Exclusion from service consumption in Polish health care system

Holecki T[1, A,D,E,*], Wróblewski M.[1,C,E], Woźniak-Holecka J.[2, B,D], Sobczyk K.[1, E,D]

1. Department of Health Economics and Management, School of Public Health, Medical University of Silesia in Katowice, Poland
2. Chair of Health Promotion, Department of Dietetics, School of Public Health, Medical University of Silesia in Katowice, Poland

---

A - Conception and study design, B - Data collection, C –Data analysis, D - Writing the paper,
E – Review article, F - Approval of the final version of the article

---

ABSTRACT

Purpose: The scientific objective of this research was to determine social groups affected by exclusion in Polish health care.
Materials and methods: Survey was carried out among local government units and non-governmental organizations by using authorial questionnaire distributed towards representative research group selected.
Results: This work depicts activities of social welfare centers in cooperation with non-profit sector entities, in the field of exclusion from the access to health care benefits in Poland, appointing circumstances, causes and the range of this exclusion. It presents the results of the countrywide research in the context of structure and tasks of the health care, but also two points of view (institutional and social one) for resolving the same population issues.
Conclusions: On the basis of the conducted analyses it has been stated that social exclusion, in the field of health care, is a significant social problem, but the biggest difficulty is the access to the rehabilitation benefits and pharmacological therapy.
Key words: social exclusion, non-governmental organizations, health care

---

DOI: 10.5604/01.3001.0009.5106

* **Corresponding author:**
Tomasz Holecki
School of Public Health in Bytom, Department of Health Care Economics and Management, Medical University of Silesia in Katowice
18 Piekarska Street, 41-902 Bytom, Poland
Tel.: +48323976537; e-mail: tholecki@sum.edu.pl

Received: 12.01.2016
Accepted: 17.02.2016
Progress in Health Sciences
Vol. 6(1) 2016 pp 25-31

INTRODUCTION

Health is the principle value and it is equally important for every human being independently on his or her social status, education, wealth and, as such, health should be possible to be achieved without visible differences, and the conditions of its achieving should be comparable for all people. World Health Organization underlines the meaning of these values in its document "Health for All in 21th Century" [1]. At the same time, the problem of inequality in health becomes an important element of developed countries' health policies, and as a result strategic documents are created in The European Union and its member countries [2,3].

Equality in access to health care is described as a lack of socially unacceptable and objectively justified differences. In a formal way, it means lack of discrimination in the range of specific law regulations and legislation, in a real way it explains equality connected with the degree of such rights' use. Whereas the first type depends only on legal records, affecting equal rights of different classes or social layers, the second one is conditioned with material, organizational and objective possibilities of the rights use and specific persons' attitudes [4].

In practical terms, equality in health care is usually understood as a vertical equality depicting the situation, in which persons and families, achieving different incomes, finance health care in varying degrees and horizontal equality assuming that persons having the same need for health care, regardless of their income, receive the same access to health services [5]. One should pay attention to the issue of overcoming barriers in an access to health care, eliminating gaps between the desired state and the actual one, taking into account modifying factors like housing conditions, individual level of life or social status. Furthermore, beyond all doubts, barriers, including those resulting from the possibility of fulfilling health needs, are socially undesirable [6].

In Polish political reality, the responsibility for activities preventing social exclusion rests on local government units (voivodeships, districts and communities), which conduct tasks in the field of health care, in the area of its jurisdiction. The whole process is conducted using institutionalized and formalized chain of public institutions – social welfare centers (community, district and voivodeship ones). Such centers can make use of the non – profit organizations' potential (foundations, associations, clubs, social integration centers etc.) by outsourcing them tasks in the range of health care at the same time providing funds necessary for its implementation.

This paper describes activities of local government administration in cooperation with subjects of the non – profit sector in the range of exclusion from the access to health care system, together with the division to hospital care, rehabilitation and health promotion. It systematizes which social groups and up to what extent are affected by social exclusion in public health care. Through the analysis of direct research results it indicates specific groups, that do not participate in the consumption of medical services alongside with other citizens. The work also mentions the circumstances, causes and the range of such an exclusion.

