III. Poverty and vulnerable groups

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Socio-economic structure of patients and their reasons for visiting pro bono clinics in Slovenia

Abstract

Background: In every country are groups of people who have trouble accessing health services, therefore they are categorized as vulnerable groups. In Slovenia, several towns have pro bono clinics for these groups, but the knowledge about them is very poor. In our research we have set out to analyse users of these clinics.

Methods: We carried out a cross-sectional research in four pro bono clinics in Slovenia with the questionnaire. The data collection lasted from the beginning of March 2019 until the end of October 2019.

Results: Among visitors of the clinics 48.3 % were unemployed, 61.7 % are non-Slovene citizens, 68.3 % do not have a permanent residence and 68.3 % of them have been visiting the clinic for more than a year. The most common reason for visiting the clinics are acute diseases. 96.7 % of patients treated in the clinics were very satisfied with the treatment.

Conclusion: Pro bono clinics in Slovenia are mostly visited by patients from vulnerable groups who have also most difficulty in accessing health services. In our study, we found no differences in disease between the at-risk vulnerable group and the general patient population.

1. Introduction

The term »pro bono publico« (abbreviated »pro bono«) comes from Latin and means good for the people. This is not traditional volunteer work, but it is about professionals from different fields (e. g. law, health, medicine) offering specific services to those people who cannot afford them.[1] In the field of healthcare, there are pro bono clinics

[1] Merriam-Webster: pro bono. https://www.merriam-webster.com/dictionary/pro%20bono (accessed 14. 9. 2019).

intended for people without health insurance. These people mostly belong to special groups of the population, which can be called »vulnerable« (lat. vulnerabilis) groups and thus indicate both the »vulnerability« of their bodies or greater susceptibility to certain diseases and their exclusion in the health system and society. Vulnerable groups are considered to be very heterogeneous, consisting of migrants, the homeless, the elderly, drug users, the unemployed, people with mental health problems, Roma, the self-employed, people with precarious employment and people with various forms of disability.[2] In many countries like the United States of America (USA), pro bono health services are the ethical responsibility of healthcare providers who try to provide fair care and non-discriminatory treatment to all, especially if the health insurance is a privilege, not a basic right. The study of Khan found out, that the policy »(…) has created large sector of socio-economically disadvantaged people who live in the USA who do not qualify for healthcare and are largely unable to afford access to healthcare services.«[3] In 2017, 27.4 million (10.2 %) adults (0–64 years) were registered without health insurance. The most common reason for this was excessive financial costs (44 %), followed by job loss or change of employment (22 %). The majority of uninsured people were adults (19–64 years old), in working families (at least 1 family member is employed) and in low-income families. Significantly higher rates of uninsured adults were among Latinos (19 %) and blacks (11 %) compared to whites (7 %).[4]

Unlike the USA, health insurance is universal in the United Kingdom (UK). This means that all residents of the UK are automa-

[2] Uršula Lipovec Čebron, Marjeta Keršič Svetel, Sara Pistotnik: Zdravstveno marginalizirane – »ranljive« skupine: ovire v dostopu do sistema zdravstvenega varstva in v njem [Marginalized health groups – »vulnerable« groups: Barriers to access and within the health system]. In: Jerneja Farkaš-Lainščak (Ed.): Ocena potreb uporabnikov in izvajalcev preventivnih programov za odrasle: ključni izsledki kvalitativnih raziskav in stališča strokovnih delovnih skupin [Assessing the needs of users and providers of adult prevention programs: key findings from qualitative research and the views of expert working groups]. Ljubljana 2016, pp. 14–25.

[3] Lori Khan: A Study on Legal and Ethical Issues Surrounding Health Practitioner Pro Bono Services. In: The Online Journal of Health Ethics 6 (2010), https://doi.org/10.18785/ojhe.0602.01.

