

Adaptation of Physical Environment in Health Care Institutions for People with Disabilities Caused by Musculoskeletal System and Connective Tissue Disease

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Abstract. *The UN World Health Organization has set a goal to ensure people-oriented universal, equal, sustainable and high quality health systems which would give priority to prevention of diseases, continuous perfection of quality, integrated provision of services, assurance of continuous care, development of patients' self-care, relocation of care close to home by 2020. People with disabilities and their opportunities to equally participate in the health system like other citizens occurred in the high focus because over recent decades various international documents acknowledge that, despite various measures and obligations, people with disabilities face violations of their rights in various spheres of living worldwide. The paper presents the research that aimed at investigating the adaptation of physical*

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environment in health care institutions focused on people with disabilities caused by the disease of the musculoskeletal system and connective tissue. The research suggests that people with disabilities caused by the disease of the musculoskeletal system and connective tissue face a greater burden, and the disability has become an obstacle to their enjoyment of human rights and freedoms in the health system. This testifies to the fact that the Lithuanian state does not guarantee this part of its citizens the same quality of health services as other citizens, as provided for in the United Nations Convention on the Rights of Persons with Disabilities (2006).

Keywords: *Healthcare, quality, disability, environment*

Introduction

The UN Convention on the Rights of Persons with Disabilities (2006, Art. 2) draws public attention to the fact that in some areas of life, people with disabilities face a “disproportionate and unreasonable burden” compared to others. This provision of the Convention has not lost its relevance to date. Recent research shows that people with disabilities experience inaccessibility of cultural venues and content (Leahy & Ferri, 2023), less happiness, less life satisfaction, and more anxiety (Emerson, Fortune, Aitken, Hatton, & Stancliffe, Llewellyn, 2020), have fewer opportunities to develop skills as professionals (Leahy & Ferri, 2023), face multiple barriers to participation in different life domains (Aitken, Bishop, Disney, George, Emerson, Kavanagh, 2022). Therefore, it is also transferred to more recent documents, such as the Council of Europe Disability Strategy 2017–2023 (2017). The latter document emphasizes that disability can become an obstacle to people’s enjoyment of all human rights and fundamental freedoms, putting them at greater risk of institutionalization, exclusion and poverty. In the interests of equality for all, the Convention (Article 5) calls on all states to take action to reduce this burden. In applying this provision, the Council of Europe Disability Strategy 2017–2023 (2017) calls for measures to prevent new barriers or remove the existing ones.

The provisions mentioned in the main United Nations and European documents are related to the issue of accessibility. Accessibility is described in the UN Convention on the Rights of Persons with Disabilities (2006, Articles 9, 13) as “accessibility of the physical environment, transport, information and communication, facilities or services accessible to the public, and access for people with disabilities to high-quality mobility facilities.” The Council of Europe Disability Strategy 2017–2023 (2017) specifies this description and draws attention to the frequent misjudgment of accessibility only as an evaluation of the urban environment adaptation to people with disabilities. The strategy mentioned above introduces a much broader understanding of accessibility: people with disabilities, like other members of society, must have access to products and services in all the areas of life, both in public and in private sectors.

The European Union aims to increase this kind of accessibility and provides for a specific action program, encouraging both the public and private sectors to take responsibility for accessibility (Council of Europe Disability Strategy 2017–2023, 2017, 35). There is a call for a proactive rather than reactive approach to accessibility (Dolmage, 2008; Oswal, 2019).

