

Summary

The dissertation is devoted to the subject of social inequalities in the health status of the population. It has been shown by earlier research that the health behaviours and health outcomes of socio-economic groups of the population strongly differ and, what is more, these inequalities are persistent and tend to increase over time. These tendencies were confirmed in countries of Western Europe and the United States, but there is little research on the subject in countries that have undergone economic transition in the last few decades, such as Poland. Demographers indicate that the improvements in the economic and social well-being of the population have contributed to health improvements, but there is little evidence of health inequalities (WHO 2009).

The main research questions in the first part of the dissertation are related to the size of the health improvements, their causes and peculiarities. Next, educational inequalities in health are examined. Finally, the impact of how unfavourable material circumstances, unhealthy behaviours and lack of social ties negatively impact on health is discussed.

The second part of the dissertation moves from the subject of health itself to issues important for the efficiency of the health care system, namely access to medical services. Obviously, access to services and their utilization might have a health effect, which makes the two phenomena related. The research questions asked in this part of analysis are whether educational inequalities in the utilization of doctor's visits, hospitalization and dentistry exist, and – if so – how they change over time. Further social and economic constraints to the utilization of the mentioned types of medical services are identified.

Finally, the important policy question of adequate targeting the causes of inequalities in health status or medical services utilization by national policies is considered.

The research begins with a discussion of possible causes of health inequalities. It refers to the theoretical framework proposed by Marmot (2003, 2006) and Bartley (2004) in which health inequalities are seen as an outcome of various underlying life circumstances, from material well-being, a willingness to lead a healthy life-style, an individual's psycho-social environment, access to health care services and having the skills to make a proper use of them. Accepting the approach that causes of health inequalities are multidimensional, the research then goes on to look at these factors more closely in the material status of the family, in the reasons why individuals take up unhealthy behaviours such as smoking and alcohol consumption and in the impact of social networks. The selection of types of explanations of health inequalities was determined by the type of data available. Naturally some variations in people's health are attributable to biology and genetics; however, these are referred to as health differences as opposed to health inequalities and are not the subject of this investigation. The research concentrates on inequalities that might be attributable to social conditions in which individuals and groups live. Another point made here is relation to the definition of terms is how inequalities are distinguished from inequities. While research into inequalities looks for social causes of health differences among individuals and groups, research on inequities goes a step further by evaluating whether existing inequalities are unfair. In this research the question of fairness is not asked as the task at hand is to recognize the size of inequalities and their possible determinants.

The analysis begins by showing the dynamics of the health improvement of the Polish population in the decades following the collapse of the communist regime. The health of Poles improved due to various reasons, with the main direct cause of the decrease in mortality being that of a drop in cardiovascular system diseases. Among the indirect causes of health improvement are the opportunities brought by the transformation: changes in state of mind of the society that accompanied political and economic transformation; greater availability of fresh products, especially fruits and vegetables throughout the year; dietary changes, especially decrease in consumption of animal fat; and finally behavioural changes with greater concern being shown by individuals to their health, which is reflected in taking up physical activity and decreases in smoking. These positive changes are reflected in increasing life expectancy which is among the highest in the Central and Eastern Europe (CEE) region, but well behind countries of Western Europe. Similarly, time spent in poor health and disability in Poland is shorter than in most of the CEE countries but much longer than in some Western European countries, especially in Scandinavia. The latter finding has an important implication for health policy, showing that further public health actions are needed to improve the quality of people's lives, especially with regard to the elderly who will become a dominant cohort in the next decades.

Health is not equally distributed in the population. Regional analysis of longevity shows that differences of life expectancy between regions was up to 4 years for males and 2.6 years for females in 2009. Interestingly, the highest life expectancies were seen in regions dominated by the traditional, rural populations in the East and South of Poland, while in the heavily industrialized regions (Silesia) or in regions where the population was

resettled after the Second World War (Western and South-Western) worse health outcomes were found. Substantial differences are also noticeable between rural and urban populations. While on average men enjoy longer lives in urban settings, females tend to live longer in rural settings. The latter differentiation might be a lifestyle effect – men are more likely to do heavy work and be prone to unhealthy behaviours (especially the consumption of high levels of alcohol) in the rural environment while women in that environment work less hard than men which has a beneficial health effect. Moreover, the scale of the health improvement also varies between regions. Analysis of trends shows that in regions of Western Poland, where health outcomes were still poor in the 1990s, longevity has substantially improved over the past two decades. As a result differences in health status between East and West Poland might decrease over the next decade. Recognizing substantial regional health inequalities, it is difficult to track their social correlates, but the analysis indicates that among the social causes the wealth of the population and increasing individual opportunities given by higher incomes have a positive health impact.