[4] Jennifer Tolbert, Kendal Orgera, Natalie Singer, Anthony Damico: Key Facts about the Uninsured Population. Henry J Kaiser family foundation, Issue Brief 2019. https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/ (accessed 15. 9. 2019).

tically entitled to healthcare services, which is mainly free of charge at the point of care. For people, such as non-European visitors and undocumented immigrants, only the treatment of emergencies and certain infectious diseases is free.[5]

However, the organization Doctors of the World, which operates worldwide, notes that even in the UK many people (especially asylum seekers, vulnerable migrants and those unable to pay for healthcare) do not have access to public health services or they are often rejected by primary care staff.[6] Similar situation is also in Germany, where the Ärzte der Welt (Doctors of the World) operates.[7] In Germany refugees and undocumented immigrants are covered by social security in cases of acute illness and pain, as well as pregnancy and childbirth.[8]

The problems associated with vulnerable groups and healthcare are not only present in the UK and Germany but also several other European countries. The study, conducted in as many as 14 European countries from 2007 to 2010, examined the experiences and views of mental health professionals for six socially vulnerable groups. Four components have been identified that represent good practice in the field of mental health: setting up programs to raise awareness and work with people about mental disorders; facilitate access to services; strengthening cooperation and coordination between different services; disseminating information about services to both vulnerable groups and health professionals in the area. All this reflects common features in countries and groups, despite the differences between them, and can therefore be understood as generally applicable.[9]

Difficulties in accessing healthcare are also encountered in the countries of the African continent. One of them is certainly Uganda, where many poor people cannot afford to pay directly for healthcare. To improve access to healthcare for these people, Community Based

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[5] The Commonwealth Fund: International Health Care System Profiles. https://international.commonwealthfund.org/features/who_covered/ (accessed 16. 9. 2019).

[6] Ärzte der Welt: Menschen ohne Krankenversicherung. https://www.aerztederwelt.org/wem-wir-beistehen/menschen-ohne-krankenversicherung (accessed 26. 9. 2019).

[7] Ärzte der Welt: Menschen ohne Krankenversicherung (Note 6).

[8] The Commonwealth Fund: International Health Care (Note 5).

[9] Stefan Priebe, Aleksandra Matanov, Ruth Schor, Christa Straßmayr, Henrique Barros, Margaret M. Barry, José Manuel Diaz-Ilalla, Edina Gabor, Tim Graecen, Petra Hocnerova, Ulrike Kluge, Vincent Lorant, Jacek Moskalewicz, Aart H. Schene, Gloria Macassa, Andrea Gaddini: Good practice in mental health care for socially marginalised groups in Europe: a qualitative study of expert views in 14 countries. In: BMC Public Health 12 (2012), https://doi.org/10.1186/1471-2458-12-248.

Health Insurance has been introduced as recommended by the World Health Organization. The impact of this measure on human health was demonstrated by a study conducted between January 2015 and June 2017 in rural south-western Uganda. The results showed that during this time, the introduction of voluntary health insurance in the community increased the use of healthcare and reduced mortality of children under 5 years of age.[10]

In Slovenia, health insurance is compulsory and voluntary. The scope of the first is determined by the Health Care and Health Insurance Act.[11] However, some people may experience limited access to the healthcare system. The right to cover the contribution for compulsory health insurance in the case of socially disadvantaged people is not an independent right, but is conditioned by other rights, it is influenced by any of the reasons for not receiving cash social assistance.[12] In recent years, the economic crisis has led to an increase in the number of people unable to pay contributions for compulsory health insurance (abbreviation in Slovene OZZ), and therefore an increase in the number of people with reserved rights to health services, but still Slovenia provides funds for emergency treatment from the budget for all persons, including foreigners, who are not included in the OZZ and are not insured in another country.[13]

According to the Health Insurance Institute of Slovenia in September 2018 were 651 persons without OZZ. This relatively small number is possible, because of co-financing of assistance, counselling and care programs for persons without compulsory health insurance that started in 2017 with the key objective of reducing the number of persons without compulsory health insurance, and increasing the

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[10] Nahabwe Haven, Andrew E. Dobson, Kuule Yusuf, Scott Kellermann, Birungi Mutahunga, Alex G. Stewart, Ewan Wilkinson: Community-Based Health Insurance Increased Health Care Utilization and Reduced Mortality in Children Under-5, Around Bwindi Community Hospital, Uganda Between 2015 and 2017. Frontiers in Public Health 6 (2018), https://doi.org/10.3389/fpubh.2018.00281.