Although accessibility includes various aspects, as mentioned before, one of the most relevant is the aspect of accessibility of the physical environment. Both the UN basic documents, and the European Union and national documents emphasize the accessibility of buildings to people with disabilities, so that they can visit the buildings in the same way as other members of society. Lithuania has legally established its responsibility to improve the accessibility of buildings for people with disabilities, has undertaken to improve the legal framework, provide guidelines for the implementation of laws, control their implementation, regardless of the sector to which the buildings belong: public or private (Law on Social Integration of Persons with Disabilities, 2004). Adaptation of buildings for people with disabilities in Lithuania is regulated by the Law on Construction of the Republic of Lithuania (1996), the Law on Social Integration of Persons with Disabilities of the Republic of Lithuania (2004), Technical Construction Regulations, and orders of the Minister of Environment of the Republic of Lithuania. In 2018, the Ministry of Environment of the Republic of Lithuania issued a regulation that technical construction projects should pay attention to universal design (2018 Monitoring Report on the Results of Social Integration Activities of Persons with Disabilities and the United Nations Convention on the Rights of Persons with Disabilities and its Optional Protocol, 2019, p. 39). This decision is based on the belief that choosing a rational and not necessarily expensive universal design can help to avoid or significantly reduce accessibility problems for people (Human Rights: A Reality for All, Council of Europe Disability Strategy 2017–2023, 2017, p. 36). The Convention on the Results of Social Integration of Persons with Disabilities and the United Nations Convention on the Rights of Persons with Disabilities and its Optional Protocol in the 2018 Monitoring Report (2019, p. 41) states that modern public buildings largely meet the requirements of universal design. The problem, however, is that the principles and application guidelines of universal design are still insufficiently regulated (2018 Monitoring Report on the Results of Social Integration of Persons with Disabilities and the United Nations Convention on the Rights of Persons with Disabilities and its Optional Protocol, 2019, p. 39).

In terms of the accessibility of buildings for people with disabilities in the health system, it can be stated that this sphere is being improved in Lithuania. In the very recent past (a decade ago), only a few national laws governing accessibility for people with disabilities existed, covering only new, renovated and modernized buildings, while others were left out and there was no obligation to ensure accessibility for people with disabilities (National Program for the Social Integration of Persons with Disabilities 2013–2019, 2012, p. 12.1). Therefore, it is not surprising that at the

time of the adoption of the National Program for the Social Integration of People with Disabilities for 2013–2019, in 2012, there were about 34,000 public buildings (including polyclinics and hospitals) that were not adapted to the needs of people with disabilities. The mentioned program mandated the public and private sectors to adapt a variety of facilities for people with disabilities, including the buildings for providing health care (2018 Monitoring Report on the Results of Social Integration of Persons with Disabilities and the United Nations Convention on the Rights of Persons with Disabilities and its Optional Protocol, 2019, p. 40). Nevertheless, despite these efforts, it has been noted that there are unresolved issues in this area. They are evidenced by the fact revealed in the analysis of the Equal Opportunities Ombudsman's decisions regarding discrimination on the grounds of disability – it was established that more than 70% decisions are related to the availability of the physical environment (2018 Monitoring Report on the Results of Social Integration of Persons with Disabilities and the United Nations Convention on the Rights of Persons with Disabilities and its Optional Protocol, 2019, p. 41).

The above considerations call for a closer examination of the accessibility of healthcare buildings, focusing on people with disabilities due to the disease of the musculoskeletal system and connective tissue. The questions arise: how is the physical environment adapted to these people in the healthcare facilities they visit? What accessibility issues do they usually encounter during their visits? Does these persons' gender, age, the nature of disability, or the reported healthcare institution (hospital/ambulatory clinic/polyclinic) predict accessibility?

Materials and methods

In this article, the authors used a subset of data from the 2018–2021 project aimed at understanding the situation of people with disabilities in the healthcare system, by focusing attention on the adaptability of the physical environment in healthcare institutions for persons with disabilities caused by the disease of the musculoskeletal system and connective tissue.

Participants and sampling. In order to get answers to the questions raised, it was decided to carry out a survey of people with disabilities caused by the disease of musculoskeletal system and connective tissue (PWD) and people who had close ones with such type of disabilities and took care of them (PWDcare). By the time of the survey (2021), there were 221335 people with disabilities in Lithuania (<https://socmin.lrv.lt/lt/veiklos-sritys/socialine-integracija/negalios-reforma-ir-asmenu-su-negalia-itrauktis/statistika-2/>). No accurate data could be found on people with disabilities caused by musculoskeletal and connective tissue diseases. Nonprobability purposive sampling was used in this study. In order to create equal opportunities for all people with disabilities and their relatives to participate in the survey, the Lithuanian Disability Forum (www.lnf.lt), uniting 14 nongovernmental organizations operating in

Lithuania, focusing on people with disabilities was approached for mediation. However, to our invitation to take part in the study responded 69 people with disabilities caused by the disease of musculoskeletal system and connective tissue (PWD) and 54 people who had close ones with such type of disabilities and took care of them (PWDcare).

