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THE CONCEPT OF QUALITY HEALTH CARE SERVICES IN LITHUANIAN HEALTH LAW

The new version of Law on the Rights of Patients and Compensation for the Damage to Their Health that came into force in 2009 and established the patient's right to quality health care services. As the claims of the patients are usually based on the evidence that the patient was provided with a health care service of poor quality it is important to define the concept of quality health care services and provide legal analysis thereof.

Keywords: Quality Health Care Services, patient, Quality Health Care Services Dimensions.

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The rapid development of science and practice of medicine has presupposed an apparent improvement of health indicators (i. e. infant mortality, life expectancy), but it had to be admitted that the possibility to control the process of treatment and to achieve the desired result is limited [1]. The application of nanotechnology and genetic engineering to medicine brought up the problem of preservation of the identity of an individual and the reconsideration of both – (i) essence and the nature of newly forming legal relationship and (ii) measures that ensure the patients' rights was needed on the conceptual level.

In year 1996 Lithuania was one of the first countries in Europe (just after Finland [2]) that enacted a law on protection of patients' rights. The version of the year 2009 of the latter enshrined patients' right to quality health care. As the claims of the patients are usually based on the evidence that the patient was provided with a health care service of poor quality it is important to define the concept of quality health care services and provide legal analysis thereof. The fact that this concept is widely analysed by the scientists of health law in other countries but not in the health law of Lithuania also suggests relevance and importance of the topic [3; 4; 5].

In the Luxembourg Declaration on Patient Safety [6] (published in April of 2005) it was recognised that the right to quality health care is one of the basic human rights. This provision is later repeated in the documents of

the World Health Organisation that followed [7, p. 78].

The Constitutional Court of the Republic of Lithuania named the right to quality and affordable health care as a precondition to a real and effective human right to the best possible health care [8]. The patient's right to quality health care services, as provided by Art. 3 of the Law on the Rights of Patients and Compensation for the Damage to Their Health (hereinafter – Patients' Rights Law) is a basic guarantee that the damage will not be caused when providing health care services. Therefore the scope of the protection afforded by Patients' Rights Law is of particular importance and examining of the concept of quality health care services reveals it. The analysis of concept of quality health care services (established in the Patients' Rights Law Art. 2 Para 2 – High quality health care services shall mean accessible, safe, efficient health improvement, disease prevention, diagnostic, patient treatment and nursing services which are provided to an appropriate patient at an appropriate time and place by an appropriate health care professional or a team of health care professionals according to the level of modern medical and nursing science and good practice, taking into account the service provider's possibilities and the patient's needs and expectations by satisfying or exceeding them) allows for division of health promotion, disease prevention, diagnostics, patient treatment and care services into the following dimensions: accessibility, safety, efficacy, timeliness, service providers and local relevance to the patient, modernity, patients' expectations are met. Analysis of each of the mentioned dimensions is significant to the shaping of concept of right to quality health care services.

ACCESSIBILITY OF HEALTH CARE SERVICES

Accessibility of health care services is a condition of health care service provision, which ensures economic, communicative and organisational acceptability of health care services to the individual and society (Law on Health System, Art. 2 Para 10). It should be noted that in the patients' rights catalogue (as defined in Art. 4 of Patients' Rights Act of 1996) the right to accessible health care was established as a separate right and not a part of the patient's other rights. As the implementation of this right was associated with «the patient's right to obtain free health care <…>», this right stems from Art. 53 in the IV part of the Constitution of Lithuania «National Economy and Labour» where it is said that The State shall take care of people's health and shall guarantee medical aid and services for the human being in the event of sickness for free in state health care institutions. In contrast with other patients' rights, this particular right is derived from social – economical rights. I. e. state guarantees health care through a developed system of health care services infrastructure [9, P. 490–492; 8] but does not guarantee to satisfy the health care needs of a particular citizen. The accessibility of health care, as one of the basic elements of Lithuanian national health care system is enshrined in Art. 20 part 2 of the Law on Health System. By granting the right to accessible health care to each patient (Art. 4 of Patients' Rights Law of 1996) an objective

right of the patient was transformed into a subjective right [10, p. 165].

