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Sociological Factors that Influence Access to Primary Health Care (PHC) Settings

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Abstract

Health services and therefore the services of a primary health care are imbedded in a structured, rational health system that should offer a global and human approach of health needs of all social groups. Health is a fundamental human right and every person should have access to health care services. Unfortunately, globally, a large number of people do not have access. As a result, a large part of the planet suffers from infections and has a very low life expectancy. In addition, health inequalities can be determined by a series of indicators that determine access to health services and therefore prevention and treatment. Health inequalities are related with a low income, cultural differences, geographical and organizational barriers. Specifically, national minorities, economic and political refugees suffer today internationally intense social exclusions to health services, especially in primary health care. Main obstacles are the lack of information materials to foreign languages, lack of translators and information from the host country. In conclusion, accessibility of vulnerable individuals to health services and human rights are protected with a number of international laws. However, the road remains long, with unfulfilled obligations as there is need for a lot of changes, in order to ensure proper health for all population groups.

Keywords: sociological factors, health inequalities, access to health services, primary health care

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1 Introduction

Social reality confirms that equality as social good, as well as freedom and fraternity, though it may not be absolute is the cornerstone for the creation of a «good society» [1].
Social inequalities in the concept of hierarchical social stratification are observed in every society where different social groups, occupy more or less privileged social positions resulting in differentiated access to social goods. Social inequality is socially constructed and institutionalized in a stable and repeatable system that is transferred from generation to generation, is directly linked to economic inequality and is reflected in differences in the distribution of wealth and the distribution of economic privileges but also is linked to other social characteristics such as gender, age, race, religion, language and even bodily integrity. Social inequality lead to different access to various social goods including rights to property, freedom of speech, the right to vote, educational opportunities and even the fundamental right of good health [2,3].

2 Social Inequalities and Health

The Constitution of World Health Organization (WHO) states that *"good health is a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity"*. Health is a resource for everyday life, not the object of living and is a positive concept emphasizing social and personal resources as well as physical capabilities. Health is a fundamental human right, recognized in the Universal Declaration of Human Rights (1948) [4].
Beyond WHO's definition others exist, depending on the context chosen for placing the concept of health. So according to the "negative definition" which is driven by the belief that medical science is required to find treatments for diseases so as to make people healthy, health is considered as "the absence of symptoms and disease".
This definition, in theory at least, becomes more understandable as it offers health "measurable status" while serving and prevailing biomedical model, although it certainly cannot be always the measure of other people and other aspects define health [4].
According to the experiential definition of Kelman [5] is important "how the person is perceives health" while for functionalist Parsons [6] "the feature that marks the existence of health is the possibility of a satisfactory response to social roles that each person is required to play".
Finally, considering in particular sociological aspects *"health and overall well-being of humans are affected by a number of factors such as beliefs and the cultural system in which is included the individual, income, nutritional needs, habits and housing potential , educational opportunities, and ultimately the general ecological and socio-economic environment in which the person lives and grows"* [7].
Therefore, from a sociological point of view health depends on principle of socio-economic environment in which the person lives and grows and the environment including the residential and nutritional possibilities, educational opportunities will be given as the widen work and ecological environment.
Theoretically all people living in a country have the right to access and use of health services. In Greece and in accordance with Article 5 paragraph 2 of the Constitution "*due to all people in the Greek territory, is the absolute protection of life, honor and freedom*" and of course there can be no absolute protection of life without health and therefore

without access and use of health services.
According to Aristotle's "Eudemian Ethics", the following quotation was inscribed over the temple of Leto at Delos: "*Justice is fairest and Health is best. But to win one's desire is the pleasantest*".
Every person should, in terms of equity, have the opportunity to access those sanitary and social measures necessary to protect, promote, and maintain or recover health [8].
Unfortunately, globally, according to international statistics [9]:

- 1/5 of people on our planet do not have access in contemporary health services
- 1/4 have not adequate housing
- 3/5have no opportunity to keep basic health rules and
- Approximately, 1/3 have not access to clean water!

