The International Health Policy Program aims to stimulate innovative policies and practices in the United States and other industrialized countries.

[22] E.C. Schneider, *Mirror, Mirror 2021 – Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries*, Commonwealth Fund Aug. 2021, https://doi.org/10.26099/ 01DV-H208 (accessed on 30.09.2022).

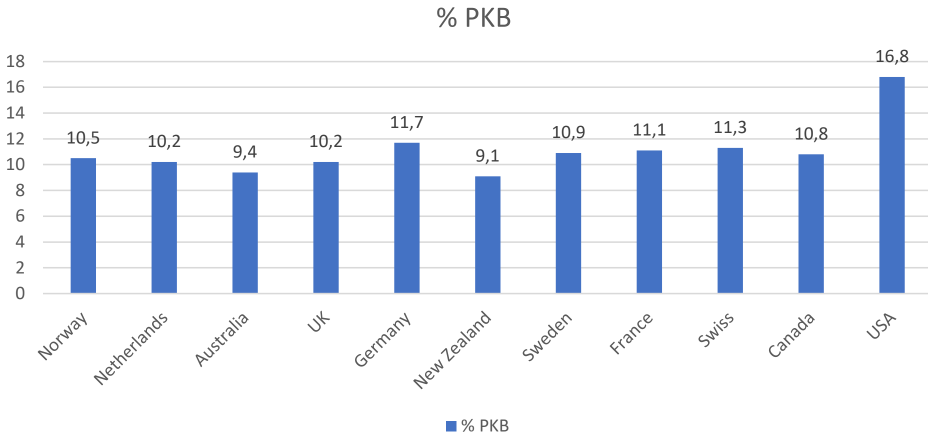

Figure 1. Percentage of GDP allocated by country to health care
Source: E.C. Schneider, *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries*, Commonwealth Fund Aug. 2021, https://doi.org/10.26099/01DV-H208 (accessed on 30.09.2022).

Based on the data presented here, the following ranking was created: Norway (#1), Netherlands (#2), and Australia (#3). United Kingdom (#4), Germany (#5), New Zealand (#6), Sweden (#7), France (#8), Switzerland (#9), Canada (#10), United States (#11). By comparison, these countries ranked as follows in the 2000 and 2018 rankings by WHO and Ipsos, respectively: Norway (WHO – #11, Ipsos – no data), Netherlands (WHO – #17, Ipsos – no data), Australia (WHO – #32, Ipsos – #3), United Kingdom (WHO – #18, Ipsos – #1), Germany (WHO – #25, Ipsos – #9), New Zealand (WHO – #41, Ipsos – no data), Sweden (WHO – 23, Ipsos – 13), France (WHO – 1, Ipsos – 10), Switzerland (WHO - 18, Ipsos – no data), Canada (WHO – 30, Ipsos – 6), United States (WHO – 37, Ipsos – 5). The Commonwealth Fund survey found that the United Kingdom, Germany, and New Zealand had very similar scores. The United States, on the other hand, fared the worst, with a result well below the average for the other countries and well below Switzerland and Canada, which ranked directly above the US. The only area in which the U.S. did not come in last place was Care Process, where it ranked second. As stated in the report "The United States is such an outlier that we calculated an average score based on the other 10 countries, excluding the United States"[23]. It should also be noted that while all countries increased health spending as a share of gross domestic product (GDP), spending growth in the United States – by far the worst performer overall - far outpaced that of the other 10 countries. The data

[23] *Ibidem*.

presented in Figure 1 shows that the amount of money spent on health care does not translate proportionately into quality. The U.S., which fared the worst overall, allocates the largest share of GDP, at 16.8%, while Norway, which ranked first in the ranking, allocates only 10.5%. Interestingly, the United Kingdom, Germany, and New Zealand, which ranked fourth, fifth and sixth respectively, allocate 10.2%, 11.7%, and 9.1% of GDP, respectively. In the author's opinion, the above proves that proper management and appropriate legal solutions, combined with reasonable levels of funding, can translate into an effective, high-quality health care system.