The main research question and focus of the study is of the existence of health inequalities at the individual level. For their assessment health survey data from 1996 and 2004 are used and concentration curves and concentration indices are the main measures used to assess the size of health inequalities. Analysis shows that not only do health inequalities in less-than-good and poor health between educational groups exist but that they have also increased over time. This result is not unique because – as in all European countries despite their public health efforts to decrease inequalities or rich welfare programmes – educational or income inequalities in health status measured by longevity or self-assessed health are found to have increased over the years. Two facts lie behind the results for Poland: the first is that self-reported health has improved with a large group of individuals shifting from poor to average health status, and the second is that the structure of education has substantially changed with a higher proportion of individuals having higher education. But even controlling for the changes in educational groups, health inequalities in less-than-good health are found to be large and persistent. At the same time groups of individuals with poor and very poor self-reported health are concentrated in lower social strata, accumulating unfavourable social conditions with poorer education, less wealth and poorer access to various institutions and fewer chances for moving upwards on the social ladder. People in the lower social strata experience not only material deprivation but they also tend to live more unhealthily with higher consumption of alcohol and habitual smoking.

When the social determinants of health are examined, the existence of social networks is also found to be important. The significance of having close ties with family was not confirmed as being important for health outcomes, but a belief that assistance would come from an extended network of family and friends if the need arose was found to be significant determinant of health. So, three trends of explanations of health inequalities as proposed by Bartely (2004) were confirmed: material deprivation, unhealthy behaviours and social support are all important correlates of health status.

Since health inequalities exist, the question whether the healthcare system stimulates their existence arises. What is meant by “stimulation” of inequalities is that access to medical services is restricted to lower social strata while higher social groups do not face similar constraints. Again, education is used as a marker of social position and concentration curves/indices are the basic measures for assessing the size of inequalities. Before concluding on inequalities it is worth noting that utilization of all types of services – even costly ones such as dentistry – strongly increased between 1996 and 2004. This happened despite the fact that a reform of the healthcare system was introduced in 1999 with cost-control mechanisms of having gate-keepers in primary care. Growing utilization of all types of care, including that by the elderly, has important implications for the efficiency of the healthcare system as it could contribute to increasing waiting times for services and increasing costs for the healthcare system. Higher utilization of medical services could be attributed to increasing health awareness. Improved economic conditions combined with more attention given to care could have a positive impact on the health of the population in the future, but it could also lead to an increase in health expenditure due to a rising demand for medical care, especially for more costly treatments. Still, medical services such as visits to doctors and hospital care are equally distributed between educational groups. Unfortunately distinguishing primary from secondary care was impossible. These findings are similar to results of analyses conducted in most of the OECD countries, but not in Poland, where primary and tertiary care were found to be equally or even pro-poor distributed (Doorslaer et al. 2006). However, results of an analysis of dentistry indicates large inequalities in utilization. They might be caused by the fact that dentistry is an expensive treatment, which is only in a very restrictive manner covered by health insurance and so costs are covered mostly out of pocket. An increase in utilization of dentistry, even in older cohorts, suggests that care for teeth is becoming a social status factor with a growing need for this type of care, but availability of services for lower social strata is not satisfactory.

To sum up, the results of the analysis of existing inequalities in health and access to medical services are contrasted with national policies towards health inequalities. An overview of strategic documents with

respect to health and healthcare shows that while health improvement has been articulated as a policy goal since the mid-1990s, social and economic inequalities in health have only been targeted by the National Health Programme which was introduced in 2007. Health policies are dominated by the medical approach which means that direct causes of inequalities are addressed (illness and causes of mortality), but little attention is given to social determinants of health. At the same time national policies recognize that regional inequalities are large, but recommendations on specific actions targeting the problem are vague. The results of the presented research show which regions are more deprived with respect to health clearly indicating that more policy actions should be targeted those regions with the poorest health outcomes and less dynamic health improvement throughout the whole process of economic transformation. Addressing the issue of health inequalities between social groups needs action in at least three areas: health education stimulating more care and healthy living, access to education that increases individual life opportunities, and actions against poverty.

Finally, it should be underlined that any successful policy on health inequalities is not possible without proper data on health and the social and economic status of the population. Typically there is administrative mortality data available but it does not tie in with any socio-economic data. The only source that could combine both types of data is survey research, but as yet no analysis on the size of inequalities has been undertaken. Thus an important policy implication is related to the data collection. Namely, more data combining health, social and economic aspects are needed and tools to measure inequalities on a regular basis should be developed. These tools could be of further use for the implementation of policy measures against inequalities, as they are stated in the National Health Programme. The last important policy implication is that any policy on health inequalities should go beyond the basic activities of the Ministry of Health, being also a subject of interest for the Ministry of Education, the Ministry of Labour and for Social Policy so that a concerted effort is made against the health inequalities that have been pointed out in the previous paragraphs.