AVANT, Vol. XV, No. 3, ISSN 2082-6710
https://doi.org/10.26913/ava3202412

Is Health Care an Example of Inclusiveness or a Space of General Exclusion?

Exclusion in Health Care Using the Example of Disadvantaged Groups

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Received 2023-12-31; accepted 2024-12-14; published Online First 2024-12-27.

Abstract

According to the Constitution of the Republic of Poland, every citizen has the right to health care. Unfortunately, some disadvantaged or minority groups have difficulties accessing a general practitioner, psychologist or other specialists in broader medical care. The article reviews scientific research on the issues outlined in the title using the following groups as examples: persons with a substance abuse disorder, the elderly, people with HIV or AIDS, immigrants, refugees and people from the LGBT community. For years, the World Health Organization has stressed that improving the health of members of socially excluded groups can improve the health of the entire population. However, there is still no program in Poland focusing on combating inequalities in the healthcare system. The article presents research results from other countries. Unfortunately, in Poland, there is still a lack of studies on minority groups, their access to the health care system, and the attitudes towards those groups of medical personnel.

Keywords: health care exclusion, health care, disadvantaged groups, immigrants, LGBT

1. Introduction

Szarenferberger (2005) distinguished four areas in defining the concept of social exclusion. The first refers to participation in social life, the second relates to access to goods and resources of various types along with institutions and the social system, the third to poverty and deprivation of needs, and the last to social rights and their implementation. Healthcare and exclusion within it seem to go beyond a single area of exclusion described by the author. Thus, the term "health inequality" appears in the literature to refer to systematic inequalities in the observed health condition between some socio-economic groups (although within these groups, there may be various inequalities due to, for example, gender, race or social position). There is no doubt that the feeling of exclusion, regardless of how long an individual has had it, affects their functioning. The experience of exclusion is associated with strong negative feelings and additional stress, which affect emotions, self-esteem and functioning (Wesselmann et al., 2012). Stigmatization may also influence the effects of therapy and treatment. Such correlations were found in the case of people suffering from mental illnesses who experience very high levels of social exclusion. It is exacerbated by the attitude of medical staff and medical students who, despite their knowledge in this field, are often unable to treat patients in a professional manner without prejudice. Stigmatized individuals often feel fear and insecurity, a sense of rejection, and increased sensitivity to the opinions of others. A division of stigma into felt and enacted stigma has been adopted. The former is directly related to the stigma, e.g. disease or disability. It is perceived as shame or disgrace accompanied by an obsessive fear of being stigmatized by the environment. In order to protect themselves from the undesirable behavior of the environment, such a person will hide the stigma for as long as possible. Enacted stigma, on the other hand, otherwise known as discrimination, is defined as current episodes of stigmatization (Suwalska et al., 2016). The feeling of stigmatization affects the quality of life of an individual and reduces life satisfaction. These people have a poorer assessment of their lives and suffer from chronic diseases, lower self-esteem, a sense of helplessness, anxiety, and depression (Chodkowska et al., 2010). The experience of exclusion in childhood results in differences in personality traits, such as caution and fearfulness (Killen et al., 2013). Studies on young children who exhibited aggressive behavior showed that their aggression was reinforced by lack of acceptance and exclusion from their peer group (Stenseng et al., 2014). Long-term ostracism increases the risk of depression and suicide attempts (Zadro et al., 2004). It has also been confirmed that social exclusion is a risk factor for suicide attempt mortality in European men (Yur'yev et al., 2013). Research on transgender people has shown that discriminatory attitudes towards them and their exclusion from society make this group susceptible to risky behavior, forcing them to become commercial sex workers, beggars, or drug addicts and even causing suicidal thoughts (Shah et al., 2018).