The basis for the entitlement to medical services in Poland

In Poland, on the basis of a health care benefits act [7], a wide catalogue of circumstances creating compulsory health insurance in National Health Fund (Narodowy Fundusz Zdrowia - NFZ) –, a quasi – monopolistic institution responsible for financing most medical procedures, has been foreseen. The requirement to enter the system is the regular payment of contributions which causes that such a form of providing access to medical services is achievable for that part of society that is financially viable. As at the same time, according to Polish constitution, everyone has the right to health care, public authorities are obliged to provide citizens, with equal access to medical services publicly funded, independently on their material situation. Bearing in mind constitutional provision [8], public authorities should aim at minimalizing the risk of exclusion, discrimination or unfair limiting to an access to services of health care market caused by low social and economic status of a person.

An access to free health services, publicly funded, gain all people that are bracketed together with the term "beneficiary", defined by the criteria present in health care benefits legal act which divides beneficiaries, of the common health care system, into insured people, who were reported according to the appearance of the formal obligation, for example through the fact of employment on the basis of work agreement or business activity, and people who are not the subject to this obligation and made a voluntary health insurance agreement with NFZ. Other people who can benefit from the system are those who have not been reported to health insurance in NFZ, but they have Polish citizenship, their place of residence is located in Poland and additionally they fulfill one of three conditions: achieve respectively low income defined in social welfare rules [9], are under eighteen years old or in case of women they are during pregnancy, childbirth or confinement period. Furthermore, the legal act also indicates other exceptional situations, which obligate public tax payer to return the cost of procedures to the beneficiary. It applies to circumstances, in which

the patient was provided with medical services on the basis of the rules connected with raising in sobriety, preventing alcoholism and drug addiction, mental health coverage or preventing and fighting against infections and infectious diseases [10-12].

What is more, exceptional cases also include the situation when the patient was provided with medical service on the basis of State Emergency Medical Service (Państwowe Ratownictwo Medyczne) rules, foreigners put in guarded centers or being in custody in order to be expelled from the country [13] , Pole card owners, but only in emergency situations [14]. One should underline the fact that no health protection institution can refuse to provide medical service in emergency situations connected with states of imminent danger to health or life.

In practice, outside the health care system are usually those people, who for many reasons, are inefficient socially and practically, avoid performing administrative procedures including them into the insured people community, for which health care premiums are paid by a relevant public authority (depending on circumstances).

MATERIALS AND METHODS

The research covered local government units in consent with administrative division (public partner), which realize tasks in the field of health care, in the area of its jurisdiction. The research also covered non-profit organizations (social partner), which realize tasks in the same field as local government units, burdening de facto public entities.

As having health insurance or the right to purchase it does not automatically mean full participation in benefiting from health care products and services, but only such a formal possibility, the scientific objective of this research was to determine social groups affected by exclusion in health care, ascertaining the range of such exclusion, groups of products and services moving beyond the bracket of availability and its causes. The distinction in perception of the same problems by public administration and non-profit organization employees was also significant.

The data was acquired using authorial survey questionnaire directed towards representative research group selected, proportionally, from the amount of all territorial division units (2,5k communities, 380 districts, 16 regions) and NGOs operating in the field of health care (11k subjects).

The research questionnaire was directed to the respondents by means of the internet survey (CAWI – Computer-Assisted Web Interview) and telephone interview technique CATI (Computer-Assisted Telephone Interview).

RESULTS

More than a half (51.5%) of hird sector organizations realizing tasks from the field of health care, pointed that their wards report problems connected with exclusion in access to health products and services. Most often indicated causes of exclusion were barriers in access to benefits, where the biggest problem affected benefits in the field of rehabilitation (29.9%), access to a General Practitioner was mentioned (22.1%) and hospital treatment (20.8%). Interestingly, the lowest percentage of answers (10.4%) applied to dental treatment, which in Polish system, very often needs factual financial participation from the patient. The details are presented in Fig. No. 1. In the criterion applying to pharmacotherapy, the biggest problem seems to be lack of refunding of some medications (45%), whereas the second problematic issue was limited access to generic medicines (27.5%).