In the science of health management there is a wide variety of criterions of organisational acceptability: territorial network of health care institutions, nomenclature and types of services provided, resources of healthcare professionals, technological (medical equipment and the level of IT) health care provision, patient services at a convenient time and duration of the service provision [11]. As few criterions of organisational acceptance are established in laws, big importance is being put on the decision of the Constitutional Court of the Republic of Lithuania (hereinafter – Constitutional Court) of May 16th, 2013 regarding the obligation to pay state social insurance, mandatory health insurance fees and reduction of maternity allowance. Analysis of the mentioned decision of the Constitutional Court allows us to tie organisational acceptance with the obligation of institutions that implement and form the state health policy to create the infrastructure of health care services which allows for effective and timely health care service. The implementation of this obligation is related to other criterion of organisational acceptance – the minimal requirements to the location and structure of national health system institutions as set forth by the Ministry of Health and the State Patient Fund. To our regret, this requirement that is enshrined in Art. 11 of Law on Health Care Institutions is not yet implemented.

From the year 1998, when the new version of the Law on Health System came into force, the principle of voluntary health care provision may be held a traceable criterion of organisational acceptance in legal doctrine. Its expression is patients voluntary application for health care services and the only general precondition for specialised health care is implemented – a doctor's referral. When medical indications exist, patients' right to obtain a referral for specialised health care is unlimited.

Criterions of communicational acceptance, such as time limit within which the patient has to be transported to health care facilities, development of network of transport, and the distance to health facilities were set forth in Conception of the Reorganisation of Health Care Institutions. However, acceptable values (more specifically – target values) of these criterions were not established.

The criterion of economic acceptance was never established but when analysing it from a patient's perspective of, this criterion is undoubtedly fulfilled by the free health care services, i. e. services compensated from the state budget or municipality budget or Mandatory Health Insurance Fund. Furthermore, the term of financial accessibility, as used by the Constitutional Court in its decision of May 16th, 2013, is interpreted as the affordability of health care services. Art. 4 of Patients' Rights Law of 1996, which granted the patient the right to accessible free health care is a directing norm. This norm stated that conditions of such health care services are established in the Law on Health Insurance and other laws. The main condition on which the provision of health care services compensated from the Mandatory Health Insurance Fund depends is the existence of an insured event. The concept of an insured event in health care system was developed in

the Art 4 of Law on Health Insurance. It was stated, that «<...> insured events are health disorders or state of health of individuals insured by compulsory health insurance which are specified in this Law and diagnosed by a medical doctor and which entitle the persons covered by compulsory health insurance to be provided individual health care services provided for by this Law and other statutory acts». Art. 8 of the Law on Health Insurance provided for mandatory compensation of all types of health care services from the Mandatory Health Insurance Fund. It meant that when an insured occurred, a person's right to health care services compensated from the Mandatory Health Insurance Fund was not limited. The Art. 4 Para 2 of the Patients' Rights Law of 2004 warranted for emergency health care to all patients with no exceptions. The norm in the 3rd paragraph of the mentioned article, which warranted provision of «other services» which include paid health care services provided by the institutions, which are a part of national health system and both paid and unpaid health services provided by institutions which are not a part of national health system, is a blanket norm. Therefore it can be held that the Patients' Rights Law of 2004 warranted free health care services to all insured patients if the appropriate medical indications and mandatory conditions health care services are present. This conclusion is affirmed by the Supreme Court of Lithuania as it was stated that under certain conditions the state is «unconditionally obliged to provide health care services». As it can be seen the Patients' Rights Laws of 1996 and 2004 did both provide patients with wide warranties to free health care services but the provision of services was associated not with the quality o services but rather with the patients right to services accessibility. Therefore in this context it is very important to stress that the version of Patients' Rights Law currently in force does not provide with the right to free, i. e. financially accessible health care services. Furthermore, the analysis of reveals that the law contains norms setting legal grounds for limitation of patient's right to free health care services. For instance, patient's right to obtain free health care services may be limited when patient is exercising his right to choose a particular health care institution or the right to second opinion of a same qualification practitioner. (Art. 4 of Patients' Rights Law of 2009).

