INEQUITIES IN ADDRESSABILITY AND ACCESSIBILITY OF VULNERABLE GROUPS TO HEALTH CARE SERVICES

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Keywords: *medical services, addressability, accessibility, vulnerable groups, inequities*

Abstract: *Health services access is legislatively stipulated and guaranteed in the EU Charter of Fundamental Rights, Article 33: "Everyone has the right of access to preventive health care and the right to benefit from medical treatment" (Health and care in an enlarged Europe, 2003). This study highlights the inequities that exist in the population's access to health care, especially in rural areas, stressing the importance of equity and accessibility to services regarding the health of the population. Study results highlight the fact that people in rural areas are disadvantaged in terms of access to health services, compared to the urban population, which exerts a negative influence on their health.*

Cuvinte cheie: *servicii medicale, adresabilitate, accesibilitate, grupuri vulnerabile, inechităţi*

Rezumat: *Accesul la serviciile de sănătate este statuat la nivel legislativ şi garantat în Cartea drepturilor fundamentale a Uniunii Europene, articolul 33: „oricine are dreptul la accesul la serviciile medicale preventive şi dreptul de a beneficia de tratament medical" (Health and care in an enlarged Europe, 2003). Studiul de faţă evidenţiază inechităţile care există în accesibilitatea populaţiei la asistenţa medicală, în special a populaţiei din mediul rural, subliniind importanţa echităţii şi accesibilităţii la servicii, asupra stării de sănătate a populaţiei. Rezultatele studiului evidenţiază faptul că persoanele din mediul rural sunt defavorizate în ceea ce priveşte accesul la serviciile medicale, în comparaţie cu populaţia urbană, ceea ce exercită o influenţă negativă asupra stării lor de sănătate.*

INTRODUCTION

The economic development of Romania in the last 20 years has led to the formation of poor population groups, vulnerable in terms of health. Poverty has deepened gradually, especially in recent years of domestic and international economic crisis.

In correlation with poverty, elements with negative influence on the health of these populations began to appear, namely: inadequate or unbalanced diet, poor living conditions, lack of hygiene etc. Beyond the phenomenon of poverty, however, a large part of the population has health education issues. The low level of economic development has meant fewer resources for the health system, with long-term repercussions. Thus, on one hand, in the groups with low levels of education, there is a lack of knowledge, a lack of awareness of the role of health prevention and lack of information about family planning, with the consequences thereof. On the other hand, addressability and accessibility issues to health services also affect human health in a negative way. Most of the rural population has difficult access to public health services, many of the villages in Romania do not even have primary care units (General Practitioner).

The changes in the health system after 1996 have not solved the problems of these vulnerable groups regarding the access to healthcare or equipment. Investments were made mainly in hospitals, leading to a polarization of the supply of health services around the hospital. The patients in the large cities benefit from relatively high quality hospital services, while the rest of the population cannot solve their health problems, either due to the lack of specialists or due to the lack of modern medical technology.

The current health system is facing serious problems of chronic underfunding and lack of resources, including human resources, which are otherwise the most important.

It is estimated that by the end of 2015, the number of health professionals in Romania will decrease by 50%.

PURPOSE

The purpose of this study is to evaluate the inequities existing in terms of population's addressability and accessibility to healthcare, especially of rural population, who cannot receive the medical services they need because of costs, transportation, distance, poor health, which negatively affects their health.

METHODS

This study was designed as an opinion survey using the anonymous questionnaire with pre-formulated answers.

The study was conducted in 2012 in Sibiu, on a group of 70 randomly selected patients.

1. Distribution according to gender, age groups, and origin environment of the studied persons;
2. Distribution of subjects according to the average monthly income;
3. Distribution of patients by insurance status;
4. Distribution of persons according to the current health status;
5. Distribution of patients according to the degree of addressability and accessibility to health care;
6. Distribution of persons by obstacles encountered in the accessibility to health services;

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RESULTS

Following the analysis of the opinion survey, we found that 62.86% of the surveyed people are from rural area and 37.14% from urban area and 67.14% of the respondents are female (figures no. 1-2).