The majority of respondents were females: 66.7% PWD ($n = 46$) and 87.0% PWDcare ($n = 47$). Males were 33.3 % in PWD ($n = 23$) and 13.0 % in PWDcare ($n = 7$) groups. The age of participants ranged from 18 to 92 years ($M = 56.1$, $SD = 16.71$) in PWD and from 23 to 70 years ($M = 47.8$, $SD = 12.17$) in PWDcare groups. Less than half of the participants were from big cities (38.2% in PWD, 43.4% in PWDcare), a quarter from district centers (27.9% in PWD, 20.8% in PWDcare), and the rest were from other cities, towns, villages (33.8% in PWD and 35.8% in PWDcare). These and other important topic-specific characteristics are presented in Table 1.

Table 1.

Characteristics of participants by group

Characteristics	Variables	PWD*	PWDcare*
Gender	Females	66.7%	87.0%
	Males	33.3 %	13.0 %
Place of residence	Big cities	38.2 %	43.4 %
	District centers	27.9 %	20.8 %
	Other places	33.8 %	35.8 %
The nature of the disability	Moderate disability	70.6%	68.5%
	Severe disability	29.4%	31.5%
Healthcare institution	Hospital	31.7%	32.7%
	Ambulatory clinic	27.0%	22.4%
	Polyclinic	41.3%	44.9%

Note. * PWD means people with disabilities caused by the disease of musculoskeletal system and connective tissue; PWDcare means people who had close ones with such type of disabilities and took care of them.

Research instrument. In order to examine the adaptation of physical environment for people with disabilities, a 6-item Likert-type scale “Adaptation of physical environment“ (APhE) was developed (see Table 2). The development of the instrument was based on in-depth interviews with people with disabilities, their relatives, doctors, nurses, physiotherapists and other professionals. The interviews asked about the physical environmental barriers that people with disabilities (caused by the disease of musculoskeletal system and connective tissue) face when visiting health care institutions. Based on the responses, 6 key factors of adaptation to the physical environment were identified and transformed into APhE scale items. While answering the questions, the respondents had to use a 5-point scale (1 – strongly disagree, 5 – strongly agree). The scale was piloted with 10 volunteers from the study population and refined in the light of the points raised.

Reliability analysis of the scale was carried out by analyzing the responses of the survey respondents. After the assessment of the reliability of the scale APHE, it was found that Cronbach's alpha coefficient was .793. It was calculated that premovement of one item from the scale would increase the Cronbach's alpha coefficients slightly. In addition, there was not a single item whose resolution of r/iit was less than .2. Considering the mentioned above, it could be argued that the scale is characterized by an internal coherence and is a suitable measurement instrument.

Data analysis. Data analysis was performed by using SPSS 22. Firstly, the total APHE scale score was calculated. The range of scores was from 6 to 30. The median ($Mdn = 21$) is higher than the mean ($M = 20.1, SD = 6.2$) and is closer to the maximum score, showing that major outliers are in the lower end and more scores are above average. The Kolmogorov–Smirnov test was used to indicate the normality of distributions of APHE scores in PWD and PWDcare groups. Since the score did not follow normal distribution ($p > \alpha = 0.05$), the Mann–Whitney test was used to determine the between-groups differences (Rupšienė & Rutkienė, 2016). The Mann–Whitney test indicated that there were no statistically significant differences in the overall score of APHE between PWD ($Mdn = 44.37$) and PWDcare ($Mdn = 41.04$), $U = 806.500, Z = -0.613, p = 0.540$. Therefore, it was decided to analyze the data of the respondents' groups brought together, to calculate descriptive statistics for the APHE items score and to perform Friedman test to detect differences in the scale items score. The multiple regression was used to determine whether the adaptation of physical environment for people with physical disability was predicted by their gender (men/women), age, the nature of disability (moderate/severe disability), or the reported healthcare institution (hospital/ambulatory clinic/polyclinic). In this analysis, independent variables – gender, age, the nature of disability, the healthcare institution (last visited by the respondents) – were entered. There was one dependent variable – APHE. When checking the mentioned regression analysis assumptions, it was determined that tolerance values in all the cases were between .81 and .94, the VIFs (variance inflation factors) were less than 4 (the maximum VIF was 1.230), the Durbin–Watson statistic was adequate (2.107). The correlated analysis of independent variables showed that the highest correlation was .469. The scatter plots have the (approximate) shapes of a rectangle, the scores are concentrated in the center (around 0 point) and distributed in a rectangular pattern without clustering or a systematic pattern. Normal P-P plots indicate that the points lay in a reasonably straight diagonal line from bottom left to top right, and this suggests no major deviations from normality. To look for influential outliers in a set of predictor variables and identify the points that negatively affect the regression model, the Cook's distance was used. The Cook's distance value is .016 less than 1. It suggests that there are no outliers in the regression models. Thus, the assumptions for performing the regression analysis are satisfied.