When it comes to health, social exclusion has been proven to affect mental health and overall physical well-being (van Bergen et al., 2019). Struggling with minority stress, homophobia, discrimination, victimization, anxiety, and persecution all contribute to more frequent alcohol consumption, drug use, and cigarette smoking in the LGBT group compared to heterosexuals (Kołodziej, 2018). Stigmatization, prejudice and exclusion result in constantly increased vigilance and a sense of threat as well as fear of humiliation in social situations. Very often, the consequence of such obsessive anxiety is increased suspicion of members of the majority group. This, in turn, has a major impact on the misinterpretation of this group's behavior, which may cause a strong emotional reaction (Major et al., 2003). The lack of openness and negative attitudes towards different social groups also have an impact on the number of hate crimes. Moreover, exclusion increases health problems and significantly worsens the quality of life (Fabiś et al., 2015). According to the World Health Organization, health exclusion means systematic differences in health status between different socio-economic groups. These inequalities are caused by social factors (and therefore can be modified) and are unjust (Whitehead, 1992). In 2010, the same organization concluded that in 53 countries of the European region, poverty and social exclusion are the main factors of health inequalities.

2. Examples of excluded groups in the healthcare system and the reason for selecting these groups

Social exclusion in the health system affects many groups. In these article, the following groups have been selected: persons addicted to psychoactive substances, people treated psychiatrically, the elderly, people with AIDS, and LGBTQ+ individuals. This choice results from the policy of the Polish state, the war in Ukraine and the ageing of the population in Europe. This article is not an analysis of Polish research on the attitudes of medical personnel but aims to show how important it is to change the healthcare system in Poland and educate future and current medical personnel in the context of working with excluded groups. The reason for choosing the LGBT group is the fact that Poland has been the most homophobic country in the European Union for the last three consecutive years (ILGA-EUROPE, 2023). The choice of refugees and immigrants is linked to the outbreak of the war in Ukraine in 2022. After this event, a very large number of refugees came to Poland (UNHCR, 2024). According to the results of a survey made by UNHCR, the vast majority (63%) declare that they plan to stay in their current host country (Chugaievska, 2023). Due to the influx of a large number of war refugees, a higher incidence of HIV and AIDS was also noticed in our country (ECDC, 2022). For several years now, there has been a clear trend in Poland towards an increase in the number of deaths due to alcohol use, reaching a peak of 14,048 cases in 2021 (Malczewski & Jabłoński, 2023). Regarding the elderly, many authors have noticed changes to the demographic structure of our society (ageing) that require reforms of the statutory

health care system (Jodkowski, 2014). The first argument is the need for more frequent visits to the health sector. On the other hand, many authors emphasize the problem of poor treatment of the representatives of these groups in the health care system (Malewicz-Sawicka et al., 2022; Krüger et al., 2023; Rogala et al., 2023; Burak & Reczyńska, 2015). The article presents research results from around the world and an analysis of the literature available on this issue in Poland.

One of the previously mentioned groups that suffer from exclusion in health care is people addicted to drugs and alcohol. Research on 222 medical students and social work students about patients addicted to alcohol or nicotine and those suffering from depression showed that both groups were less willing to treat people with addictions than those with depression (Ahmedani et al., 2011). In another study on medical students, a high stigma against patients with depression and addiction to alcohol and drugs was observed (Fernando et al., 2010). Medical students often believe that the patient is to blame for their addiction (Imran & Haider, 2007). According to some scientific studies, nurses' attitudes towards alcoholism are influenced by many variables such as age, type of specialization, working hours, their own habits related to alcohol consumption, competences related to collecting information and additional training in this area (Seabra, 2023). Moreover, nurses ask patients about the amount of alcohol consumed far less often than doctors do. As many as 53% of nurses feel apprehension related to an offensive reaction from the patient (Tan et al., 2022). In Poland, many employees of the health care system assess working with this type of patients as unpleasant and unsatisfying. Such patients very often arouse many negative feelings among this professional group, including reluctance, anger, and even impatience and disgust. The greatest reluctance on the part of medical personnel was caused by vulgar behavior (80.6%), intoxication (68.0%), and personal hygiene (43.7%) of the patient (Burak et al., 2016). Similarly, health care system employees often do not have an open approach to patients undergoing psychiatric treatment. In this group of patients, social exclusion is very common, frequently intensified by the lack of awareness of medical staff and students of medical universities, who are often unable to treat patients in a professional and unbiased manner (Suwalska et al., 2016). Furthermore, it has been noticed that among medical students, there is a high stigmatization of people with mental health conditions (James et al., 2012). A more open attitude towards patients in this group was influenced by the experience of treating people experiencing a mental illness or the occurrence of this type of disease in a family member of the respondent (Korshun et al., 2012; Ay et al., 2006). There are students who believe that mental illnesses such as schizophrenia and depression can be cured (Naeem et al., 2006). Some medical students consider this type of patient to be dangerous. In the case of anxiety and depression, patients are assumed to be responsible for their condition and should "pull themselves together" (Imran & Haider, 2007). Social exclusion is deepened by the lack of support from anyone other than immediate family and structural