As a result of all these, is, that a large part of the planet suffers from infections, neonatal and infant mortality and has very low life expectancy.
In the relatively recent example of the destroyed by the earth quakes Haiti [10,11], which according to the economic indicators is considered to be the poorest country in the western hemisphere, about half of its residents are under the age of eighteen (18) years, four (4) to ten (10) children grow up in absolute poverty and one (1) to five (5) children has not access to clean water. It is paradoxical, but in the USA, the richest country of the world, until the recent reform efforts "Obama", the majority of residents was completely uninsured, consequently was lacked any access to the health system. WHO published one of the most recognized rankings of health care system performance in the 2000 report titled "Health Systems: Improving Performance". In this report USA placed 37th out of one hundred ninety one (191), behind Costa Rica, on overall health system performance [12, 13].
According to international organizations [14,15,16], about half of the Roma have not health insurance while they lack the purchasing power to cover cost of medical examinations and purchase of medicines, consistently, approximately two (2) to three (3) of the Roma often resort to self-treatment methods or use "alternative" therapies.
Unfortunately, even if they manage to approach the system and health services they will consider it very bureaucracy and will not feel safe enough to contact with health professionals. Health inequalities can be determined by a series of indicators and variables that determine access to health services and therefore prevention and treatment. Violating any constitutional right, accessibility is not specified neither the health status of the individual, nor the choices of one's own.
It is an indisputable fact even today that "people who most need of health services, they are the ones who are less recipients of those services" [17, 18].

3 Health Inequalities

Firstly, health inequalities include the existence and availability of dissimilar resources, or otherwise no existence and consequently no availability for all people resources of health services.
Secondly, there is unequal accessibility to resources and unequal opportunity for use of these resources.
An interesting indicator measuring these inequalities is the so-called «degree of fit»,

which is influenced and is inversely proportional to the obstacles of access and use of health services. It is obvious that some people, especially some more vulnerable social groups, are the ones who must face discrimination and increased obstacles to access and use of health services [19, 20]. Obstacles to access to health services prevent individuals and whole social groups, patient and healthy individuals, since part of the health care relates to the provision prevention in healthy individuals, who belong to "vulnerable groups" of populations from receiving the necessary health care or receive less than other privileged groups.

The term vulnerability, a more general term that is related not only to the social good of health, is described as "*unsatisfactory access to economic goods, social and cultural limiting because of this poverty and access to proper care and in general all services of health system"* [21].

The problem of dealing with health inequalities and health promotion globally, has pre-occupied and continues to pre-occupy the international community mainly through the efforts of WHO to promote equitable health in every part of the globe.

Significant efforts have been done by the Conference of ALMA ATA, which held on 09.12.1978 in Kazakhstan of the former USSR, by the WHO and UNICEF with the participation of one hundred thirty four (134) countries, sixty seven (67) international organizations and a number of international non Governmental Organizations, where "is reconfirmed that goal must be" "Health for All "with a more suitable and convenient way to achieve this goal the development of primary healthcare [22].

Moreover, conducted the 1st International Conference on Health Promotion by WHO on 21.11.1986 in Ottawa, Canada [23] where is defined as Health Promotion *"the process through which the weaker social groups will be developed so as to improve their Health"* since *"People cannot develop the best possible health, if they are not control factors defining their health"*.

4 4 Why do Health Inequalities exist?

Health services and therefore the services of a primary health system are principle imbedded in a structured, rational health system that should offer a global and human approach of health needs of all social groups. Interpretations of inequalities in the health sector are many and clearly depend on the way of approach of social inequalities [24]. In literature, health inequalities have received Marxist and Neo-marxist analysis, sociological, socio-psychological, behavioral, cultural but also biological, mechanistic and even "arte fact" analysis and interpretations.

According to the Health Belief Model of Rosenstock, as key variables should be considered social class, personality and also the previous contact with the disease [25], while Andersen in Behavioral Model distinguishes certain key factors that determine the first contact and then the use of health services, classifying them in three (3) major categories [26]:

- The first category includes age, sex, personal perceptions and attitudes about health care system
- The second category includes variables such as income, insurance cover and availability of health services
- The third category includes parameters related to the overall health level.

In 2007, the British study SACOCO found that the main factors affecting the demand of health care, in which the first step should be the primary health care, can be summarized as follows[27]:

1. Socio-economic obstacles - Lack of money. More than a billion people, mainly in low- and middle-income countries, are unable to access needed health services as these are unaffordable [28]. Lack of money is regarded as the most fundamental factor, being often the precursor agent of all other and very often is associated with the complete or limited existence of health insurance coverage. This category includes the partial or absolute poverty.

