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Gwarancja bezpieczeństwa zdrowotnego w ramach powszechnego ubezpieczenia zdrowotnego w Polsce w opinii społecznej

Streszczenie

Wstęp. Poprawa zdrowia populacji i zmniejszenie nierówności w zdrowiu są głównymi celami publicznego system opieki zdrowotnej.

Cel. Celem badania była analiza opinii społecznej dotyczącej bezpieczeństwa zdrowotnego obywateli w ramach powszechnego ubezpieczenia zdrowotnego w Polsce.

Materiał i metody. Anonimowe badania przeprowadzono wśród różnych grup społecznych w Polsce w 2008 roku. Narzędziem badawczym był autorski kwestionariusz ankiety opracowany na potrzeby niniejszego badania. Instrukcje wysyłano drogą pocztową, otrzymano 711 prawidłowo wypełnionych ankiet. Wyniki badań poddano analizie statystycznej.

Wyniki. Możliwość leczenia w publicznej opiece zdrowotnej, takie same dla wszystkich ubezpieczonych, ankietowani ocenili średnio na 2,21 w pięciostopniowej skali. Inaczej postrzegają możliwość równego dostępu do opieki zdrowotnej w ramach powszechnego ubezpieczenia zdrowotnego w Polsce mężczyźni niż kobiety oraz badani z różnym wykształceniem. Największym problemem związanym z korzystaniem z publicznej opieki zdrowotnej jest długie oczekiwanie do specjalistów (87%) i na badania diagnostyczne (56,54%). Prawie 60% respondentów uważa, że nie ma gwarancji bezpieczeństwa zdrowotnego w ramach powszechnego ubezpieczenia zdrowotnego w Polsce. Świadczenia publicznej opieki zdrowotnej częściowo zaspokajają oczekiwania 50% badanych, podczas gdy 31,5% uważa, że ich oczekiwania nie są zaspokajane.

Wnioski. Większość respondentów uważa, że zarówno państwo, tworząc sprawny system ochrony zdrowia, jak i sami obywatele są odpowiedzialni za stan systemu ochrony zdrowia.

Słowa kluczowe: bezpieczeństwo zdrowotne, zdrowie publiczne, powszechne ubezpieczenie zdrowotne, opinia społeczna.

Warranty of occupational health and safety within public health insurance in public opinion in Poland

Abstract

Introduction. Public health care systems are aimed at the enhancement of health of the population and decrease in health inequalities.

Aim. The aim of the study was the analysis of social opinion concerning health safety of the Polish population within the system of public health insurance (PHI) in Poland.

Material and methods. The study was conducted anonymously among various social groups in Poland in 2008. The research tool was a questionnaire form designed by the authors for the needs of the presented study. The instructions were mailed, and 711 correctly completed questionnaires were returned. The results were subject to statistical analysis.

Results. The respondents evaluated the opportunities of treatment in public health care – the same for all the insured – to be 2.21 according to a five-degree scale. Males perceive the possibility of equal access to health care within the PHI differently to females and respondents with various levels of education. The greatest problem associated with the use of public health care is a long waiting time after the registration for a specialist visit (87%), and for the performance of diagnostic tests (56.54%). Nearly 60% of the respondents expressed an opinion that there is no warranty of health safety within the PHI in Poland. Public health care services partially meet the expectations of 50% of the respondents, while 31.5% admit that their expectations are not satisfied.

Conclusion. The majority of respondents indicated that both the State, creating an efficient system of health protection, and the citizens themselves are responsible for the state of the Polish health care system.

Key words: health safety, public health, public health insurance, public opinion

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INTRODUCTION

Public health care systems attempt to enhance health of the society and to decrease inequalities in health [1-3]. The ethical basis for the 'Health 21' assumptions for the WHO European Region comprise three fundamental values: 1) health as a basic human right; 2) equality in health and solidarity in acting on behalf of health inside countries and between countries and their citizens; 3) participation in constant development of the health sector and responsibility for the effects of activity of individuals, groups, institutions and local communities.