discrimination in mental health care. The lack of sufficient funding for this field of science favors the continuity of the stigmatization process (Podogrodzka-Niell & Tyszkowska, 2014). Assigning uselessness and low value to patients undergoing psychiatric treatment reduces their activity on the principle of a self-fulfilling prophecy. It diminishes their intellectual and social competence, further deepening social alienation (Kowalik, 2007). Polish research from 2022 showed that one-third of patients in psychiatric wards experienced various types of ill-treatment by medical staff (Malewicz-Sawicka et al., 2022). In a 2017 survey of psychiatrists, as many as 95% of them admitted that mental illness in Poland is a health problem hidden from others (Kochański & Cechnicki, 2017).

Another group that should be mentioned are the elderly. One form of exclusion that affects this group of people is digital exclusion. In this case, the limitation is understood primarily as unequal access to information, including medical information, as the Internet is where we often look for information about health. Additionally, this limitation is related to the possibility of using telemedicine services such as medical consultations or prescription renewal (Korczak, 2019). A frequently overlooked topic in Poland, also by medical staff, is the sexuality of senior citizens. Many international studies show that older people feel the need for sexual intercourse and declare sexual desire (Helgason et al., 1996). Marginalization of the elderly may also be a predictor of suicidal thoughts and suicide attempts (Crnek-Georgeson et al., 2017). It should be added that for many people, old age is associated with various types of disabilities. Many studies indicate that people with disabilities often have difficult access to the health care system (Temple et al., 2020a). A 2019 study in Australia of the elderly with disabilities found a very high risk of discrimination or engaging in health care avoidance behaviors, which was related to the reporting of unmet healthcare needs by primary care physicians, medical specialists, hospitals and dentists (Temple et al., 2020b). In Polish studies by Kropińska (2013), 14.9% of seniors felt discriminated against while in healthcare facilities, and 19.4% witnessed discrimination against other seniors. In addition, 60.9% of the elderly believe that age discrimination in the healthcare sector is a social problem.

People suffering from AIDS or those who are HIV carriers often face social exclusion. HIV-infected patients have reported stigmatization in health care and even changes in attitudes on the part of physicians after disclosing information about their HIV status (Bunting, 1996). In a 2011 study in EU countries, 60% of respondents reported negative and discriminatory attitudes among health sector workers (ECDC, 2017). In many cases, stigma and social exclusion can add up. Research shows that discrimination against people infected with HIV may be more acute than against people suffering from other diseases. HIV primarily affects groups that are stigmatized in the absence of infection (e.g., gays, people who inject drugs) and also disproportionately affects African Americans and Latinos, who experience racism/ethnic discrimination independent of HIV