Results

Main characteristics of adaptation of physical environment in health care institutions for people with disabilities caused by musculoskeletal system and connective tissue disease. Evaluations of all APhE scale items ranged from 1 to 5. For the item “Basic information about offices, doctors, etc., is clearly visible on the walls, doors and in common areas,” the median was 4.5, for 4 items the median was 4, and for the item “There are no problems in the office due to the difficulty in moving,” it was 3. The Friedman test indicated that items of APhE were evaluated statistically differently ($\chi^2(5) = 24,678, p < .001$). The Mean Ranks for the items “Basic information about offices, doctors, etc., is clearly visible on the walls, doors and in common areas” (*Mean Rank* = 4.17), “The diagnostic equipment is adapted to the type of disability” (*Mean Rank* = 3.62) were higher, while other items scored lower: “Examination couches and/or other furniture are adapted to the type of disability” (*Mean Rank* = 3.21), “There are no problems in the office due to the difficulty in moving” (*Mean Rank* = 3.13). The descriptive characteristics of APhE are summarized in Table 2.

Table 2.

Descriptive characteristics of APhE

Scale items	Mean Rank	M	SD	Mdn	1*	2*	3*	4*	5*
1. Basic information about offices, doctors, etc., is clearly visible on the walls, doors and in common areas	4.17	4.03	1.21	4.5	5.7%	7.4%	14.8%	22.1%	50.0%
2. The diagnostic equipment is adapted to the type of disability	3.62	3.62	1.45	4	15.8%	7.5%	13.3%	25.8%	37.5%
3. The area is conveniently accessible from outside with a wheelchair	3.46	3.61	1.52	4	17.2%	9.0%	11.5%	19.7%	42.6%
4. Patients in that institution can move freely in a wheelchair in the common areas of the institution, as there are no architectural restrictions on movement	3.41	3.52	1.48	4	17.6%	9.2%	11.8%	26.1%	35.3%

Scale items	Mean Rank	M	SD	Mdn	1*	2*	3*	4*	5*
5. Examination couches and/or other furniture are adapted to the type of disability	3.21	3.34	1.48	4	21.3%	7.4%	13.9%	31.1%	26.2%
6. There are no problems in the office due to the difficulty in moving	3.13	3.11	1.48	3	16.9%	24.7%	16.9%	13.5%	28.1%

Note *Respondents' answers: 1 – strongly disagree, 5 – strongly agree

The 'table shows that half of the respondents (50%) could clearly see the basic information about offices, doctors, etc., on the walls, doors and in common areas; less than a half of the participants (42.6%) stated that the area could be conveniently accessible from outside with a wheelchair. Almost one third of the respondents strongly agreed that the diagnostic equipment was adapted to their type of disability (37.5%) and there were no architectural restrictions in the common areas for movement (35.3%). A little over a quarter of the participants confirmed without doubt that there were no problems in the institution due to the difficulty of moving (28.1%) and the examination couches and/or other furniture were adapted to their type of disability (26.2%). Yet, about a fifth of respondents (21.3%) strongly disagreed that the examination couches and/or other furniture were adapted to their specific needs; less than a fifth strongly disagreed that they could freely move in the common areas of the institution as there were no architectural movement restrictions (17.6%), that the area was conveniently accessible from outside with a wheelchair (17.2%), that there were no problems due to the difficulty in moving (16.9%), and that the diagnostic equipment was adapted to the type of disability (15.8%). A small proportion of participants strongly disagree that the basic information about offices, doctors, etc., is visible on walls, doors and in common areas (5.7%).

Relationship between adaptation of physical environment in health care institutions for people with disabilities (caused by musculoskeletal system and connective tissue disease) and these people gender, age, the nature of disability and health care institution type. Table 3 summarizes the multiple linear regression analysis.

Table 3.