Figure no. 1. Distribution of the studied persons according to the origin environment

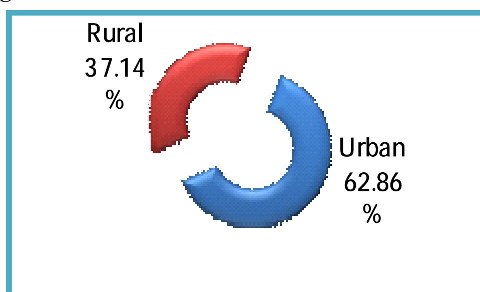
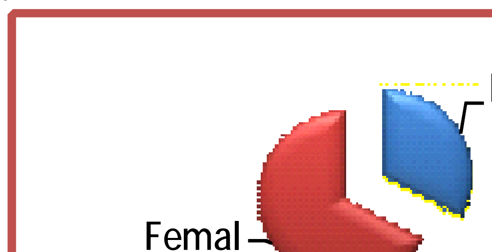
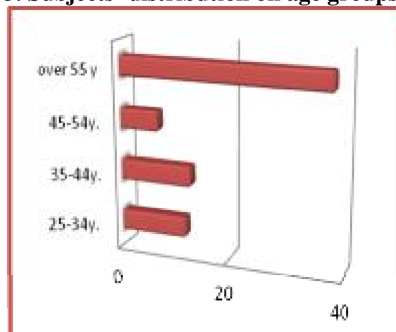


Figure no. 2. Distribution of the studied batch according to gender



In relation to age distribution, it is noticed that most subjects (72.34%) were over 45 years old (figure no. 3).

Figure no. 3. Subjects' distribution on age groups

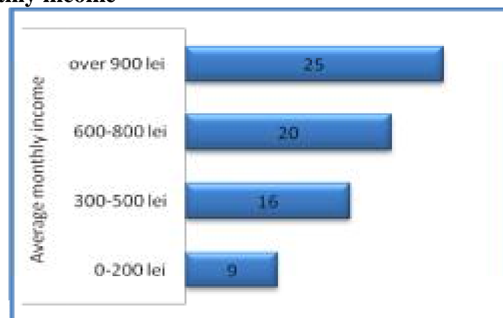


In terms of education level, the proportion of subjects with secondary education is 45%, the rest having vocational school, or 8-10 years of schooling. A small percentage of patients have higher education.

Most people surveyed are retired, but they also come from other socio-professional categories: workers, private entrepreneurs, unemployed, housewives and intellectuals.

We also studied the average monthly income of the subjects. Thus, we found that the people in rural areas have the lowest income; they have completed secondary school and most of them are farmers. From the following income category, which includes the minimum wage there are especially those employed in urban areas, with secondary education. The average and large revenues belong mainly to the subjects with higher education in urban areas (figure no. 4).

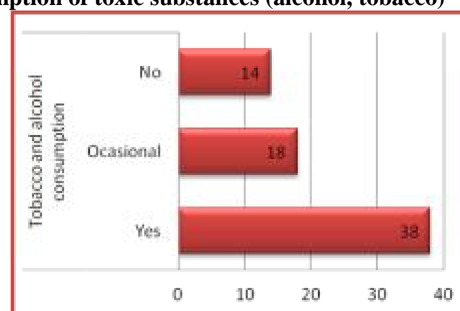
Figure no. 4. Subjects' distribution according to the average monthly income



Regarding the housing conditions, most subjects consider them satisfactory, and nutrition in terms of quality and quantity is relatively appropriate.

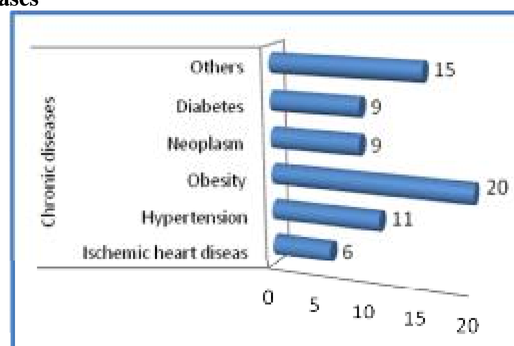
The consumption of toxic substances (tobacco, alcohol) is presented in the following figure (figure no. 5).