[11] Amendments to the Health Care and Health Insurance Act 2019. Official Gazette of Republic Slovenia No. 36/19.

[12] Martina Bofulin, Jerneja Farkaš Lainščak, Karmen Gosenca, Ajda Jelenc, Marjeta Keršič Svetel, Uršula Lipovec Čebron, Sara Pistotnik, Juš Škraban, Darja Zaviršek: Kulturne kompetence in zdravstvena oskrba: priročnik za razvijanje kulturnih kompetenc zdravstvenih delavcev [Cultural competences and health care: a handbook for developing the cultural competences of health professionals]. Ljubljana 2016.

[13] Bofulin, Farkaš Lainščak, Gosenca, et al.: Kulturne kompetence (Note 2).

transition of uninsured persons to the public health system.[14] According to data for 2021, in Slovenia, more than 130,000 people had no access to a general practitioner.[15]

The first pro bono clinic started operating in January 2002 and still operates successfully today.[16] The former head of the pro bono clinic Alexander Doplihar found out that the most common diseases of users of this clinic are: diseases related to the inability to take care of personal hygiene, diseases associated with excessive alcohol consumption, smoking-related diseases and mental health problems.[17]

There are currently seven pro bono clinics existing in Slovenia. Four of them were included in the research: the pro bono clinic in Koper, the Mobile Asylum Clinic in Ljubljana, the outpatient clinic for persons without compulsory health insurance with a consultation room – Maribor and the pro bono clinic in Murska Sobota/Tišina.

The purpose of our research was to determine the socio-economic structure of patients who visit these pro bono clinics in Slovenia and the reasons for their visits, as the knowledge of patients who visit these clinics in Slovenia is very poor.

2. Methods

We carried out a cross-sectional research in four pro bono clinics (Koper, Maribor, Ljubljana – mobile refugee clinic and Murska Sobota/Tišina). The subjects were patients who visited the above-mentioned pro bono clinics and agreed to participate in the study, which means that they solved a paper questionnaire when visiting the clinic. The data collection lasted from the beginning of March 2019 until the end of October 2019.

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[14] Public tender for co-financing of programs of assistance, counselling and care for persons without compulsory health insurance, for the years 2017 and 2018. Official Gazette of Republic Slovenia No. 3/2017.

[15] Sarah Neubauer: Iskanje osebnega zdravnika je skoraj misija nemogoče. N1SLO, 26. 6. 2021. https://n1info.si/novice/slovenija/osebni-zdravnik/

[16] Ambulanta s posvetovalnico za osebe brez zdravstvenega zavarovanja, Pro Bono [An outpatient clinic with a counselling centre for people without health insurance, Pro Bono]. https://www.ordinacija.net/members/www-pzs.php?mg_pzs_id=74&lang= (accessed 17. 9. 2020).

[17] Bofulin, Farkaš Lainščak, Gosenca, et al.: Kulturne kompetence (Note 2).

Confirmation and consent for the implementation of this quantitative descriptive research was given by the Commission of the Republic of Slovenia for Medical Ethics on 21 February 2019 under number 0120–379/2018/9.

Data were collected using a two-part questionnaire. The first part (Demographic data) was compiled with the help of the manual Methodological explanations – Socio-economic characteristics of the population and migrants, published by the Statistical Office of the Republic of Slovenia.[18] In this part, we asked patients about demographic data: gender, age, education, activity status, citizenship, country of birth, mother tongue, understanding of the Slovenian language and residence. The second part (Reasons for visiting the clinic) was compiled by us. This part of the questionnaire was completed by the patients together with the doctor. We asked them how many times they visited the clinic, how long they have been visiting it, why they visited it that day when they filled out the questionnaire, what disease (or diseases) they have and how satisfied they are with the visit to the clinic. The doctor filled in the part of the questionnaire where the diagnosis of the disease had to be written in words or with a code from the MKB-10 classification.