Standardized (β) and nonstandardized (b) predictors of dependent variables and significance (p) in APHE

Independent variables	APHE		
	b	β	p
Gender	-2.566	-.193	.096
Age	0.018	.052	.653
Nature of disability	-4.833	-.384	.001*
Institution type	-1.801	-.259	.023*

Note * $p < .05$

Almost twenty-one percent (20.9%) of the variance in APhE accounted for the variables (gender, age, the nature of disability and institution type). The results are statistically significant ($p = .003$, $F = 4.561$, $df = 4$). The nature of disability ($\beta = -.384$, $p = .001$) and institution type ($\beta = -.259$, $p = .023$) were significantly associated with an increase in APhE score, whereas gender and age were not. Clinical characteristics such as moderate (vs severe) disability and hospital (vs ambulatory clinic and polyclinics) are associated with higher score on APhE.

Discussion

When analyzing how the physical environment of health care institutions is adapted for people with disabilities caused by the disease of the musculoskeletal system and connective tissue, it was determined that these respondents and their family or close ones evaluated the situation a little better than average, thus revealing a problematic fact that a significant proportion of people with reduced mobility do not have good access to health care in healthcare facilities. This result is partly in line with the findings of a survey conducted in 2017 in State and Municipal healthcare institutions in Lithuania that in some institutions services for people with disabilities are difficult to access (Union of people with disability [UPWD], 2017). However, this problem is relevant not only at the national level; the fact that people with disabilities often face barriers in accessing essential healthcare services has been stated in many other countries (AIHW, 2015; Baart & Taaka, 2018; Lee, Kim & Shin, 2014; Senjam & Singh, 2020; U.S. Centers for Medicare & Medicaid Services, 2017, Vergunst et al., 2017).

During the study, respondents were asked to evaluate the adaptation of the physical environment in the last visited health care institution according to the following criteria: the area is conveniently accessible from outside with a wheelchair, patients in that institution can move freely in a wheelchair in the common areas of the institution, as there are no architectural restrictions on movement, there are no problems in the office due to the difficulty in moving, basic information about offices, doctors, etc., is clearly visible on the walls, doors and in common areas, the diagnostic equipment is adapted to the type of disability, examination couches and/or other furniture are adapted to the type of disability.

It turned out that the respondents estimated best the informational aspect of the physical environment – that the basic information about offices, doctors, etc., is clearly visible on the walls, doors, common areas of the institution. The vast majority (72.1%) fully or partially acknowledged that this was the case at the last healthcare facility they visited, still 13.1% did not admit it in part or in full. Respondents also evaluated well enough the other three aspects of the physical environment: that the facility can be conveniently accessed in a wheelchair, that patients can use the wheelchair freely in common areas, as there are no architectural restrictions, that the diagnostic equipment is adapted to the type of disability. A major part of the respondents (61–63%) partially

or fully admitted that this was the case in the last health care institution they visited, but approximately one in four respondents partially or completely opposed it. The study found a relatively worse situation concerning the adaptation of examination couches and/or other furniture to the type of disability. A larger share of respondents (57.3%) partially or fully acknowledged that this was the case in the last health care institution they visited, but 28.7% expressed the opposite view. Half of the study participants admitted, in part or in full, that at the last health care facility they visited, they or their close ones with disabilities had problems due to difficulty moving, and only 41.6% expressed the opposite view.

Problems to get to healthcare institutions in Lithuania were also stated in the Survey of State and Municipal Subordinate Institutions conducted in 2017 – then 19.1% institutions indicated that it was not possible to make them accessible to people with disabilities (UPWD, 2017). Yet, this is a problem not only in Lithuania. For example, researchers in the US, Canada and the UK also find that patients with disabilities face barriers to accessing healthcare institutions (Lagu, Griffin & Lindenauer, 2015; McMillan, Lee, Milligan, Hillier & Bauman, 2016; Sakellariou & Rotarou, 2017). In addition, another study also reveals that people with disabilities face various problems in Lithuanian healthcare institutions due to the difficulty in moving. It is stated that as much as 63% of the registration desks in healthcare institutions are not adapted to the needs of people with disabilities; even 36.5% have no showers/baths adapted to the needs of people with disabilities; 13.8% of toilets, showers/baths have no handrails, no shower hose, no emergency call button, mirrors are hung too high, etc.; in 8% of the institutions with wards, there are no wards adapted for people with disabilities at all; 36% of the institutions with sports and physical education facilities and swimming pools do not provide access to them for people with disabilities. Only 19% of the institutions are fully adapted to people with disabilities, while 13% are not adapted. In 6.1% of healthcare institutions, differences in floor levels are higher than 2 cm, without any adaptations provided, making it very difficult or impossible for people with disabilities to move around in such buildings (UPWD, 2017). In a survey conducted at dental clinics in 2012, one in four respondents indicated that the waiting room was not adapted for patients with mobility impairments, and a fifth mentioned that there was no toilet for people with disabilities. Studies in other countries also point to a number of problems in health systems related to ensuring freedom of movement for people with reduced mobility in healthcare facilities. For example, a 2015 US study found that 83 percent of toilets and 93 percent of the health check facilities did not meet at least one of the ADA (Americans with disabilities act) requirements, and the health check of 70–87% patients took place while they were sitting in wheelchairs (Frost et al., 2015).