Equality in health according to the WHO means, in an idealistic approach, that every citizen should have a genuine opportunity to develop and maintain their health [4,5]. Nevertheless, from the pragmatic point of view, if it cannot be avoided, no one should be deprived of the access to health resources understood as life conditions. Therefore, equality in health care is a universal value and denotes striving for the elimination of disparities in attaining the basic standard of services [6,7].

A basic standard of medical services is possible to achieve by: 1) possessing the opportunities to use the system of health care (obligatory and voluntary insurance); 2) having access to indispensable medical services; 3) the presence of service providers who are able to satisfy the expectations of individual patients and with whom patients can start a long-term relationship based on mutual understanding and trust [8].

At the end of the 90s of the 20th century in Poland, the term health safety was introduced in the context of changing the method of financing health care in association with the transition from the budget towards the insurance system. Since then, health safety has appeared, with subsequent attempts to reform the health care system, as expression of the authorities concern about the health of citizens.

The primary problem faced by nearly all health care systems worldwide is the fact of continuously growing costs. Growing costs bring about a serious risk of destabilisation of health care systems. It seems that a totally free market of medical services will not fulfil the assumptions of a good health care system, such as universality, public management and effectiveness. The danger of market solutions may start two-stratum health protection: the first will be characterised by good quality, more expensive and available only for the wealthy, while the other will be of a poorer quality, less expensive and available for the poor. In the European systems of health care, however, such traits as solidarity, responsibility and justice are deeply rooted [9]. The public management currently focuses on tasks which serve the enhancement of health care systems, such as: greater interest in efficiency, quality, results, competitiveness and identification of a patient, i.e. the user of a public institution as a 'client', 'consumer' [10].

AIM

The study analyzed public opinion concerning health safety of the Polish population in the public health insurance system (PHI).

MATERIAL AND METHODS

The study was conducted in Poland in January 2008 among various social groups from five regions: Warsaw, Katowice, Szczecin, Zielona Góra and Lublin. The research tool was an anonymous questionnaire designed by the authors, containing 35 closed questions concerning the functioning of the health care system in Poland. The questionnaire included the following questions and answer options: 1. In your opinion, are the possibilities of treatment in public (i.e. state) health care the same for all the insured? (a. definitely yes; b. rather no; c. difficult to say – yes and no; d. rather no; e. definitely not); 2. According to your opinion, what are the difficulties associated with the use of public health care? (a. long waiting time to see a specialist; b. long waiting time for diagnostic tests; c. long waiting time for admission to hospital; d. lack of genuine and comprehensive information from physicians; e. inappropriate treatment by medical staff; f. informal payments; g. non-aesthetic rooms; h. fees for selected visits; i. lack of opinion); 3. Are you of the opinion that obligatory public health insurance guarantees health

TABLE 1. Socio-demographic characteristics of respondents.

Age	30 and under	44.72%	Education level	elementary/ vocational	16.01%
	31-40	19.27%		secondary school	47.68%
	over 40	36.01%		university	36.29%
Monthly income/ person	up to 700 PLN	25.32%	Health status	very good	21.79%
	701-1,300 PLN	33.05%		good	47.12%
	1,301-1,600 PLN	15.47%		satisfactory	22.93%
	1,601-2,000 PLN	11.67%		poor	6.75%
	> 2,000 PLN	14.49%		bad	1.41%
Place of residence	rural area	23.63%	Gender	female	66.39%
	urban area up to 25000 tys.	20.53%			
	25-150,000 inhabitants	42.62%		male	33.61%
	>150,000 inhabitants	13.22%			

safety? (a. yes; b. no; c. lack of opinion); 4. Do health services received within the obligatory insurance system satisfy your expectations? (a. yes; b. partially; c. no; d. lack of opinion); 5. Who, in your opinion, is responsible for health protection? (a. we ourselves are responsible; b. the State; c. difficult to say; d. the State creates an efficient system of health care, but we have to take care of our own health).