The victims of exclusion are usually people being in poor health (disability, illness, old age), economic (unemployment) or family situation (loneliness, domestic violence, incomplete families). Majority of non – profit organizations claim that the main activity, which can cause the elimination of this phenomenon, is the improvement inside the health care system and the betterment of its economic aspects.

Surveyed NGOs indicated social groups, which were mostly affected by exclusion, being healthy at the same time. These were mainly disabled, addicted, mentally ill and unemployed people (Fig. 2). What is more, it has been proved, that public benefit organizations are active entities in actions against social exclusion. More than ¾ of them led active social policy in the field of health care. These activities are mostly legal advice and psychological counselling, but also health education.

Among surveyed respondents, 91% replied that in order to reduce the phenomenon of social exclusion, health education may appear to be necessary. But on the other hand, comparing it to other alternative methods of preventing exclusion in health care, health education was indicated by only about 15% of respondents as the most important element. The vast majority of answers pointed changes in the health care system as the most crucial. The research demonstrated that 77% of NGO respondents led an active policy in the issue of helping wards in a fight with social exclusion in health care, relying on guidance affecting health problems. Among those actions 62% of non – profit organizations pointed psychological counselling, 27% - legal advice and other guidance forms – 11%. Furthermore, 62% of answerers mentioned that during the last 5 years preceding the survey, they provided their wards with health education. It usually referred to eating habits and addictions.