Other studies also acknowledge that there are problems in Lithuania with the adaptation of diagnostic equipment and examination couches and/or other furniture for people with disabilities. It was found that only 25.8% of medical equipment in healthcare institutions are adapted to the special needs of people with disabilities, only

25.4% of healthcare facilities have X-ray equipment adapted for people with disabilities who move in a wheelchair, only 70% institutions are determined to provide the service even if the medical equipment in their institution is not adapted for a person with a disability (UPWD, 2017). The same study states that women with wheelchairs are still finding it difficult to get a qualified gynecologist because of the unsuitable equipment for their special needs – only 22% institutions have adapted gynecological equipment. Lack of accessible equipment for persons with mobility impairments causes problems not only in Lithuania, they are also encountered in other countries (Lagu, Griffin & Lindenauer, 2015). However, the problem is not necessarily solved even if institutions have examination couches adapted for people with disabilities – research shows that even with such adapted couches, doctors do not always use them as intended (Agaronnik, Campbell, Ressalam & Iezzoni, 2019). And this shows incomprehension that unadapted couches, like unadapted scales, mammography and radiology equipment, impact people with disabilities (Iezzoni, 2011).

As the study found, the physical environment of healthcare facilities is better adapted for people with moderate (vs severe) disabilities caused by the disease of the musculoskeletal system and connective tissue. This fact only confirms the findings of other studies in different countries that people with disabilities potentially face more additional barriers to healthcare participation than those without disabilities (McMillan et al., 2016; Kuper & Hanefeld, 2018; Kurowski-Burt & Haddox, 2018), while people with severe disabilities experience even more problems in the health system (Eide et al., 2015; Sakellariou & Rotarou, 2017).

The research has shown that the physical environment in hospitals (vs ambulatory clinics and polyclinics) is better adapted for people with disabilities caused by the disease of the musculoskeletal system and connective tissue. In Lithuania, the physical environment of hospitals is the best of all healthcare institutions for people with disabilities: it can be concluded from the 2017 survey, which found that the majority of healthcare institutions that are well adapted for people with disabilities are hospitals, they are best prepared to move between floors, and usually have toilets adapted to the needs of people with disabilities (UPWD, 2017). Studies in other countries do not necessarily indicate that the physical environment in hospitals is better adapted for people with disabilities due to the disease of the musculoskeletal system and connective tissue. For example, a US study shows that medical diagnostic tools are better adapted for people with mobility impairments in primary care facilities than in hospitals (Pharr, James & Yeung, 2019).

Conclusion

The present study suggests that persons with disability caused by the disease of the musculoskeletal system and connective tissue face a greater burden, and disability has become an obstacle to their enjoyment of human rights and freedoms in the health

system. This testifies to the fact that the Lithuanian state does not guarantee this part of its citizens the same quality of health services as other citizens, as provided for in the United Nations Convention on the Rights of Persons with Disabilities (2006). It is especially true for people with severe disabilities and who seek health care from health facilities other than hospitals. This confirms the OECD conclusion that the Lithuanian healthcare system lacks mechanisms to ensure optimal quality and accessibility of services, and therefore there is a great need to develop a more efficient public health policy, reform the healthcare system and invest in improving its quality (OECD, 2019). However, these conclusions are based on a rather limited sample of survey participants, and the conclusions are drawn in the context of rapid change, so it is reasonable to continue researching the problem in order to monitor changes in the situation and to look for the best solutions.

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