From among 1,200 questionnaire forms sent by post, 711 correctly completed forms were returned. Socio-demographic characteristics of the respondents are presented in Table 1. The results of the study were subject to statistical analysis. In order to evaluate the correlation between two traits, chi-square test for independence, and chi-square with Yates correction were used. The level of significance 0.05 was adopted. The following traits were analysed: age, occupational status, occupational activity, and the income earned.

RESULTS

The respondents evaluated the opportunities of treatment in public health care - the same for all the insured – to be 2.21 according to a five-degree scale (definitely Yes – 4; rather Yes – 3; difficult to say – 2; rather No – 1; definitely No – 0). Males more often considered the opportunities for treatment in public health care as being the same for all, and according to the five-degree scale obtained the average result of 2.25 scores, compared to females – 2.18 scores. The statistical analysis showed a statistically highly significant difference on the error level of less than 2%.

The analysis of the opportunities for equal access to medical services in public health services also showed a statistically significant correlation with respect to respondents' education level. According to the five-degree scale, the highest evaluations were expressed by the respondents possessing university education – 2.38 scores, followed by those with elementary or vocational education level – 2.24, and secondary school education – 2.06. A statistically significant difference was observed between the respondents with university and secondary school education level, on the level of confidence higher than 99%.

In respondents opinions, the greatest problems associated with the use of public health care are as follows: long waiting time after registration with a specialist (87%), and long waiting time for the performance of diagnostic tests (56.54%), long waiting time for admission to hospital (35.02%), lack of genuine information from physicians (32.07%), and inappropriate treatment by medical staff (21.52%) (Figure 1).

Evaluating the warranty of health safety in Poland, nearly 60% (58.1%) of respondents expressed an opinion that there is no such warranty within the current public health insurance system, 14.3% of them mentioned that they have such a warranty provided, while 27.3% of respondents had no opinion concerning this problem.

According to the respondents, the warranty of health safety within the PHI system showed a correlation with age. The respondents aged 31-40 considerably more often admitted that the obligatory public health insurance does not guarantee health safety, compared to the respondents from the

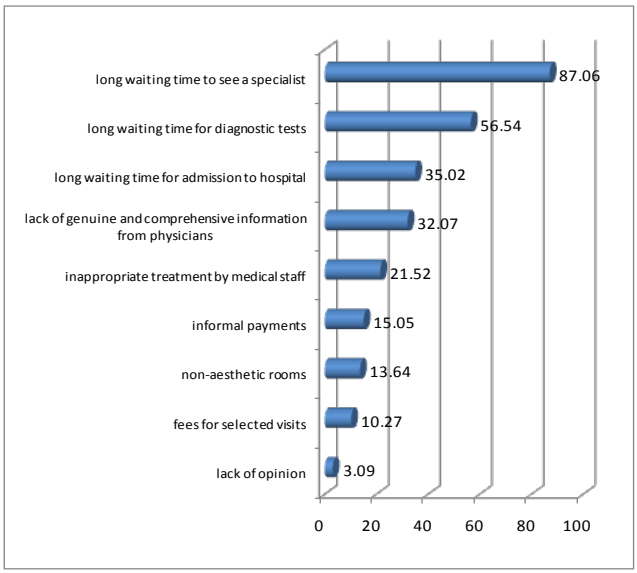

FIGURE 1. Difficulties associated with the use of public health care according to respondents' opinions.

two remaining age groups. However, they were more rarely convinced that this is a sufficient warranty. The percentage distribution of replies provided by people aged 30 and under, and those over 40, was similar. The statistical analysis of the correlation of opinions concerning the warranty of health safety and respondents' age showed the presence of a correlation on the level of error lower than 5% (Table 2).

TABLE 2. Warranty of health safety within the current obli-gatory public health insurance system by respondents' age.

	30 and under		31-40		Over 40	
	N	%	N	%	N	%
Yes	51	16.04	13	9.49	38	14.84
No	82	57.23	93	67.88	140	54.69
Lack of opinion	85	26.73	31	22.63	78	30.47
Total	318	100.00	137	100.00	256	100.00
χ^2	6.700					
p	<0.05					

In the group of respondents obtaining an income from 701-1,300 PLN per family member (20.85%), the largest number of respondents was convinced about the warranty of health safety within the current obligatory public health insurance. The largest number of respondents who mentioned that the present system does not guarantee heath safety was noted in the group with the highest income. Statistical analysis showed a correlation between respondents' income and percentage distribution of the replies received (Table 3).