Since the criterion of economic acceptance was only analysed from the patients' perspective, an analysis from the perspective of a health care institution is expedient. As mentioned previously, most of the health care services procedures are being compensated from the state budget (the main financial source is Mandatory Health Insurance Fund [12]) and therefore not directly paid by the patients themselves. The Law on Health Insurance sets forth the basis for health care services compensation from the Mandatory Health Insurance Fund. The health care services are being paid for on the basis of an agreement between the health care institution and the territorial patient fund (which represents the patient in the financial relationship with the health care institution) (Art. 26 of the Law on Health Insurance). The agreement contains a yearly sum, i. e. the financial obligation of the territorial

patient fund (the provided health care services are being paid for by basic fees that are set by the Ministry of Health (Art. 25 Para 1 of Law on Health Insurance)). The fact that health care services are being paid for by basic fees means that (i) health care institution is being paid for disregarding the factual costs, incurred when providing the health care services, (ii) when the sum of provided health care services exceeds the yearly sum set forth in the contract with the territorial patient fund, the health care institution cannot expect to have these costs covered (Art. 27 Para 1 of Law on Health Insurance). When analysing the situation it must born in mind that a special law sets forth, that the Mandatory Health Insurance Fund has to be balanced within a 3-year period. However, as the government has failed to resolve a socially extremely important question of the deficit of the social insurance fund in a number of subsequent years, political and executive powers avoid making commitments that exceed the planned income in the accounting period in health care system. Therefore the budget of Mandatory Health Insurance Fund which is approved yearly by an ad hoc law has never been deficit. On the other hand it is publicly acknowledged that the basic health care fees do not represent their real costs [13]. In this situation, when the current legislation does not provide for sufficient financing of health care services from the Mandatory Health Insurance Fund, patient is being excluded from a possible conflict regarding insufficient financing. On the other hand, the wide variety of rights to de facto free health care afforded to the patients and a still present post soviet mentality that the state resources (financial, infrastructural etc.) are unlimited encourages to rethink the balance of patients, state and society health interests in health care relationship.

In legal doctrine it is acknowledged that because of the increase in demand for health care services and higher quality standards, more complex and expensive health care equipment and technologies, the costs of providing health care services is imminently on the rise whereas the Mandatory Health Insurance Fund is limited. Financial obligations of the state with regard to free health care services are ought to be evaluated with reference to «<…> state's financial possibilities which are not and cannot be limitless. Furthermore, balance of social sustainability, responsible administration and other constitutional values must be observed. The state budget may not be burdened with obligations that outreach its financial possibilities, which eventually may lead to failure or significant impedance of execution of other state functions» [8]. The Constitutional Court stated that the legal regulation of free health care services is ought to ensure that each individual is encouraged to take care of his health, to take on the obligation to contribute to the financing of health care system in accordance with his financial possibilities and use the health care services responsibly and rationally [8].

HEALTH CARE SERVICE SECURITY

World Health Organisation defines patient safety as patients' right to be protected from unnecessary or possible damage related to health care services [7]. This definition presupposes that

health care service is safe if during its provision the patient is protected from unnecessary or possible damage related to the services provided. On the other hand, it is extremely important that unnecessary or possible damage is related to undesired events occurring during provision of health care services, for instance failure of medical equipment, failure to follow instructions of medical equipment usage, wrong drugs dosage, prescription of a wrong drug, wrong diagnostics etc. The concept of undesired events is close to the concept of treatment (diagnostics) error. However the main difference between the two concepts is that most undesired events are of systematical [14] and not individual nature. Therefore the most suitable preventative action is considered to be the appropriate application of managerial principles of health care process organisation, not the improvement of qualification of health care specialists. The concept of safety of health care services cannot be understood as a warranty that a patient will get better or will not experience any damage when providing health care services. Therefore it is more accurately described by setting certain negative criterions, i. e. what damage that arose when providing health care services is unavoidable. These concepts of unavoidable damage are widely used in health care law in countries of North Europe. Unavoidable damage is understood as damage which was either (i) not possible to avoid when choosing a different treatment or trial method or (ii) the risk materialised is not considered controversial by the health care specialists in particular community or (iii) patient's health state has decreased due to natural course of the disease [15, p. 194–196; 16, p. 75; 17; 35].

The importance of concept of health care safety is acknowledged in the documents of the European Union on patient safety [18; 19; 20], multiple soft law sources [21; 22; 23; 24]. It is also acknowledged by national and international organisations (Council of Lithuanian Patient Organisation Deputies, World Health Organisation Alliance for Patient Safety, International Alliance of Patients' Organisations etc.), special committees (Patient Safety and Quality of Care Working Group of European Commission) and currently developed patient safety policy [25; 26].