2. Barriers to access to health services. Access barriers, also, can be classified in some basic sub categories. So there are:

-Geographical barriers such as lack of health centers in accessible distance, bad roads, lack of public transport, impossibility for home treatment, especially in rural areas [29],

-Organizational barriers such as long queues waiting and delays may be prohibitive for a pressed time employee. In addition other organizational barriers may be absence of wheelchairs, Braille and accompanying facilities to serve people with special needs, no foreign language material, translators and staff who will be able to communicate efficiently with foreign migrants [30],

-Cultural differences. Culture and ethnicity have often been cited as barriers in establishing an effective and satisfying relationship with patients. Cultural differences may come from patients or healthy people, who contact the medical system as a precaution. The main problems of culture-related communication are identified as: cultural differences in explanatory models of health and illness, differences in cultural values, cultural differences in patients' preferences for doctor–patient relationships, racism /perceptual biases/ taboos and linguistic barriers [31].

1. The illness was not serious. According to the SACOCO study, third category of reasons related to the non-approach of patient in the health system was the small gravity of illness or significant improvement.

2. Other obstacles. This category includes all kinds of events that cannot be included in the previous classifications as some combination of the above reasons.

It appears that there are some groups that are more vulnerable to social exclusion usually have to deal with a combination of all these barriers when they try to have their first contact with the services of a health system even with theoretically easily reach primary health services. Such vulnerable groups are mainly the following [32]:

•People experiencing poverty, homeless, unemployed and mainly chronic unemployed
•Elderly
• People with chronic health problems
• People with mental or psychiatric disorders
•Drug users, former drug addicts, ex-prisoners
• Single parents
•Religious/ national minorities
•Immigrants and refugees
•Gays, transsexuals, people who work in the sex industry
•Victims of trafficking

Specifically, national/nationality minorities, economic and political refugees suffer today internationally intense social exclusions and exclusions also in the social good of accessibility to health services, especially in primary health care. The main obstacle that might have to deal with these vulnerable groups is the first contact and communication in a

foreign language. The lack of a common language is accompanied by the additional barriers of lack of information materials to foreign languages, lack of translators and information from the host country [33]. Most health care organizations provide either inadequate interpreter services or no services at all [34].
Since armed unrest erupted more than 4 (four) years ago in Syria, resulting in huge movements of the population inside the country spilling into neighboring countries, millions of people are in need of assistants. A series of outbreaks of war are still raging in the Mediterranean region and producing horrible effects with a considerable number of refugees. Studies relating to conflicts of the past suggest that the mental health consequences of these wars may affect future generations for many years [35]. Health organizations and their staff have been working to ensure that: life-saving medicines and medical supplies reach Syrians and the region's host populations and governments, technical assistance is given to the region's ministries of health, with health care workers being trained and mass vaccination campaigns are supported [36].
Financial burden is the main reason that many health care providers do not provide adequate interpreter services. Often, persons enlisted to help patients communicate with health care providers are not trained interpreters. Instead, they are fellow patients or are family members, friends, untrained nonclinical employees, or non-fluent health care professionals [37]. Reliance on such services has been shown to have negative clinical consequences. These health care providers fail to take into consideration both the consequences of not providing services and the potential cost benefits of improving communication with their patients [38].
In addition, health professionals are not sufficiently trained to problems that may arise by differences of culture, taboo, habits and beliefs regarding health, resulting prejudices and stereotypes. From the perspective of "foreign" patients fear for bad or wrong therapy, stigmatization of certain diseases, poor communication and the expulsion in security (immigration status) result in misunderstandings with health professionals [33, 37].

5 Conclusion

Human rights as the accessibility to health services are protected internationally. A number of international laws, guidelines and conditions with main shaft perhaps the EU Charter of Fundamental Rights is somehow present to protect especially vulnerable individuals and groups. However, the road remains long, with unfulfilled obligations if there is:

- Need for improvement and development of health infrastructures
- Need to offer proper health service at the right time and the right place
- Need to ensure health for all different population groups
- Need for comprehensive training of workers in the field of health
- Need to improve access in terms of transparency and social justice and principle of access to health care services.

We know what make us ill
When we are ill we are told
That it's you who will heal us
When we come to you
Our rags are torn of us and you listen all over our naked body

As to the cause of our illness one glance at our rags would tell you more
It is the same cause that wears out our bodies and our clothes

Worker's Speech to a Doctor, Bertolt Brecht (1898-1956)

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