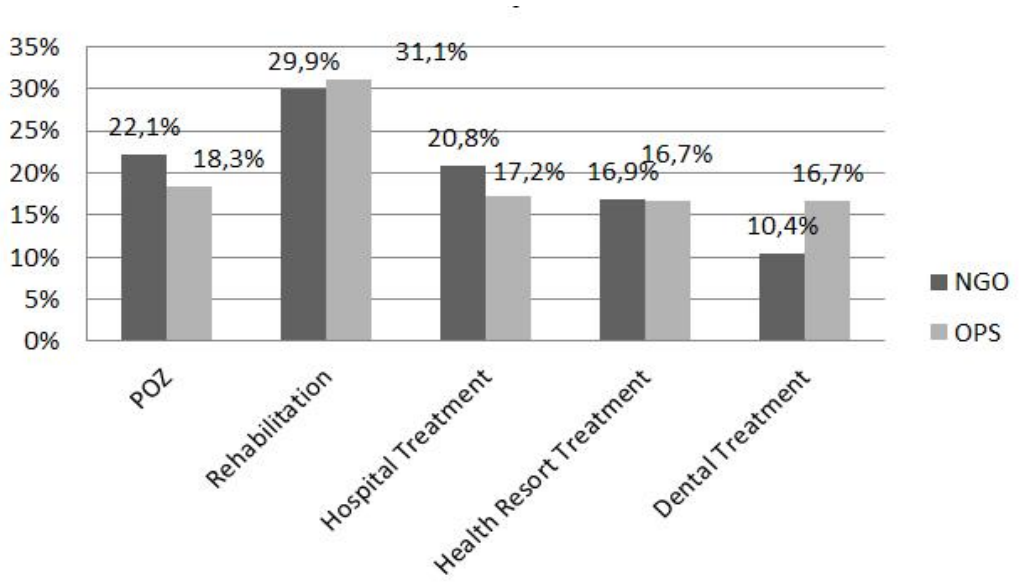

Figure 1. Barriers in access to health services in NGO and OPS opinion

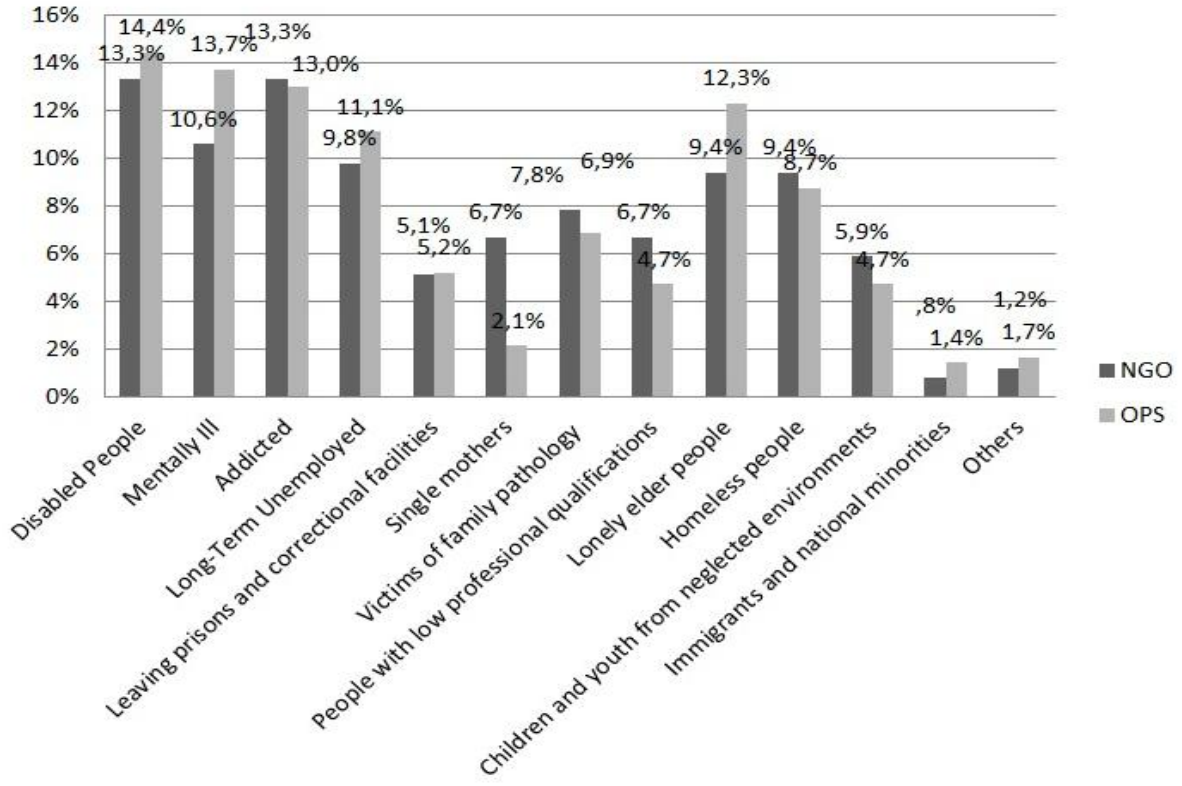

Figure 2. Social groups affected by exclusion in health care according to OPS and NGO