In legal sphere the patient safety is ensured by following mandatory or legally unbinding patient safety requirements. In Lithuania mandatory (i. e. minimal) level of patient safety is ensured by licensing health care institutions (Art. 16 para 2 of Law on Health System, Art. 5 para 1 of Law on Health Care Institutions). The general requirement is that health care institutions can provide services only after obtaining licences. Art. 5 of Law on Health Care Institutions sets forth conditions on obtaining a licence, licence re-registration and revocation. It is worth mentioning the Art 6 of the mentioned law also sets forth another – voluntary measurement of health care services quality (safety) level – accreditation, which is based on accreditation requirements for high schools and other educational institutions with health care specialists. Accreditation that started in 1996 yet did not catch its momentum as Orders of Minister of Health were annulled and the accreditation procedure was equated to mandatory licensing.

In contrast to licensing procedure, which is done in all countries by competent governmental institutions based on requirements and procedure set forth in particular laws, accreditation and certification of health care institutions is usually done by non-governmental organisations or organisations representing professional health care specialists, for instance Haute Autorité de Santé in France, Joint Commission on Accreditation of Healthcare Organisations in United States of America, United Kingdom Accreditation Forum in Great Britain etc. The concepts of accreditation and certification ar used inconsistently, for instance Joint Commission on Accreditation of Healthcare Organisations describes accreditation as a process of evaluation of a certain activity type, whereas certification process is understood as compliance with standards set forth by competent national institutions, international standards (ISO (International Organisation for Standardisation) standards) or European standards (CEN (in french – Comité Européen de Normalisation) etc. As in Lithuania there is only one special standard applied for health care services certification [28], usually general process quality management standards are applied when certificating health care institutions [29].

EFFICACY OF HEALTH CARE SERVICES

National Health Care Quality Program for 2005–2010 periods defines efficacy as possibilities of health care interventions to achieve the set objectives and results of health activities in a normal environment (Order of Minister of Health № V-642 of September 14th, 2004). The objectives of health care associate efficacy with assessment of health care technologies that is done by applying evidence based medicine – methodology based on objective scientific criterions, which originated in the second half of 20th century. It means that when pursuing to identify if the provided health care service was effective it is ought to be evaluated from medical perspective and not legal perspective.

TIMELINESS OF HEALTH CARE SERVICES

Assessment whether health care services were provided in a timely manner closely relates to organisational and communicational acceptance of the services provided. Health care timeliness is an obsolete assumption for efficiency of health care service. Laws define particular criterions of timeliness of health care service, such as provision of urgent health care services from the moment of making it to the health care institution (Order of Minister of Health № V-208 of April 8-th, 2004), time from registration of a call for ambulance to first aid provision in life threatening situations should not be longer than 10–15 minutes in urban areas and 20–25 minutes in rural areas and in other situations – no longer than 30 and 45 minutes accordingly (Order of Minister of Health № V-895 of November 6th, 2007). Patient waiting time for health care services provision is required to be no more than three days in the event of chronic diseases, one day in the event of chronic disease exacerbation and ten days for planned specialised outpatient health care services (Order of Director of State Patient Fund № 1K-203 of August 27th, 2012). However the consequence of violation of the set criterions of health care timeliness varies: when fail-

ing to provide necessary health care service in a set time, the deed is qualified illegal and the patient may in a set period of time claim for damages if other conditions for civil liability are present. Whereas failing to provide planned outpatient health care services or failure of an ambulance to arrive in a set time period likely would not be qualified illegal based on the different goals of legal acts: (i) planned outpatient health care services providing criterion is set forth only in relation to health care services compensation from the Mandatory Health Insurance Fund; (ii) requirement for an ambulance to arrive in a set period of time is a criterion of desirable quality indicator. Timeliness of hospital health care services is not legally defined, but the obligation to ensure important diagnostical and emergency health care service availability round the clock may be regarded as indirect criterion of timely hospital health care service criterion (Order of Minister of Health № V-1073 of December 16th, 2010; № V-1242 of December 8th, 2008).