The data presented in the Access to care section deals with access to health care, which examined affordability and waiting times for medical care. In this area, of the 11 countries, the Netherlands performed best, ranking at or near the top in both subdomains. Norway and Germany also scored well in terms of access to health care, but all three countries were overtaken in terms of affordability by the UK. The last ranked country in terms of access to care was the United States, which recorded the weakest score in terms of affordability. The second least attractive country in this regard was Switzerland. Residents of the top-performing countries in the timeliness subdomain are more likely to have same-day and after-hours care. In this case, the United States ranked 9th.

The Care process section included assessments of preventive care activities, health care safety, coordinated care, and patient engagement and preference.

In this survey, the United States ranked a high second. The United Kingdom, Sweden, and the United States outperformed in the preventive care subdomain, which included rates of mammography screening and influenza vaccination, as well as the percentage of adults who talked to their doctor about nutrition, smoking, and alcohol consumption. New Zealand and the United States, with their large numbers of reported computerized warnings and routine drug reviews, scored best in terms of safety of care. In all countries, more than 10 percent of adults report that treatment or medication errors occurred during their care.

In the subdomain of coordinated care, New Zealand, Switzerland, and the Netherlands performed best. And in communication between primary care physicians and specialists, Switzerland, New Zealand, Australia, Norway, and France scored well. In terms of patient engagement and preferences, the highest scores were achieved by the United States and Germany. Among patients with chronic diseases, Americans showed the highest level of awareness manifested by the fact that they were most likely among those surveyed to show interest in the goal, priorities, and possible therapeutic methods. The findings on e-medicine are also noteworthy. Well, in the year preceding the COVID-19 pandemic, Swedish and Australian primary care physicians were most likely to use video consultations.

Administrative efficiency noted that in many countries with good health care systems, over-documentation was reduced for patients who use health services frequently, and insurance coverage, billing, and payment were simplified. In this area, Norway, Australia, New Zealand, and the United Kingdom boasted the best results, and the United States the worst. It is U.S. physicians who most often encounter problems in providing patients with medications or treatment due to limitations imposed by the scope of benefits covered by health insurance.

The Health Care Outcomes section was devoted to health care outcomes. It emphasized that better outcomes are not dependent on higher spending. In terms of efficient use of resources, Australia, Norway, and Switzerland ranked top. The study found that Norway has the lowest infant mortality rate (2 deaths per 1,000 births) and Australia has the highest life expectancy after age 60 (25.6 years of additional life expectancy for those who survive to age 60). In nine out of ten indicators, the United States was again the worst performer.

An analysis of the reports compiled by Ipsos, and the Commonwealth Fund allows us to conclude that problems in the area of health care arise even in those economically developed countries where resources allocated to the system are substantial. Nonetheless, lessons from countries at the top of the rankings may prove helpful to other countries in designing changes to improve health care.

The proper directions for health care development in a modern state

A modern country's drive to improve health care and the health of its population requires both changes in health policy and beyond. Countries recording the best results in the rankings are guided by the following:

- Ensure universal access to health care services and remove financial barriers so that people can get the proper care when they need it, in a manner consistent with their will and ability. Countries at the top of the ranking provide near-complete coverage for preventive services, primary care, and effective management of chronic diseases. Germany abolished co-payments for medical visits in 2013, while several countries have introduced fixed annual limits on health spending (ranging from about $300 a year in Norway to $2,645 in Switzerland). In Australia in 2019, 86 percent of citizens incurred no out-of-pocket costs for primary care visits;
- Investing in primary care systems so that high-value services are evenly available locally in all communities, to all people - reducing the risk of discrimination and inequity;

- Reducing the administrative burden on medical staff and patients. Administrative procedures both consume the time and money of patients, medical staff, and managers, and move them away from the goal of improving health care. Many countries have simplified their health insurance and payment systems through changes in legislation, regulation, and standardization. In Norway, for example, patient payments for physician fees are determined at the regional level. In doing so, standardized surcharges are applied to all doctors practicing in the public sector within a given specialty in a given geographic area. In contrast, in countries such as the Netherlands, where private insurance companies compete for customers, the standard includes a mandatory minimum package of basic benefits, community classification, and cost-sharing ceilings. All of this is intended to make it easier for beneficiaries to choose an insurer. It also aims, for insurers to compete on service and quality, rather than avoiding people with higher health risks. In Germany and Canada, mechanisms for joint negotiation and standardized payments for services are used at the national or regional level, which is intended to translate into simpler transactions and fewer errors and appeals;
- Investing in social services that increase equal access to nutrition, education, childcare, community safety, housing, transportation, and employee benefits, leading to a healthier population and less need for health care;
- Carrying out policies aimed at reducing premature mortality by, among other things, developing maternal primary health care to ensure continuity of care from conception to the postnatal period, and expanding primary health care services to include mental health diagnosis and early intervention and treatment, as well as promoting social connectedness and suicide prevention. For example, countries such as the Netherlands, Sweden, and Australia often integrate mental health practitioners into primary care teams.