A higher percentage of respondents engaged in occupational activity of an intellectual character, or with prevalence of office work (65.4%), expressed an opinion that there is no warranty of health safety within the public health insurance system in Poland, compared to those performing manual work (53.6%) and those not engaged in occupational activity or students (52.8%) ($p<0.05$) (Table 4).

TABLE 3. Warranty of health safety within the current obligatory public health insurance by respondents' monthly income.

	Up to 700 PLN		701-1,300 PLN		> 1,300 PLN	
	N	%	N	%	N	%
Yes	27	15.00	49	20.85	26	8.79
No	92	51.11	125	53.19	198	66.89
Lack of opinion	61	33.89	61	25.96	72	24.32
Total	180	100.00	235	100.00	296	100.00
χ^2	6.907					
p	<0.05					

TABLE 4. Warranty of health safety within the current obli-gatory public health insurance by respondents' according to character of respondents' occupational activity.

	Office workers or with prevalence of office work (I)		Manual workers or with prevalence of manual work (II)		Those not performing occupational activity/students (III)	
	N	%	N	%	N	%
Yes	44	14.38	21	15.22	37	13.86
No	200	65.36	74	53.62	141	52.81
Lack of opinion	62	20.26	43	31.16	89	33.33
Total	306	100.00	138	100.00	267	100.00
t(p)	6.597 (<0.05)					
	6.958 (<0.05)					
	2.191 (NS)					

Public health care services partially satisfy the expectations of 50% of the respondents, whereas 31.5% are of the opinion that their expectations are not being satisfied (Figure 2).

A statistically significant difference was noted between people performing office work or with prevalence of office work and those engaged in manual work or with prevalence of manual work, concerning the evaluation of the satisfaction of expectations with respect to medical services. The respondents performing office work more often expressed an opinion that medical services provided within the public health insurance do not fulfil their expectations (38.2%), compared to [the respondents who were] manual workers (21%).

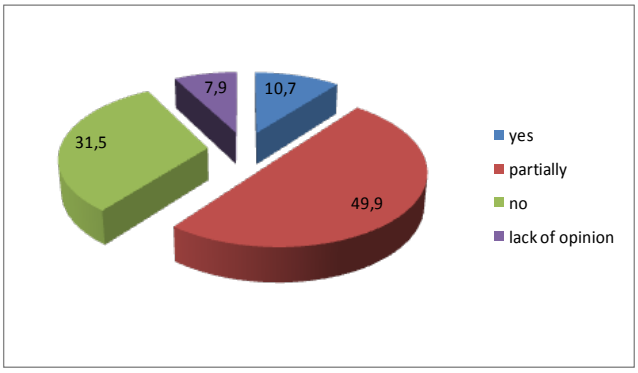

FIGURE 2. Satisfaction of respondents' expectations with respect to medical services within the obligatory health insurance system.

The analysis of responsibility for health protection according to education level showed that the percentage of people who were of the opinion that the State should create an efficient system of health care, but that the citizens should also take care of their own health, increased with respondents' education level - 36.84% in the group with elementary or vocational education level followed by secondary school education - 51.33%; and university education level - 56.20%. A decrease was observed in the number of people indicating exclusively the State: 20.18%, 16.81%, 10.85%, respectively, and those who mentioned themselves – 30.70%, 25.37%, and 25.97%, respectively. The results of the statistical analysis showed a statistically significant relationship on the level of confidence higher than 95%.

The respondents engaged in office work or with prevalence of office work significantly more often (54.9%) admit that health protection should be the responsibility of the State and ourselves, compared to those performing manual work or with prevalence of manual work ($p<0.05$) (Table 5).

TABLE 5. Institutions responsible for health protection by the type of respondents' occupational activity.