The importance of the health care service timeliness criterion is obvious from its relation to EU regulation No. 1408/71 of June 14th, 1971 on the application of social security schemes to employed persons and their families moving within the Community. Art. 22 Para 2 sets forth a condition to use a person's right to leave for health care service in another EU country – when evaluating if a patient is able to receive equally effective treatment national health care institution is ought to consider all the circumstances defining particular disease, pain suffered by the patient or his disability [30]. However, in practice, the timeliness of health care services is a significant social problem, which in some countries is decided on the legislative level. Norway was the first country that in 1990 enacted a «warranty» system: having obtained a general practitioner's reference, the patient is entered in a list and the necessary analysis must be executed in 30 days. However, patient's entry in such a list did not entitle him to a judicial claim for necessary health care service provision even the specified term is overdue. Analogous systems were introduced in Sweden (in 1992), Denmark (in 1993), Finland (in 1995) etc. Some countries, for instance, Iceland, did specify that with regard to clinical situation availability of health care services to patients might be different (Art. 19 Iceland Patient Rights Act № 74/1997 <http://www.lexadin.nl/wlg/legis/ nofr/eur/lxweice.htm> [21]). On the other hand, in Finland it was widely demanded for the state to take on higher obligations and since the year 2004, patients right to planned health care accessibility in specified terms was set forth (Act on the Status and Rights of Patients, amended by Act of 17 November 2004/857 (in force of 2005)). This legislation provided patients with opportunity to claim for recognition of their right to health care services if the «warranty» term health care service provision was overdue.

PROVISION OF HEALTH CARE SERVICE BY THE APPROPRIATE HEALTH CARE SPECIALIST OR SPECIALIST TEAM IN AN APPROPRIATE PLACE

Initial evaluation of health care service compliance with this dimension

does not result in legal problems because of the double licensing rule adopted in Lithuanian health law: health care services may only be provided by legally licensed service providers, i. e. both institutions and natural persons (Art. 16 Law on Health System). Since the health care institution licence contains the licensed health care activities and address where the services are provided, quality health care services may be provided only in a particular place as specified in the health care institution licence. This rule is disobeyed only in cases of emergency health care provision when health care services are initially provided at the scene of an accident (Para 7, Order of Minister of Health № v-208, May 8th, 2004). A decision of the Government set forth minimal requirements for volumes of certain health care services, for instance number of surgeries or childbirths (Government decision of December 7th, 2009 № 1654). Furthermore, another Government decision sets forth particular stationary services (in other words, the profile of health care services, for instance abdominal surgery, orthopedy – traumatology) that a particular health care institution may provide (Government decision of December 7th, 2009 № 1654 and order of Minister of Health of February 11th, 2010, № V-110).

When evaluating the eligibility of provided health care service with relation to health care specialists or specialist team, these aspects are ought to be born in mind: (i) if the specialist has a valid licence for medical (nursing) practice; (ii) if the services provided do confirm with professional qualification competence, which is set by special orders of Minister of Health – Medical Norms; (iii) if the patient was routed for specialists that have the necessary qualification when the persisting medical indications or clinical situation required for more competence than the primary specialist had.

The requirement of quality health care conformity with current level of medicine and nursing science and good practice (as defined in Law on Patients' Rights) may be stemmed from one of the conditions set forth in Art. 15 Para 2 of Law on Health System – criterion of health care acceptance. Health care acceptance is a condition of health care service provision, which ensures the conformity of provided services with medical principles and medical ethics (Art. 9 Para 2 of Law on Health System). Even though quality health care definition does not explicitly use the wording of medical ethics, especially bearing in mind the needs that required for adoption of Human Rights and Biomedicine Convention (Official Gazette, 2002, № 97–4258) it follows that the best medical and nursing practice must confirm with ethical requirements. This assumption is supported by the study conducted by World Health Organisation, which showed that the science of health management, health care acceptance as a dimension of quality health care is the third most common dimension (first comes effectiveness, second – efficiency) [32, p. 4]. The study defines acceptable health care as humanly and attentively provided health care paying regard to patient's cultural and age peculiarities [32, p. 7, 33], i. e. in accordance with the requirements of ethical health care provision.

Mandatory health care services conformity with nowadays medical and nursing science level and good practice requires a separate analysis. Art. 20 Para 1 of Law on Health System sets forth that when providing health care services only approved by the Ministry of Health diagnostics, treatment methods and technologies are to be used. It should be mentioned that current order of Minister of Health (№ V-979, 30th December, 2004) defines legal ways of possible disease diagnostics, treatment methods and technologies approbation:

Orders of Minister of Health regarding approval of requirements of general and specialised services provision;

Orders of Minister of Health regarding approval of Medical Norms;

Orders of Minister of Health regarding approval of disease diagnostics and treatment methods;

Methodologies drawn up and approved by health care institutions;

Methodologies drawn up and approved by committees in universities, scientific research institutions, doctors' professional associations or committees set up by the Minister of Health.