As the Commonwealth Fund report rightly notes, “Health outcomes are influenced by a wide variety of social and economic factors, many of which are beyond the control of health systems. Public policies and investments in education, employment, nutrition, housing, transportation, and environmental safety shape population health”. This is borne out by the health situation in the United States, where relatively little government funding is allocated to social programs such as early childhood education, parental leave, income support for single parents, support for workers such as unemployment protection, and labor market incentives. This is an ideal, though not isolated, the example of a country where health outcomes can be improved through measures beyond health care.

Health care in a modern state should not aim to provide high-quality care for the population that has access to care and the means to pay for it, while providing low- or no-quality care for the portion of the population that does not have those means. The health care system should also not create obstacles to its use by poorer and socially excluded people. Low-income people who work long hours, as well as those with limited health literacy, may find it difficult to navigate the health care system or complex insurance eligibility procedures. In the face of these problems, the United States can serve as a model, where health navigators are employed to help patients navigate both the insurance and health care systems.

Attention should also be paid to the use of new technologies in the health care field. On the one hand, their presence in the modern state seems to be a natural phenomenon. The use of high-tech devices in medicine undoubtedly serves to improve the quality of health care. The same effect is achieved by conducting educational campaigns using the Internet. However, at this point, it is worth quoting data published in the report „Wykluczenie społeczno-cyfrowe w Polsce. Stan zjawiska,trendy, rekomendacje"[24], which was created in 2021 as a result of cooperation between the Orange Foundation and the Stocznia Foundation. This report shows that 10% of Polish society does not have access to the Internet, with more than 52% of households without access to the network citing a lack of appropriate skills as the reason for not using the Internet. 55% of those who have never used the network live in rural areas. According to the report's authors, the key form of digital exclusion determining non-use of the Internet remains motivational exclusion. Nearly 66% of those who do not use the network justify it by lack of need, even though - depending on the sociodemographic group – 20-45% of them have a device at home that provides access to the network. Low awareness of the need for things that are important in the lives of individuals that can be done through the network, and lack of knowledge of what the Internet can be used for, were cited as the basis for motivational exclusion. Although exclusion due to physical inability to access the Internet is already a marginal problem in Poland, lack of appropriate skills as a reason for not using it was indicated in more than 52% of households without access to the network. Interestingly, although the COVID-19 pandemic, nationwide, contributed significantly to the increase in Internet use, the group of households with the lowest income did not have access to the Internet, as many as 25% of them. The above data should not so much cast doubt on the sense of using

[24] A. Bartol, J. Herbst, A. Pierścińska, *Wykluczenie społeczno-cyfrowe w Polsce. Stan zjawiska, trendy, rekomendacje*, Fundacja Orange i Fundacja Stocznia 2021, https://fundacja.orange.pl/strefa--wiedzy/post/wykluczenie-spoleczno-cyfrowe-w-polsce-2021 (accessed on 30.09.2022).

the network as a tool for improving the level of health care and modernizing it, as it should be a contribution to the undertaking by relevant authorities and entities, both public and private, of extensive information and education campaigns on the opportunities offered by the use of a tool such as the Internet and other goods, such as the various types of applications that can be used through it.

Conclusion

When considering health care in a modern state, it is necessary to keep in mind the content of the international regulations cited in this study, which, although not the latest legal developments, remain relevant all the time. So, what attributes should distinguish the health care of a modern state? In the author's opinion, it should be characterized in particular by general accessibility, trust on the part of patients, use of only up-to-date medical knowledge, patient safety, use of new technologies, respect for the dignity of patients and medical personnel, transparency and completeness of health care information understandable to patients, public education, security of sensitive data concerning the patient, efficiency translating primarily into short waiting times for necessary services, low or no direct payment, reasonable and adequate to the possibilities of society, and effective management.

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