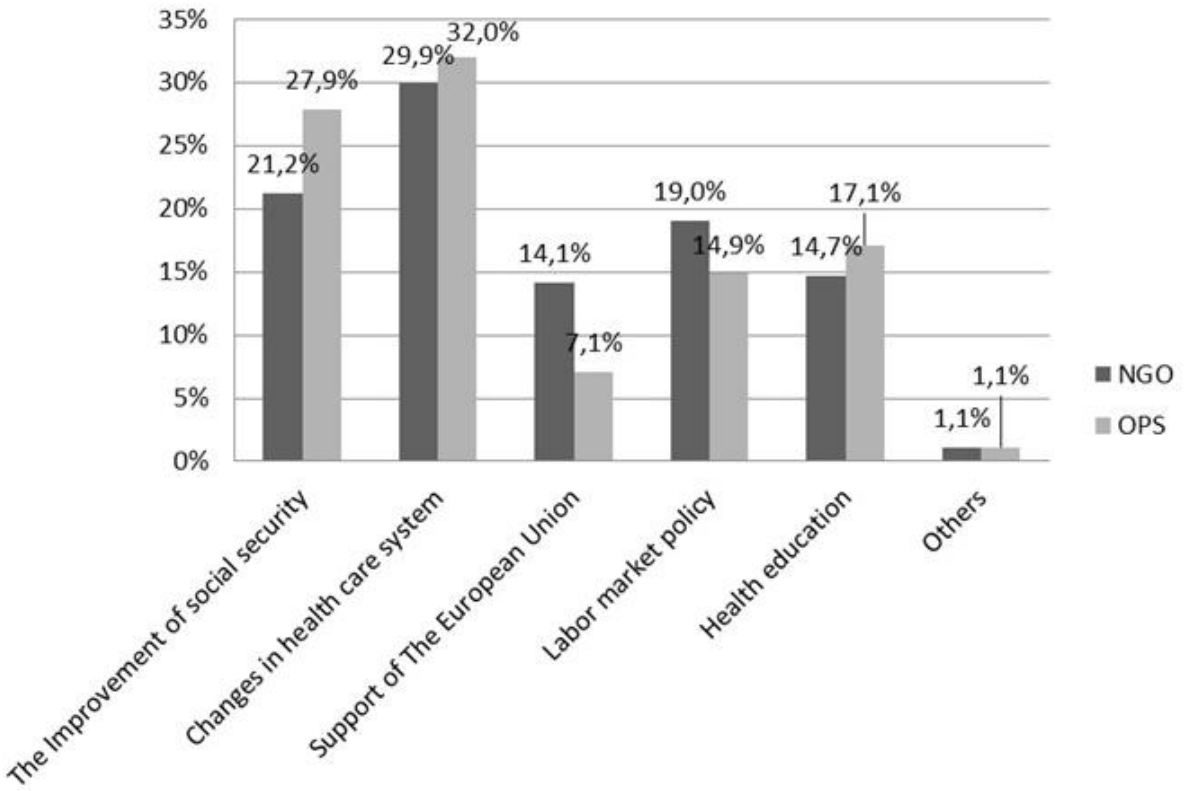

Figure 3. Preventing exclusion in health care

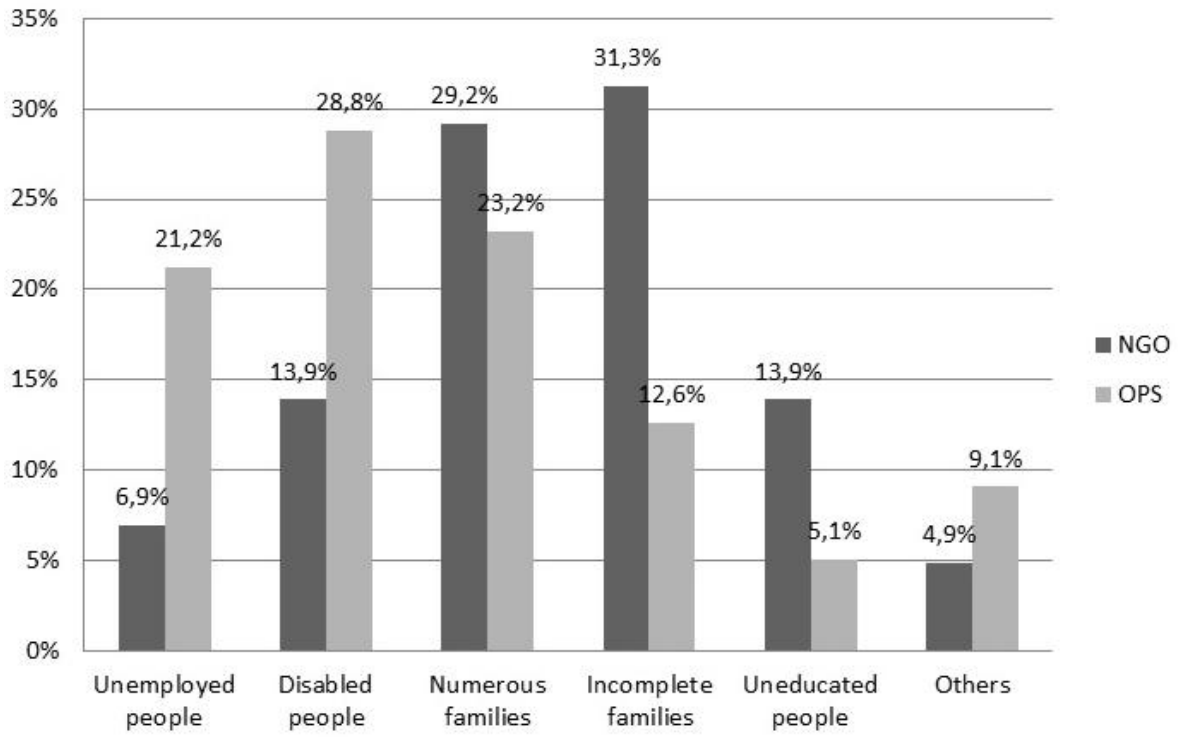

Figure 4. Social groups having the best availability of health services

Social groups , for which the availability of social services is the best are, according to NGOs, people living in incomplete and numerous families, hereas in OPS opinion, disabled people.Acquired data can lead up to the conclusion that in the issue of social exclusion, combined with the lack of access to health services, public health centers do not completely fulfill its function institutions of social activation. According to the research, exclusion in the context of health care, affects 64% beneficiaries, and performed tasks that are to prevent this phenomenon mainly come down to the payment of health care premiums, whereas other forms of activation like health education, rehabilitative therapies or rehabilitation stays are implemented by only a very small percentage of institutions.

DISCUSSION

An interesting example of research on inequality were the analyses from the year 1996, in which G. Kaplan et al., described health inequalities in 50 states of America, making an assumption that "the health of the poor is affected proportionally to the income gap between the rich and the poor" [15]. In order to prove this thesis, the distribution of income in particular regions was examined, the results were next compared to the rate of death from different causes. It turned out that the more irregular is the distribution of income, the more correlated is the rate of deaths. The discussion of social exclusion in health care approaches to treat it and describe in a dynamic way because the exclusion is not defined here as a state, but all the time changing process.

In Poland, the issue of social exclusion in health care has been made public for the first time in 2004 in the document called National Strategy of Social Integration (Narodowa Strategia Integracji Społecznej) [16]. The part of this document devoted to health included the analysis of relations between health, poverty and social exclusion. The document claimed that despite formally wide availability of health care benefits, not all social groups were covered with the full range of such benefits. In addition, it identified social groups, which were on the verge of exclusion risk in the field of health care with particular emphasis on children and youth from neglected environments, children raised outside the family, single mothers, occupationally inactive women, victims of violence, unqualified people, unemployed, living in poor housing conditions, disabled, mentally ill, but also elder people, lonely ones and immigrants.