Technologies are ought to conform with Lithuanian laws, i. e. medical equipment must be made, evaluated and marked in accordance with orders of Minister of Health regarding technical regulation of medical equipment safety requirements, which implement EU medical equipment directives (90/385/EEB, 93/42/EEB, 98/79/EB, 2000/70/ EB, 2001/104/EB, 2002/364/ EB, 2003/12/EB, 2003/32/EB).

The legislators have acknowledged the fast progress of medicine science and foreseen a special case when health care specialists may use new, scientifically justified but yet unapproved diagnostical and treatment methods and technologies – only when trying to save or extend a patient's life. Furthermore, a rule for patient's safety has been set forth – a written patient's consent for unapproved method or technology application is mandatory (Art. 20 Para 2 Law on Health System). In case J. Raudonienė ir Z. Raudonius v. VšĮ Vilniaus universiteto ligoninės Santariškių klinikos (case № 3K-3-206/2005) the Supreme Court based if the method was approbated for multiple use not only on case material, but also on medical literature. The Supreme Court held a treatment method, which was not used in Lithuania, experimental and it was stressed that it can only be applied when an informed patient's consent is obtained.

A requirement to meet or exceed patient expectations that is mentioned in quality health care service definition is a challenge for health care institutions. Obviously, the goal of each patient when turning to a health care specialist is to get better. However, despite the progress of medical science, health care institutions cannot guarantee the desired result – a full recovery (Supreme Court decision № 3K-3-408/2009). Therefore proper implementation of this dimension of quality health care service requires special attention for a patient, comprehensive information about diagnostics and treatment process, possible risks and prognosis and nurturing of cooperation culture. Evaluation of the dimension of meeting patient's needs may not have significant influence on the level of patient satisfaction. When evaluating from an ethical perception, the implementation of

an obligation to meet or exceed patients' expectations as a service quality dimension may encourage consumerism in the health care relationship and when evaluating from a legal perspective, the basic principle of health care regulation – balance of patients, society health and state interests is confronted (Art. 5 Para 1 subparagraph 2 Law on Health System). Yet there are no cases in Lithuanian case law, which would be based upon the failure to meet this dimension of quality health care service. However, the fact that meeting patients' expectations became one of quality health care service evaluation criterions will likely strengthen positions of patients as plaintiffs and influence courts' decisions. As patients' interests that are expressed via his expectation of health care service provision were given preference, it will likely influence health care service professional's obligation to provide service with maximum efforts (Supreme Court decision № 3K-3-1140/2001, L. M. Sandienė v. VšĮ Kauno Raudonojo Kryžiaus ligoninė). A patient survey conducted in primary health care institutions revealed patients' satisfaction with with the health care services provided. Answer to the question «medical services I received so far were excellent» was given 3.71 points from possible 5 [34], i. e. expectations of 40% of patients were not met. If patient expectations were to be evaluated as a legal category, all unsatisfied patients could claim either pecuniary or moral damages.

Special law on protection of patients' rights provides with quality health care definition by introducing an exhaustive list of dimension. Particular dimensions are not of legal nature, but rather stem from other sciences (efficacy is a dimension of medical science, meeting and exceeding patient expectations is an ethical and managerial dimension);

Laws set forth some criterions of health care services accessibility (economical) and timeliness (planned health care) as aspirational, therefore these criterions do not result in a subjective right for patients;

Expediency of implementation of meeting patients' expectations and exceeding them as a dimension of quality health care service is questionable, because application of this dimension as a legal category confronts with one of the main principles of health care – balance of patients, society health and state interests and encourages consumerism in health care relationship.

Bibliography:

1. LAT Civilinių bylų skyriaus teisėjų kolegijos 2009 m. spalio 13 d. nutartis civilinėje byloje D. B. v. VšĮ Kauno medicinos universiteto klinikos (case № 3K-3-408/2009).

2. Finland Act on the Status and Rights of Patients No.785/1992. Legislation Finland [online]. – [previewed 2008-02-21]. <http://www.finlex.fi/fi/laki/-kaannokset/-1992/en19920785.pdf>.