(Capitanio & Herek, 1999; Kelly et al., 1987). It should be mentioned that the level of perceived stigma is associated with more depressive and HIV-related symptoms, lower levels of antiretroviral therapy adherence and poorer health-related quality of life in cross-sectional analyzes (Rintamaki et al., 2006; Vanable et al., 2006; Stirratt et al., 2006). The fact that Poles have no knowledge about the HIV virus, AIDS and the ways of its transmission does not help here. Medical staff often have a low level of knowledge about disease transmission. The lack of information about the disease and the stigmatizing approach of health care workers have a negative impact on the prevention and treatment of people with AIDS (Stutterheim et al., 2009). The fear of being mistreated by medical staff means that patients often do not seek help in the medical sector. Very frequently, sick people and those infected with the virus can be treated against their will, medical confidentiality is not kept and even access to treatment is limited (Dong et al., 2018). It should also be added that stigmatization, discrimination and isolation contribute to an increased risk of HIV infection (Magnus et al., 2010; Arnold et al., 2014). Polish studies have shown that 27.5% of HIV patients, after being informed of their positive result, were refused healthcare services by medical personnel (Rogala et al., 2023). Another example of a large nationwide project is a study conducted in 2010 on a sample of 502 in 7 Polish cities. The respondents were asked how often they had been refused health services, including dental care, due to HIV infection, in the previous 12 months. A total of 20% of the respondents indicated refusal—of varying frequency—as an example of discrimination (Sieć Plus, 2011).

Refugees and immigrants are often mentioned as groups affected by social exclusion (Ringold & Kasek, 2007). Unfortunately, racism and discrimination also occur among health care workers. Many patients from this group reported that their ethnicity resulted in poorer access to health care and lowered its quality. Negative attitudes of doctors and nurses affect compliance with recommendations related to the treatment of these people (Van Ryn & Fu, 2003; Williams & Rucker, 2000; Sorkin et al., 2010). Another problem in this group is overcoming the language barrier, which is also necessary to guarantee the quality of health services. In the case of patients who do not speak fluently the language spoken by health care workers, the risk of incorrect diagnosis and medical errors increases (Ku & Flores, 2005). It turns out that for such people, the hospitalization time is also longer and the frequency of readmission to the hospital after the patient's discharge increases. Other studies in English-speaking countries have proven that people with low English proficiency who did not use professional translation services were more likely to be readmitted to a hospital within 30 days after discharge (Lindholm et al., 2012). In the literature, there have been documented many examples of delayed diagnosis, misdiagnosis, inappropriate referral, failure to explain the patient's condition or recommended care, or failure to ensure confidentiality or obtain informed consent because the patient's native language differs from that of the health care provider

(Bowen, 2001). In the absence of confidentiality and lack of access to an interpreter, such patients may avoid medical care and be reluctant to communicate about matters that may be difficult or embarrassing for them but may be important to the overall clinical picture (violence, sexuality-related topics) (Stevens, 1993; Li et al., 1999). This problem also concerns Poland. Moreover, it is worth mentioning that in Poland alone, there are almost a million war refugees from Ukraine.

Another group that often experiences discrimination are people from the LGBT community (gay, lesbian, transgender and bisexual persons). One of the largest reports in recent years on the health of people from the LGB community in Switzerland showed that compared to heterosexual people (38.4%), LGB people were significantly more likely to visit a specialist (40.8-58.5%). The additional "LGBT Health" study shows that many Swiss LGBT people are at risk of experiencing discrimination or violence because of their sexual orientation or gender identity (67.6% at least once in their lives). These types of experiences also occur in health care (26.6% at least once in their lives), and they most affect trans/non-binary people (Krüger et al., 2023). The following aspects are mentioned in the literature about limiting the access of trans people to medical care: discrimination in the health care system, specialists who do not have adequate knowledge about transgender health issues, past negative experiences in medical care, and the lack of coverage of necessary services, including health insurance (Heng et al., 2018; Lerner & Robles, 2017; Ziegler et al., 2020; Cicero et al., 2019). In Poland, few researchers focus on the access of LGBT individuals to the healthcare system. A 2016 study examining the attitudes of various professional groups found that medical personnel exhibited the most homophobic attitudes among all the groups surveyed (Kołodziej, 2016). Knowledge about other studies was a significant predictor in examining attitudes towards homosexual people and knowledge of topics related to this issue among Indian doctors and trainees (Banwari et al., 2015). Many specialists admit that they do not have the knowledge to work professionally with non-heterosexual patients (Erwin, 2006). Other studies have indicated that a significant predictor of attitudes towards LGBT patients is knowledge about this group (Kowalczyk et al., 2016).