		Office workers or with prevalence of office work (I)		Manual workers or with prevalence of manual work (II)		Those not performing occupational activity/ students (III)	
		N	%	N	%	N	%
We ourselves are responsible		72	23.53	45	32.62	71	26.59
The State		43	14.05	22	15.94	43	16.10
Difficult to say		23	7.52	14	10.14	17	6.37
The State creates an efficient system of care, but we have to take care of our own health		168	54.90	57	41.30	136	50.94
Total		306	100.00	138	100.00	267	100.00
t(p)	I – II	7.199 (<0.05)					
	I – III	1.409 (NS)					
	II- III	3.669 (NS)					

DISCUSSION

The EU aims to develop a knowledge-based economy and to strengthen employment, economic reform and social cohesion. It is clear that these goals cannot be reached without improving physical and mental health in the member countries and without decreasing health disparities between and within them. Considering the values of public health it may sound unethical to ground health protection and health promotion on economic objectives. For us, public health people, health and its even distribution represent a normative value, not a means to achieve other goals [11].

In the presented studies, the respondents evaluated the provision of treatment opportunities in public health care - the same for all the insured - as lower than average. Males and females, and respondents with various levels of education differently perceive the possibility of an equal access

to health care within the public health insurance system. The greatest problems associated with the use of public health care are long waiting time for visits to specialists and for diagnostic tests.

Previous studies conducted in Poland in 2003 concerning the availability of medical services indicated that in almost all aspects positive evaluations did not exceed 55% of the total number of respondents [12].

The study conducted after five years of functioning of the new system, allowed the presumption that an improvement was observed in many spheres, while only the availability of the first contact physician services remained on a level close to that which existed before the reform (this concerned the availability of a visit to an outpatient department or home visit). Considerably more negative evaluations of access to specialist services were maintained, compared to the period from before the reform. The study also shows that far fewer people actually used specialist advice, diagnostic tests and rehabilitation procedures. Compared to the period before the introduction of the PHI, no changes were noted in the degree of use of hospital treatment, with its relatively good availability [12].

One of the problems remaining at the focus of attention is the issue of so-called exclusions, which means an inequality of opportunities in access to socially valued goods. For this reason, the authors of the presented study were interested in what way the place of residence, the level of material standard and education, as well as other traits of social position, affect the use of health services and the evaluation of their availability.

The 2003 study confirmed the persistence of unfavourable changes, which after the introduction of the PHI afflicted the inhabitants of big cities (with the population of over 500,000 inhabitants) – the opinions of respondents belonging to this category indicated that the implementation of the reform caused a considerable deterioration in the access to various health services in big cities (although, the number of negative evaluations was slightly smaller than directly after the implementation of the reform). However, the study did not confirm the maintenance of an unfavourable tendency with respect to selected health services for old-age pensioners, users of health benefit and people who evaluate their material standard in negative terms [12].

In the subsequent, later studies of 2006, accessibility to the first contact physician was evaluated in relatively more positive terms, whereas the evaluations of the availability of specialist advice were considerably more negative. Changes were observed in the hierarchy of difficulties associated with access to public health care. Difficulties with the access to both the first contact physician and a specialist, which were most often mentioned, are associated with a long waiting time after registration with a physician, and for diagnostic tests. Compared to 2003, a clear increase was noted in the percentage of people indicating the sequence of admissions as a method of obtaining hospitalization, and the usage of informal ways remained on an unchanged, mediocre level [12].

Based on own material, nearly 60% of respondents reported that there is no warranty of health safety within the PHI in Poland. Public health care services partially satisfy the expectations of 50% of respondents, while 31.5% are of an opinion that their expectations are not being satisfied. Although in the report by the Centre for Computer Science and Information Services in Poland of 2006, there prevail respondents opinions concerning equal for all opportunities of treatment within the pubic health care (45%), a considerable percentage (35%) do not share this conviction. According to respondents, disparities concern primarily the social groups distinguished based on economic criterion (the rich/the poor), and informal relationships, while the dimensions of the discrimination are connected with both the lack of access to the more expensive medical services, inability to pay the informal costs of treatment, and lack of information pertaining to the opportunities of treatment, as well as improper treatment by physicians [13]. The results of the 2007 study supported the respondents' conviction (60%) about equal for all opportunities of treatment within the public health care; however, the opinions concerning inequality criteria, as well as the forms of their manifestation, did not change. In respondents' opinions, the material status of a patient is a basis for inequality, and decides about better or worse access to treatment. The situation of inequality or discrimination, to a greater degree, is perceived by respondents with university education, the self-employed, office workers, the inhabitants of big cities, and people of the younger and medium age groups [14].