3. Sriubas M. Paciento teisių ir pareigų reglamentavimas Lietuvoje / M. Sriubas // Justitia. – 2008. – № 1(67). – S. 27–39.

4. Šimonis M. Gydytojų ir pacientų teisiniai santykiai / M. Šimonis // Justitia. – 2005. – № 2(56). – S. 58–63.

5. Kutkauskienė J. Paciento teisių ir pareigų teisinio reglamentavimo Lietuvoje problematika ir raidos tendencijos / J. Kutkauskienė // Jurisprudencija. – 2008. – № 12(114). – S. 82–91.

6. Luxembourg Declaration on Patient Safety (2005) [online]. – [previewed 2013-09-25] http://www.eu2005.lu/en/actualites/

documents_travail/2005/04/06Patientsafety/Luxembourg_Declaration_on_Patient_Safety_05042005-1.pdf.

7. Patient Safety Performance Measurement Manual. World Health Organization, 2007.

8. Lietuvos Respublikos Konstitucinio Teismo 2013 m. gegužės mėn. 16 d. nutarimas «Dėl pareigos mokėti valstybinio socialinio draudimo ir privalomojo sveikatos draudimo įmokas, taip pat dėl motinystės (tėvystės) pašalpų sumažinimo».

9. Lietuvos Respublikos Konstitucijos komentaras. 1 dalis. [Jovaiša K. (ats. red.)]. – Vilnius: Teisės institutas: K. Jovaišo PĮ, 2000.

10. Vaišvila A. Teisės teorija / A. Vaišvila. – Vilnius: Justitia, 2004. – 527 p.

11. Jankauskienė Danguolė. Sveikatos priežiūros paslaugų kokybės ir prieinamumo vertinimas. Sveikatos sistemos vystymo perspektyvos : konferencija : 2012 m. spalio 24 d. [online]. Mykolo Romerio universitetas. Vilnius : Mykolo Romerio universitetas, 2012. – P. 1–74.

12. Higienos instituto Sveikatos informacijos centro duomenys. [online]. – [previewed 20-08-27] http://sic.hi.lt/.

13. Realios paslaugų kainos taps realybe? 2009 spalio mėn. 19 d. Respublika [online]. – [previewed 20013-08-22] http://www.respublika.lt/lt/naujienos/mokslas/sveikata/realios_ paslaugu_ kainos_taps_realybe/,print.1; Ar sveikatos apsaugos komunizmas būtų pacientų rojus? Veidas.lt. [online]. – [previewed 2013-05-11] http://www.veidas.lt/ar-sveikatos-apsaugos-komunizmas-butu-pacientu-rojus.

14. Komisijos komunikatas Europos Parlamentui ir tarybai dėl pacientų saugos ir su sveikatos priežiūra susijusių infekcijų prevencijos ir kontrolės. Briuselis, 2008-12-15 KOM(2008) 836 galutinis [online]. – [previewed 2013-09-21] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0836:FIN:LT:HTML.

15. Cases on Medical Malpractice in a Comparative Perspective [Faure M., Koziol H. (Eds.)]. Wien: Springer – Verlag, 2001. – 352 p.

16. Westerhäll L. Sweden // International Encyclopedia of Laws: Medical Law. Ed. Nys H. Boston: Kluwer Law International, 993.

17. Fallberg H. L., Borgenhammar E. The Swedish No Fault Patient Insurance Scheme // European Journal of Health Law. – 1997. – № 4(3). – P. 279–286.

18. Tarybos rekomendacija dėl pacientų saugos ir su sveikatos priežiūra susijusių infekcijų prevencijos ir kontrolės. Europos Sąjungos Taryba, Briuselis, 2009 m. birželio 5 d. (OR. en) 10120/09 2009/0003 (CNS) [online]. – [previewed 2013-09-28] http://ec.europa.eu/health/ph_ systems/patient_eu_en.htm.

19. Recommendation Rec(2006)7 of the Committee of Ministers to member states on management of patient safety and prevention of adverse events in health care [online]. – [previewed 2013-08-22] http://www.simpatie.org/Main/wp1157459643.

20. Communication from the Commission to the European Parliament and the Council on patient safety, including the prevention and control of healthcare-associated infections. COM(2008) 837 final.

21. Declaration on Patient Safety. World Medical Association. [online]. – [previewed 2013-08-15] http://www.wma.net/en/30publications/10policies/p6/.