3. What are the patient's needs?

In a study from 2012 in which the aim was to find factors influencing patients' assessment of the quality of medical care services, the number of staff and their level of education, medical equipment, organizational structure and management structure were mentioned (Czerw, 2010). As can be seen, in most cases, a good and professional team is needed to achieve the best possible result in these components of success. The need for good and competent medical staff and good patient-staff relations is also visible in another study. In 2000, Grażyna Bartkowiak referred to the expectations of patients staying in hospital

towards medical staff. If the reason for staying in hospital was a disease requiring surgical intervention, the most important factor determining the assessment of the service was the professionalism of the staff; however, if there was no such need, the importance of relationships with the medical staff was emphasized (Bartkowiak, 2000). In studies assessing patients' expectations towards nursing staff, the most important features were observation skills, appropriate medical knowledge, humane attitude towards the patient and diligence in performing procedures. However, the traits of character desired in nurses by the respondents were trust, selflessness, respect for the dignity of others and responsibility (Moczydłowska et al., 2014a). When it comes to the medical staff, the most desirable character traits of a doctor were trust, selflessness, respect for the dignity of others and responsibility (Moczydłowska et al., 2014b). Many patients expect a sense of security and trust from medical staff. In research on the LGBT community, it turned out that these people would be more willing to tell their doctor about their sexual orientation if they were sure that the doctor would keep medical confidentiality (Allen et al., 1998). According to patients, disclosing non-heteronormative orientation or transsexuality should be important for every member of the treatment team (Cloyes et al., 2018). The effects of good therapy for alcohol-dependent transgender people were visible among therapists who respected their patients' requests and did not use their "deadnames" during meetings (Lyons et al., 2015). Additionally, this group emphasizes the importance of the inclusive attitude of medical staff (Kowalczyk et al., 2016).

4. Conclusion

Positive social inclusion is influenced by the following factors: family activity, social activity, professional activity, income, political and civic activity, public sector services, financial services, safety at home, place of residence, transport, free time, mental health, physical health and educational activity (Huxley et al., 2006). Other EU countries have developed guidelines for healthcare professionals on how to work with socially excluded people. An example is Great Britain, where the UK's Royal College of General Practitioners (RCGP) and National Health Service (NHS) have developed guidance specific to primary healthcare professionals and health service managers relating to the care of socially excluded groups (Department of Health, 2010; Force, 2010).

For many medical professions, the basis is working to promote social justice in health care (Reutter & Kushner, 2010). For this purpose, it is recommended that the already working medical staff increase their knowledge about social exclusion and its impact on health and quality of life. It is also necessary to modify medical professions training programs in response to today's ever-changing social problems related to health care needs. Classes conducted at medical simulation centers are helpful in this regard. Special information on the health of people from minority groups is also being gathered, often by organizations and associations that have a hard time influencing the healthcare system in Poland.

We must also not forget that some of the medical staff themselves may be people from minority groups. It can be seen, among others, in homosexual medical staff, who very often do not admit their psychosexual orientation in the work environment (Mays & Cochran, 2001).

Primary health care workers (POZ) are the key group in combating social exclusion in health care. Already in 1995, Dr Iona Heath stated that in the functioning healthcare system, the health of the weakest people in society suffers the most (Heath, 1995). This has been confirmed by, among others, research on alcohol addicts and persons with mental illness (Trnka et al., 2010; Le Boutillier & Croucher, 2010). It is crucial to remember that good communication with the patient and an inclusive attitude influence the continuity of care and the ability to provide information regarding the patient's history, treatment, preferences and goals of care (Care, 2013).

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