The questionnaire was first validated on 20 randomly selected patients who visited the family doctor's clinic at the Gornja Radgona Health Centre. Each subject (patient) received a questionnaire in Slovene in paper form when visiting the pro bono clinic. The first part of the questionnaire was completed by the patients themselves, and the second part together with the doctor. If any of them had difficulty completing the questionnaire (poor understanding of the Slovenian language, poor literacy), the person was assisted in completing it by the head of the clinic or another employee in the pro bono clinic (nurse, volunteer) appointed by the head of the clinic and we previously educated him on how to help complete the questionnaire. Each subject completed the questionnaire only once, but not during repeated visits to the clinic.

[18] Barica Razpotnik: Methodological explanation. Socioeconomic characteristics of the population and migrants (2017). https://www.stat.si/StatWeb/File/DocSysFile/8351 (accessed 21. 10. 2019).

3. Results

The study involved 60 patients from four pro bono clinics in Slovenia. Patient demographics are given in Table 1.

	n = 60	**%**
Gender		
Male	34	56.7
Female	26	43.3
Education		
incomplete primary school	21	35.0
primary school	8	13.3
vocational school	11	18.3
secondary vocational or high school	17	28.3
college	3	5.0
	AV±SD	range
Age in years	43.7±18.1	7–86

Table 1: Patient demographics (AV = average value; SD = standard deviation)

Most patients were in age group 30–39 years 20 %, then 40–49 years 18.3 % and 50–59 years 15.0 %, less were in other age groups: < 64 years 13.3 %, 60–64 years 11.7 %, 20–29 years 10 %, < 15 years 6.6 % and 15–19 years 5.0 %. In activity status, the results showed that 5.0 % patients were employed, 48.3 % were unemployed, 8.3 % were pupils or students in high school, 1.7 % were students in college, 6.7 % were retired and 30 % were other.

Among the patients, there were 3 (5 %) statelessness patients, 21 (35 %) patients with Slovenian citizenship and 36 (60 %) patients who had other citizenship: 1 patient had USA (United States of America) citizenship, 1 Ukrainian, 9 Serbian, 1 Slovak, 1 Syrian, 3 Northern Macedonian, 1 Russian, 2 Romanian, 1 Moroccan, 3 Kosovo, 1 Iranian, 2 Croatian, 1 French, 1 Eritrean, 2 Bulgarian, 3 Bosnia and Herzegovina (BIH) and 3 patients had Afghan citizenship. Some patients have changed citizenship because the country of birth was not the same as current citizenship. According to the country of birth, the

results showed that 2 patients are born in Union of Soviet Socialist Republics (USSR), 4 in Serbia, 20 in Slovenia, 1 in Syria, 3 in Northern Macedonia, 1 in SFRY (Socialist Federal Republic of Yugoslavia), 2 in Romania, 2 in Germany, 1 in Morocco, 1 in Hungary, 8 in Kosovo, 1 in Iran, 2 in Croatia, 1 in France, 1 in Eritrea, 1 in Montenegro, 1 in Czechoslovakia, 2 in Bulgaria, 3 in BIH and 3 patients are born in Afghanistan.

Only 30 % of the pro bono clinics visitors used Slovene as their mother tongue. Other mother tongues were: Serbian 21.7 %, Bosnian 6.7 %, Farsi/Dari 6.7 %, Croatian 5 %, Macedonian 5 %, Albanian 5 %, Bulgarian 3.3 %, Romanian 3.3 %, Russian 3.3 %, Arabic 3.3 %, Czech 1.7 %, Hungarian 1.7 %, French 1.7 % and Eritrean 1.7 %. Among those visitors to the pro bono clinics whose mother tongue was not Slovene: 40.5 % understood and spoke Slovene well, 28.6 % understood Slovene, but didn't speak it well or didn't it speak at all, 16.7 % understood and spoke Slovene poorly and 14.3 % didn't understand or speak Slovene at all.