22. Helsinki declaration on Patient Safety [online]. – [previewed 2013-05-11] http://www.eba-uems.eu/Safety/1/helsinki.html.

23. London declaration. Patients for Patient Safety. WHO World Alliance for Patient Safety [online]. – [previewed 2013-05-11] http://www.who.int/patientsafety/ patients_for_patient/London_ Declaration_EN.pdf.

24. Declaration on Patient-Centred Healthcare. International Alliance of Patients' Organizations [online]. – [previewed 2013-05-11] http://www.patientsorganizations.org/declaration.

25. Nacionalinė pacientų saugos platforma. 2010 – 2014 m. [online]. – [previewed 2013-05-11] http://www.vaspvt.gov.lt/node/135.

26. Patient safety and human factors: policy and strategy. The Royal College of Nursing [online]. – [previewed 2013-09-06]

http://www.rcn.org.uk/development/ practice/patient_ safety/uk_wide_resources/patient_safety_policy.

27. Joint Commission on Accreditation of Healthcare Organizations [online]. – [previewed 2013-08-15] http://www.jointcommission.org/accreditation/accreditation_main.aspx.

28. LST CEN ISO/TS 22367:2010 «Medicinos laboratorijos. Klaidų kiekio sumažinimas, taikant rizikos vadybos ir nuolatinio gerinimo priemones» (ISO/TS 22367:2008, įskaitant Cor.1:2009).

29. LST EN ISO 9000-1:1998 «Kokybės vadybos ir kokybės užtikrinimo standartai. 1 dalis. Parinkimas ir naudojimas. Rekomendacijos» (ISO 9000-1:1994).

30. I. Watts v. Bedford Primary Care Trust, Secretary of State for Heath [online]. – [previewed 2008-11-25] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX: 62004J0372:EN:HTML.

31. Fallberg Lars. Patients rights in the Nordic countries/ Patients' Rights and Citizens' Empowermwnt: through Visions to Reality. World Health Organization, 2000.

32. Helena Legido-Quigley, Martin McKee, Ellen Nolte, Irene Glinos. Assuring the quality of health care in the European Union. A case for action [online]. – [previewed 2013-04-28] http://www.euro.who.int/__data/assets/pdf_file/0007/98233/E91397.pdf.

33. The right to health. Fact sheet N°323. November 2012 [online]. – [previewed 2013-06-06] http://www.who.int/mediacentre/factsheets/fs323/en/.

34. Asta Aranauskienė «Sveikatos priežiūros paslaugų kokybė ir teisinis reguliavimas: kiek svarbi pacientų nuomonė» [online]. – [previewed 2013-09-12] http://vadybospraktika-mokslas.mruni.eu/wp-content/uploads/2011/01/pranesimo_tezes-Aranauskienes.doc.

35. Coppolo G., Spigel S. Medical Malpractice – No-Fault Systems. Old Reseaerch Report [online]. – [previewed 2008-11-25] <http://www.cga.ct.gov/2003/-olrdata/ins/rpt/2003-R-0885.htm>.

Куткаускієне Є. В. Концепція якості медичних послуг у галузі права про охорону здоров'я в Литві.

2009 року набув чинності новий закон Литовської Республіки про права пацієнта і право на компенсацію за шкоду його здоров'ю, який установив право пацієнта на якісні послуги охорони здоров'я. Претензії пацієнта з відшкодування збитку здоров'ю головним чином базуються на доказі того, що послуги охорони здоров'я не відповідають вимогам до їх якості. У статті надано визначення і правову оцінку концепції якісних послуг охорони здоров'я в Литовській Республіці.

Ключові слова: якість медичних послуг, пацієнт, деменції якості медичних послуг.

Куткаускиене Е. В. Концепция качества медицинских услуг в области права о здравоохранении в Литве.

В 2009 г. вступил в силу новый закон Литовской Республики о правах пациента и праве на компенсацию за ущерб его здоровью, который установил право пациента на качественные услуги здравоохранения. Претензии пациента по возмещению ущерба здоровью в основном базируются на доказательстве того, что услуги здравоохранения не соответствуют требованиям к их качеству. В статье дано определение и правовая оценка концепции качественных услуг здравоохранения в Литовской Республике.

Ключевые слова: качество медицинских услуг, пациент, деменции качества медицинских услуг.

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