At present it is recognized that one of the most crucial exclusion area in the field of health care is the access to medications, which has financial ground. It is due to the fact that medications in Polish health care are refunded only partially by a public payer. This inconvenience caused that 26% of households resigned from purchasing necessary medications. To the exclusion also contribute defects of health care system functioning. Other things that also influence this state are negligence in the fields of prevention and health promotion and also limitations in the access to rehabilitation [17].

In accordance to legal definition, social welfare is defined as the "social policy institution, which aim is to allow persons and families to overcome hard life situations, that they are not able to deal with using their own powers, means and capabilities" (Social Care Act),it should lead to removing undesirable phenomena, whereas in practice, dissatisfying level and range of actions made by Social Welfare Centers cause that some of their tasks are adopted by public benefit organizations. A large influx of social needs and the decrease of trust in social institutions, not being able to fulfill all needs, cause dynamic growth of non-governmental organizations sector [18]. In accordance with Polish law, non-governmental organizations perform their function on the basis of the law of 23rd of April 2003 on the activities of public benefit organizations and volunteering, which defines them as " legal persons or entities without legal personality, which a separate law creates a legal personality, not being public finance sector's units within the meaning of the act and not operating in order to gain profits" [19]. The aforementioned act allows entities of that type e.g. performing tasks from the field of health care and health promotion [20].

In practical terms, the cooperation of the third sector organizations operating in the field of health care with local government units undoubtedly contributes to the improvement of local and regional indicators associated with social exclusion. The potential that is hidden in social partners' environment is big enough, to influence significantly the effectiveness of performed tasks. What is important for this cooperation is that public authority units should not treat third sector organizations instrumentally, assigning them insignificant or precisely clarified tasks to fulfill or by using grant contests as well as in form of contracts. One should use not only a law obligation of cooperation [19], but also the potential hidden in social organizations, but one should also concern over introducing a systemic external motivating factors that will make the cooperation more attractive for both partners.

