Patient rights are a movement which originated in the Human Rights Declaration from December 1948. Patients' rights vary in different countries and in different jurisdictions, often depending upon prevailing cultural and social norms. Different models of the patient-physician relationship - which can also represent the citizen-state relationship - have been developed, and these have informed the particular rights to which patients are entitled. In North America and Europe, for instance, there are at least four models which depict this relationship: the paternalistic model, the informative model, the interpretive model, and the deliberative model. The physician's role is important in guiding treatment and hence in the implementation of economic health principles. The pioneering initiative of Cittadinanzattiva's Tribunal for Patients' Rights, active in Italy since 1980, can be considered the first building block of this project. The Tribunal for Patients' Rights mobilizes common citizens and users as actors of health policymaking in concrete ways and presently involves some 5,000 people as permanent activists nationwide.

Keywords: patient rights, health care financing, patient rights tribunal

Patients' rights vary in different countries and in different jurisdictions, often depending upon prevailing cultural and social norms. Different models of the patient-physician relationship— which can also represent the citizen-state relationship— have been developed, and these have informed the particular rights to which patients are entitled. In North America and Europe, for instance, there are at least four models which depict this relationship: the paternalistic model, the informative model, the interpretive model, and the deliberative model. Each of these suggests different professional obligations of the physician toward the patient. For instance, in the paternalistic model, the best interests of the patient as judged by the clinical expert are valued above the provision of comprehensive medical information and decision-making power to the patient. The informative model, by contrast, sees the patient as a consumer who is in the best position to judge what is in her own interest, and thus views the doctor as chiefly a provider of information. There continues to be enormous debate about how best to conceive of this relationship, but there is also growing international consensus that all patients have a fundamental right to privacy, to the confidentiality of their medical information, to consent to or to refuse treatment, and to be informed about relevant risk to them of medical procedures.

The patient has the right to receive the most appropriate care and to receive the treatment that guarantees the best efficiency and safety without taking disproportionate risks related to the benefit received. This provision does not address the cost of care, which enters both in social debate and in the individual decisions.

From genetic testing before conception, to end-of-life dilemmas, doctors, patients and their families are facing difficult ethical decisions. The 70's bioethics evolved as a domain, followed by a series of reports of the US President Commission for the study of ethical issues in medicine and biomedical and behavioral research [3]. Other important issues include now informed consent, access to health care for the entire population, screening and genetic engineering and giving up life-support treatment. These and other issues - AIDS, physician-assisted suicide, increased computerization of medical records, and doctor as an entrepreneur - prompt us to periodically reconsider subjects such as doctor-patient relationship, treatment-limiting decisions and confidentiality

The economic approach of the patient

The emergence of the economic approach to health is a new phenomenon.

This appearance was first seen as a mismatch, then as a necessity and ultimately as a danger.
Without going into ideological debates, it can be estimated that the optimal use of financial resources will allow the treatment of more patients, in other words, the rationalization of care will be profitable for a larger number of patients. The physician’s role is important in guiding treatment and hence in the implementation of economic health principles, but:
- the physician can find a financial benefit in the exaggerated consumerism of medical services,
- the doctor may be doing excessive medical records to cover his medical liability.

Ethics and deontology can appear as fragile but real regulatory elements.
So far, expenditure control has been based on professionals, especially doctors.

Two ways of action can be distinguished:
- Optimizing care
- Choice between different types of services offered

Resource optimization presents some ethical issues and is subject to an ethical approach.
The doctor is required to respect a certain economy in choosing care without compromising their quality, safety and effectiveness (French Code of Ethics - Article 8).

The doctor cannot accept in a service contract between the clauses relating to his/her incomes criteria related to the unit’s profitability, as these criteria may undermine the independence of medical decisions or the quality of care (Code of Conduct Article 92).
- In the case of employees, remuneration can not be based on productivity that would cause a limitation of independence or interference in the quality of care provided (Code of Conduct Article 97).

Medical judgment is therefore at the intersection of individual and collective interests between which the code of ethics does not make a clear distinction, since the doctor is both at the service of the individual and of public health for a common purpose, which is respect for the person's life rights and dignity, (Code of Conduct Article 2).

October 2005 The European Health Forum in Gastein, Austria, highlighted the importance of public spending on health care: "There is evidence that health investment is bringing about substantial benefits and economy. The WHO concluded that a 10-year increase in life expectancy results in 0.35% increase in a country’s GDP. On the other hand, illness is a big financial burden. 50% of the gap in economic growth between rich and poor countries is due to the impact of poor health of the population and low life expectancy" [7].