The analysis conducted in 23 European countries in the years 2002 and 2004 showed that the problem of inequalities in health is the largest in the countries with a state system of health protection, in the Scandinavian countries these problems hold an intermediate position, while the smallest - in the countries with an insurance system [15].

The problem of inequality in health has also been noted in countries where the dominant form of financing health protection is private insurance. Canadian authors report that the system of private insurance cannot provide a wide access to health care, which results from socio-economic conditions of the society [2].

American studies pay attention to racial, ethnical and socio-economic differences in the access to health care [1,16]. The report of 2007 concerning inequalities in health in the United States maintains that those who are not insured have a worse health status and die earlier. This results from the fact that the uninsured have hindered access to health care. They are diagnosed at a more advanced stage of a disease and receive worse quality care [8]. Currently in the United States, the programme 'Healthy people 2010' is being realized, which through the improvement of access to medical care assumes decrease in morbidity and mortality rates, and the quality of citizens' health. The priority groups of American society to which the programme is targeted are: the poor, females, children, the elderly and rural inhabitants [8].

REFERENCES:

1. Aaron KF, Chesley FD Jr. Beyond rhetoric: what we need to know to eliminate disparities. Ethn Dis. 2003;13 Suppl 3:S3-9-11.
2. Hurley J. Ethics, economics, and public financing of health care. J Med Ethics. 2001;27:234-9.
3. Chang WC. The meaning and goals of equity in health. J Epidemiol Comm Health. 2002;56:488-91.
4. Williams A. Thinking about equity in health care. J Nurs Man. 2005;13:397-402.
5. Baum F, Harris L. Equity and social determinants of health. Editorial. Health Promot J Austr. 2006;17:163-5.
6. Phelan JC, Link BG, Diez-Roux A, Kawachi I, Levin B. "Fundamental causes" of social inequalities in mortality: a test of the theory. J Health Soc Behav. 2004;45:265-85.
7. Braveman P, Gruskin S. Defining equity in health J Epidemiol Comm Health. 2003;57:254-8
8. National Healthcare Disparties Report. Agency for Healthcare Research and Quality. Department of Health and Human Services. USA 2008.
9. Vecchio C. Health and the market. Ital Heart J. 2000;1:1188-91.
10. Hannigan B. Assessing the new public management: the case of the National Health Service. J Nurs Manag. 1998;6:307-12.
11. Keskimaki I. The future of public health in the European Union. Eur J Public Health. 2007;17:327.
12. Dostępność świadczeń zdrowotnych w opinii Polaków 1998-2003. Centrum Systemów Informacyjnych Ochrony Zdrowia. Warszawa: Zakład Analiz Socjologicznych, 2004.
13. Dostępność świadczeń zdrowotnych w opinii Polaków. Centrum Systemów Informacyjnych Ochrony Zdrowia. Warszawa: Zakład Analiz Socjologicznych, 2006.
14. Dostępność świadczeń zdrowotnych w opinii Polaków. Centrum Systemów Informacyjnych Ochrony Zdrowia. Warszawa: Zakład Analiz Socjologicznych, 2007.
15. Eikemo TA, Bambra C, Joyce K, Dahl E. Welfare state regimens and income-related health inequalities: a comparison of 23 European countries. Eur J Public Health. 2008;18:593-9.
16. Siegel S, Moy E, Burstin H. Assessing the nation's progress toward elimination of disparities I health care. J Gen Intern Med. 2004;19: 195-200.

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