Figure no. 5. Distribution of subjects according to the consumption of toxic substances (alcohol, tobacco)



Following the analysis of chronic disease in the studied patients, we found that all have one or more chronic diseases, especially obesity, cardiovascular disease, diabetes, and tumours. A total of 15 patients have chronic diseases other than those mentioned above (figure no. 6).

Figure no. 6. Subjects' distribution according to the chronic diseases



Addressability to the doctor is variable: 32.85% went only once to the doctor's in the last year. Of these, 39.13% are patients in rural areas with an average monthly income up to 500 lei, 34.78% had a monthly income between 600-800 lei and have secondary education and 26.08% have higher education and an income of 1000 lei. 55, 71 of the patients went to the doctor's several times in the past year and only 8 of those surveyed did not need medical care in the last 12 months (table no. 1.).

Table no. 1. Distribution of the surveyed persons according to the addressability to the doctor in the last year

Total of the persons taken in the study		Addressability to the doctor in the last year		
		once	several times	never
Subjects	70	23	39	8
Percentage	100%	32,85%	55,71%	11,42%

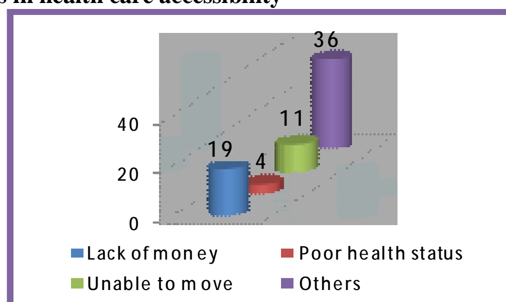
Instead, there are addressability differences in terms of public or private health care services. Thus, the people in rural areas and those with low incomes, including in the urban areas have turned to public health services in a percentage of 50%. Addressability to the private sector was of 27, 14%, represented mainly by patients with medium or high monthly income from the urban environment. Less than a quarter of the studied patients address both the public and the private sector (table no. 2).

Table no. 2. Distribution of subjects according to addressability to medical services in public and private sectors

Total of the persons taken in the study		Medical services by sector:		
		public	private	both
Subjects	70	39	19	12
Percentage	100%	55,71%	27,14%	17,14%

By analyzing the barriers encountered in the addressability to the doctor, a quarter of patients are complaining mainly the lack of material resources. Therefore, the demand for health services is often delayed, in the phase of the complication of the disease. Other barriers mentioned by the patients are related to distance, transportation costs, physicians' schedule, waiting time etc. Rural elderly patients are particular ly facing these problems (figure no. 7).

Figure no. 7. Distribution of subjects according to the barriers in health care accessibility



CONCLUSIONS

The analysis and synthesis of the data obtained from this study reveal that low income people, both in urban as in rural areas are particularly vulnerable groups, for which there are inequities in the degree of addressability to health services, especially to the private sector.

1. Most subjects have completed high school and those in rural areas have on average 8 years of educational training.
2. A quarter of those surveyed consider they have poor health; more than half of patients consume toxic (alcohol, tobacco), and the chronic disease they are suffering from are in descending order: obesity, hypertension, diabetes, ischemic heart disease, neoplasms and many more.
3. Addressability to the doctor during the year under study is higher in the people with a monthly income below 900 lei. A quarter of those surveyed postpone going to the doctor's for financial reasons.
4. The patients with low incomes, both from the urban and rural areas often delay the time of presentation at the doctor on financial considerations. Also, this population is particularly addressing the public hospital services.
5. The health services in the private sector are usually preferred by the patients with medium and large monthly income.
6. Rural patients initially present to the family doctor and only on the basis of a referral they use the services in secondary care. The rest of study persons directly address the hospital specialists.
7. Approximately one third of patients have financial difficulties in procuring drugs for various chronic diseases, which is why they buy the necessary medicines only partially. These are subjects with an average income of less than 600 lei.
8. The factors that decrease the availability and the accessibility of the studied patients to the health services are primarily the insufficient material resources and for the people in rural areas, there are the distance, transportation cost and the last but not least the poor health.

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