Things are changing: health spending can no longer be considered a burden, but must be seen as an investment in the future of a country. Good healthcare is identified as a factor that promotes greater participation in the labor market, longer active life, higher productivity and low spending on health and social care.

Investing in health infrastructure plays a significant role in the development of human capital.

According to the Euro Health Consumer Index 2009, different systems produce different outcomes.

The five best Bismarck systems (Holland, Austria, Germany, France and Switzerland) attain the best performances under the profile of the general relation between cost and benefit while, if one limits the analysis to health results, the values detected in the five best Beveridge systems (Sweden, Denmark, Norway, Finland and Italy) are the highest.

But all systems tend to have long-term sustainability issues. Health expenditures tend to increase due to strong intrinsic dynamics, including prolonging average lifespan, availability of effective new therapies for various chronic diseases, and development of diagnostic technology. All health care systems are under pressure and have had to deal with significant changes [4].

Regulatory and control functions tend to be enhanced and this appears to have beneficial effects on health system management. They have adopted measures aimed at rationalizing services, reducing the scope of public intervention and increasing citizens’ co-participation.

In Bismarck systems, there is currently no evidence on the part of insurers of patient selection mechanisms, but some governments consider it necessary to monitor the phenomenon, especially for the protection of people with disabilities and chronic illnesses. It is also noteworthy that even in the most advanced systems in Europe, such as the Nordic ones, there are notable differences between urban and rural areas, and between different socio-economic groups in terms of access to services and equity in their use [4].

In the glory period of the managed care system, in United States had circulated many horror stories with patients who were denied treatment or medication for cost reasons. These stories fueled in New Zealand a consumer protection movement that crystallized in a debate among decision-makers who adopted the 1996 Code of Patients' Rights, which provides for patients access to an independent external review of refusals and better access of citizens to federal and state courts in case of malpractice [1].

This law set up a mechanism whereby complaints of malpractice or ill-treatment could be filed with an independent mediator who has the authority to investigate, recommend changes in supplier practices, and serve as a gatekeeper for professional discipline. Significantly, although this structure was designed to provide consumers with a means of solving individual complaints, it was also intended to serve as a catalyst for improving the quality of the health system in New Zealand. Prior to the adoption of this law, patients' complaints were made before a medical council that could initiate disciplinary proceedings.
The medical profession was then criticized for its lack of independence, slowness in action and secrecy.

A public scandal broke out in 1987, when it was shown that many women diagnosed with cervical carcinoma in situ were part of a research study from the most important New Zealand Women's Hospital, without their knowledge or consent. The research has led to the cessation of conventional treatment to study the natural course of the disease, when the dominant opinion was that in situ carcinoma was a precancerous condition justifying the treatment. Forty women evolved finally to invasive cancer [1].

US Patients' Bill of Rights
As stated above, the initial Patients' Bill of Rights was established in 1973 by the American Hospital Association (AHA). It was then revised in 1992 to include additional rights and to better define the details of all patients' rights. In 1995 the Association of American Physicians and Surgeons, or AAPS, adopted its own Patient Bill of Rights, termed "freedoms" that state the groups' stand on protocols between physicians and patients and also between physicians, patients and health insurance plans. [2]

The Patient's Bill of Rights was created to try to reach 3 major goals:

1. To help patients feel more confident in the US health care system; the Bill of Rights: • Assures that the health care system is fair and it works to meet patients' needs • Gives patients a way to address any problems they may have • Encourages patients to take an active role in staying or getting healthy
2. To stress the importance of a strong relationship between patients and their health care providers
3. To stress the key role patients play in staying healthy by laying out rights and responsibilities for all patients and health care providers

This Bill of Rights also applies to the insurance plans offered to federal employees. Many other health insurance plans and facilities have also adopted these values. Even Medicare and Medicaid stand by many of them.

The Patient Protection and Affordable Care Act - Obamacare
On March 23, 2010 the Patient Protection and Affordable Care Act was signed into law by President Barack Obama. This legislation has been the topic of much debate, both prior to its passage and since. Often referred to as "Obamacare," the Patient Protection and Affordable Care Act is generally called simply the Affordable Care Act, relegating the patient protection of the law into a dusty corner.

The importance of these now federally-regulated patients' rights should not be underestimated. Previous to this law's passage, patients may have rights conferred to them through the AHA and AASP, but little to no opportunity to defend those rights if they were violated.