CONCLUSIONS

The issue of inequality in health is more often indicated as the one of the most important health problems of the modern world. The demands on eliminating or diminishing these disproportions

appear in health policies of many countries. As inequalities in health find its foundation in political stratification, the negative measures of health conditions show that health is a social product [21]. And so, when decreasing inequalities in health should firstly concentrate on reducing inequalities resulting from negative social-economic situation.

On the basis of conducted studies one can claim that social exclusion in health care represents significant social problem also in Poland, because more than a half of respondents mention this phenomenon as the one that affects his or her wards. The largest problem is the access to some benefits e.g. rehabilitation, but also pharmacological treatment, where the main barrier is the cost of medicines or the lack of its refunding as well as the unavailability of generic medicines.

Acknowledgments

The research was funded by the Medical University of Silesia in Katowice, Poland

Conflicts of interest

The authors declare that they have no conflicts of interest.

REFERENCES

1. Karski BJ, Kozierkiewicz A. Healt for All in 21th Century, Vesalius, Kraków, p. 84. (Polish)
2. White Paper of the Comission of the European Communities – Together for Health: A Strategic Approach for the EU n2008–2013, KOM(2007) 630 final version.
3. Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008-13).
4. Morecka Z. Social aspects of Managing, Warszawa, PWE, 1981, p. 22. (Polish)
5. Laskowska I. Equality in health care services financing and accessibility, Łódź, Wydawnictwo Absolwent, 2000, p. 15-6. (Polish)
6. Golinowska S. State Social Care in the Free Market Economy, Warszawa, PWN, 1944, p. 100. (Polish)
7. Health Care Benefits Act 2004, Dz. U. 2004 nr 210 poz. 2135. (Polish)
8. Constitution of Poland 1997, Dz. U. 1997, NR 78 poz. 483. (Polish)
9. Social Care Act 2004, Dz. U. z 2008 r., Nr 115. (Polish)
10. Act on Upbringing in Sobriety 1982, Dz. U. nr 35 poz. 230. (Polish)
11. Act on Counteracting the Drug Addictions 2005, Dz. U. nr 179 poz. 1485. (Polish)
12. Act on Preventing and Fighting the Infectious Diseases 2008, Dz.U. 2008 nr 234 poz. 1570. (Polish)
13. Act on Foreigners 2003, Dz.U. 2003 nr 128 poz. 1175. (Polish)
14. Act on the Pole Card 2008, Dz. U. z 2008 r., Nr 52, poz. 305. (Polish)
15. Kaplan GA. People and places: Contrasting perspectives on the association between social class and health. International Journal of Health Services, 1996, 26, p. 507–19. (Polish)
16. Narodowa Strategia Integracji Społecznej (NSIS), Ministerstwo Gospodarki, Pracy i Polityki Społecznej, Warszawa 2003, dokument elektroniczny. Available at :[http://www.mpips.gov.pl] [cited 12 November 2015] (Polish)
17. Włodarczyk C. Remarks on certain problems of Polish health care system. The issue of poverty and exclusion. Poverty and social exclusion in Poland, Polish Raport Social Watch 2010, p. 93 – 103. (Polish)
18. Tyrakowski M. The role of non-governmental organizations in coping the social problems, Zeszyty Naukowe Zakładu Europeistyki Wyższej Szkoła Informatyki i Zarządzania w Rzeszowie 2/2007 (4), p. 172-96 (Rola organizacji pozarządowych w rozwiązywaniu problemów społecznych). (Polish)
19. Act on Public Benefit Activity and Voluntary Services 2003, Dz. U. 2003 nr 96 poz. 873. (Ustawa z dnia 24 kwietnia 2003 r. o działalności pożytku publicznego i o wolontariacie). (Polish)
20. Szeja N, Sobczyk K, Woźniak-Holecka J, Grajek M, Holecki T. The cooperation of the local government administration with the non-profit organizations in the area of health education towards counteracting the addictions, Tarnów 2014, p. 129-36. (Polish)
21. Ostrowska A. Inequalities in health, Kultura i Społeczeństwo, 1998, 2, pp. 149-64. (Nierówności w zdrowiu). (Polish)