68.3 % of patients were without permanent residence in Slovenia. Among these patients 26.7 % had temporarily residence, 28.3 % had unreported residence, and 13.3 % had other.

Regarding the frequency of visits to pro bono clinics: 76.7 % of patients visited the clinic at least three times, 15 % visited the clinic twice and 8.3 % visited the clinic just once.

The results regarding the duration of visits to pro bono clinics are: first visit 8.3 %, up to 2 weeks 5 %, up to 1 month 5 %, 12 months or less 13.3 % and more than 1 year 68.3 %.

The most common reason for visiting pro bono clinics among visitors was acute diseases 38.3 %. Other reasons were: exacerbation of a chronic disease 18.3 %, chronic and emerging problems 18.3 %, prescription recipe 16.7 %, control visit 11.7 %, mental health problems 10 % and other 6.7 %.

For the reasons for visiting pro bono clinics, we also analysed the frequency of individual groups of diseases between acute and chronic diseases. Among the patients, 30 acute medical conditions were recorded and classified into groups: respiratory diseases 23.3 %, infectious diseases 23.3 %, injuries 16.7 %, skin and subcutaneous tissue disorders 13.3 %, gastrointestinal diseases 10 %, urinary tract and genital diseases 10 % and symptoms, signs 3.3 %. Among chronic diseases, circulatory diseases were the most common 28.8 %, then mental and behavioural disorders 21.2 %, endocrine diseases 15.2 %,

diseases of the musculoskeletal system 6.1 %, skin and subcutaneous tissue diseases 6.1 %, infectious diseases 4.5 %, eye diseases 3 %, urinary and genital diseases 3 %, gastrointestinal diseases 3 %, neoplasms 3 %, nervous system diseases 3 %, blood diseases 1.5 % and ear diseases 1.5 %.

Visitors of the clinics were very satisfied with the treatment in 58 cases (96.7 %) and gave a grade of 5, one patient gave grade 4 (satisfied) and one patient gave grade 3 (moderately satisfied). No one gave grade 2 (not satisfied) and grade 1 (not at all satisfied).

4. Discussion

4.1 Discussion of results

The majority of patients attending pro bono clinics (hereinafter referred to as patients) are male, with lower education (incomplete primary and primary education) and the working age population (15–64 years), but also the majority are unemployed, without permanent residence and those who they do not have Slovenian citizenship. We would also like to draw attention to the second most common response to the status of »other« activities (Table 1), which included recipients of social and other benefits and allowances, family members of insured persons (housewives), recipients of state pensions, other inactive persons registered for health insurance and migrants. This described group of patients belongs to vulnerable groups of the population already described. We could conclude that pro bono clinics in Slovenia are mostly visited by patients who are »vulnerable« and have the most barriers to accessing health services. An additional obstacle for these patients is the language, as most patients do not speak Slovene as their mother tongue and most of them do not understand or speak Slovene, so they also needed help in solving the questionnaire and were helped by people working in pro bono clinics (nurses, doctors or volunteers).

Mostly, patients are multiple visitors (they visited the clinic for the third or more time) and long-term (they visit the clinic for more than 1 year). This may indicate that it is not so easy to arrange health insurance in short time and therefore they remain marginalized in society or »vulnerable«. Thus could also make them more susceptible to certain diseases. Further research would be needed to assess the