The Patient Protection and Affordable Care Act offers rights and protections to patients not only in interactions with physicians and medical facilities, but also with health insurance providers. But insurance companies disagree with this law and have lobby and pressure groups to eliminate it. In fact, the legislation on patients' rights has been delayed for so long because of health insurance companies.

Unfortunately, this law is on the agenda of the new US President Donald Trump for repeal. He promised in replacing Obama with another insurance law, but so far has not come up with another proposal, although it is already on the verge of being abrogated and leaving 20 million Americans without any health insurance [2].

The Italian initiative of the Tribunal for Patients’ Rights and the growth of civic activism in Europe
The pioneering initiative of Cittadinanzattiva’s Tribunal for Patients’ Rights, active in Italy since 1980, can be considered the first building block of this project [4].

The Tribunal for Patients’ Rights mobilizes common citizens and users as actors of health policymaking in concrete ways and presently involves some 5,000 people as permanent activists nationwide.

Among the components that characterize this initiative and have special relevance to this project are the following:

- establishment of 80 local Charters of Patients’ Rights, through level collecting claims and reports from patients and users of health care structures, both public and private, at the local level;
- organization of Patients’ Rights Centres inside some 200 Italian hospitals, with the aim of checking troublesome situations, preventing threats to patients’ rights and promoting organizational and material changes, in addition to cultural and behavioural changes in the management of care • Organizing patient rights centers in about 200 Italian hospitals to assess difficult situations, prevent threats to patients’ rights, and promote organizational and material change in care management;
- Creating call centers at local and national level to provide information and advice on access to and the quality of health services and the protection of patients’ rights;
- Organizing a network of lawyers and legal practitioners to support citizens in promoting legal action in case of harm, medical errors and/or refusal of care;
- promoting specific campaigns and programs aimed to innovation in health services such as hospital safety and quality, prevention of medical errors, pain therapy, waiting lists, free access to medicines and reduction of technical and financial resources losses;
• Coordinating a Coalition of over 130 associations for chronic illnesses in order to promote a common policy aimed at putting patients at the center of chronic illness

Patient empowerment - a new approach
A new trend in patient rights that has emerged in Europe and is increasingly supported by many countries is "patient empowerment". [5]
Empowering patients is defined as a process that helps people gain control over their own lives and enhances their ability to act on issues that they themselves define as important. Perhaps intentionally vague, this definition of the European Patients' Forum includes everything from patient understanding of diagnosis and treatment to their ability to communicate as equal with health professionals and to make joint decisions on what therapeutic approach they should to work best for them [4].
The recent EU empowerment campaign (eu-patient.eu) found that, when properly supported, patients themselves make health systems more sustainable [4].

The essential components of patient empowerment
- **Education**: patients can only make informed decisions about their healthcare when they have access to all relevant information, with medical terms clearly explained.
- **Expertise**: patients themselves self-manage their conditions every day so they have a unique expertise on their condition which needs to be acknowledged and integrated into the medical understanding of diseases and treatment.
- **Equality**: patients need to be supported and accepted as equal partners with health professionals in the management of their condition.
- **Experience**: individual patients can work with patient organisations to represent themselves and their experience as a collective voice.
- **Engagement**: Patients can be – and are now – involved in the process of designing more effective healthcare systems and in research into better treatments and services.

As part of the "2011 Patient Year and their Rights" in France, the Ministry of Health called for a study on medical professionals perception of patient rights: The aim of this survey was to determine and understand very accurately the practices, perceptions and expectations of health professionals in the area of patient rights. To achieve this, a study was created through individual semi-structured qualitative interviews of one hour to half an hour with a sample of 40 health professionals. It was highlighted that very few of them knew the Patient Rights Act in 2002, but in return everyone knew the "Hospital Patient Charter", which is displayed in all health care institutions in France [6].

However, all have underlined a deterioration in the patient-patient relationship, primarily by increasing the "judiciarisation" of the system on the American model, where the patient's word often has more weight than their own, and the ubiquitous fear of malpractice, where intervenes the legal weight of insurance companies. In this respect, they complain that the relationship with the patient is no longer direct and "clean", but is touched by many other interests [7].

Many approaches have evolved in the evolution of patient rights legislation, which sometimes distorted the original intentions of the law, but ended with a strengthening of the role of the patient in his relationship with medical staff and society in general, the patient being placed where he is the place in the center of the medical system.

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