reasons why they have not been able to regulate their status for a relatively long time. When analysing disease diagnoses, we considered only physician codes from the ICD-10 classification; as many times the patient's self-reported disease did not match the doctor's record, and also the doctors mostly recorded more diagnoses than the patient. The most common reason for visiting the clinic among patients were acute illness, and among these on the first place were infectious and respiratory diseases, which is similar to a regular family doctor's clinic – where are the most common reason for visiting acute respiratory disease.[19] Viruses are the most common cause of acute respiratory infections,[20] so it can be assumed that respiratory infections also occurred in the group of infectious diseases and among patients of pro bono clinics are the most common respiratory infections as well as in the family doctor's clinic. Among chronic diseases, they were in first place circulatory diseases. Circulatory diseases or cardiovascular diseases have been the most common cause of morbidity and mortality in adults in the developed part of the world and in Slovenia for decades.[21] Patients who visit pro bono clinics mostly belong to the adult population and are therefore similar to other patients in Slovenia in terms of the most common chronic disease. On the second place in pro bono clinics patients are mental disorders. This result is to be expected, as vulnerable groups also include people with mental disorders.[22] On third place in chronic diseases are endocrine diseases, among which all but one response (hypercholesterolemia) was diabetes. The National Institute of Public Health (NIJZ) finds that diabetes, as one of the chronic diseases, is not only a problem of the developed world, but is increasingly a reflection of economic and social determinants of health, such as poverty and lack of education.[23] In our research, this two determinants of health were found to be the most common in pro bono patients.

With our research we can confirm that most patients were very satisfied with the treatment in pro bono clinics, which indicates a

[19] Igor Švab, Rotar Pavlič: Družinska medicina: Priročnik za mentorje študentov [Family Medicine: A Handbook for Student Mentors]. Ljubljana 2012.
[20] Švab, Rotar: Družinska medicina (Note 8).
[21] Nacionalni inštitut za javno zdravje: Srčno-žilne bolezni [Cardiovascular diseases]. https://www.nijz.si/sl/srcno-zilne-bolezni (accessed 22. 12. 2019).
[22] Lipovec Čebron, Keršič Svetel, Pistotnik: Zdravstveno marginalizirane (Note 2).
[23] Nacionalni inštitut za javno zdravje: Sladkorna bolezen [Diabetes]. https://www.nijz.si/sl/sladkorna-bolezen (accessed 22. 12. 2019).

well-organized clinic with friendly staff who have a respectful attitude towards these patients.

4.2 Discussion of methodologies and research limitations

Two questions from the first part of the questionnaire were excluded from the analysis: previous and future citizenship, as more than half of the patients did not solve these questions. Additional analyses would be needed to determine why patients did not want to answer these two questions.

The problem was also the language in some places, as the questionnaires were written only in Slovene. Some problems caused also the illiteracy of some of the patients. We solved it by assisting patients (translating, writing answers) in individual clinics with the supervisors or with the medical personal – chosen by supervisors, if patients allowed it and the confidentiality of the data was maintained.

One of the limitations of our research is also the small sample of patients. So, we could not generalize the conclusion of our research. With a larger sample we also may showed links between patient's demographics and their illnesses. Other pro bono clinics in Slovenia could be included in the research in order to obtain more accurate data for the whole of Slovenia, as well as various comparisons between clinics with larger samples of individual pro bono clinics. This would better represent the condition of patients in pro bono clinics in Slovenia and the needs of these clinics in terms of staff, supply of materials, medicines, aids, etc., and at the same time this could be the basis for policy to solve their problems with health insurance and consequently reducing health inequalities.

5. Proposals

It would be good if pro bono clinics worked with social services to help patients with financial care, housing, and finding jobs, as many patients are socially at risk. Pro bono clinics, in addition to the equipment that family medicine clinics have, also need a set of drugs to treat the most common acute and chronic diseases. We could also explore which medicines are most commonly used in pro bono clinics so that these clinics can secure a range of unused medicines from health-

care facilities or from other patients in advance. Patients who do not have health insurance also visit the family doctor's clinic on a regular basis. In the event that a patient does not need urgent treatment, family medicine teams should know the place and working hours of the nearest pro bono clinic to which they can refer these patients. Medical teams could be involved in the work of pro bono clinics if the need arises – this could be the subject of future research on pro bono clinics.

6. Conclusion

Pro bono clinics are still needed in Slovenia and mostly have to operate regularly, at least once a week. At work, they need staff who – in addition to medical knowledge – are also proficient in communication and approach to less educated and illiterate patients, be able to communicate in some foreign languages, especially languages from the former Yugoslav member states, or provide a translator and develop cultural skill competencies.