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# USING THE BENEFITS OF PRIMARY HEALTH CARE (PHC) THROUGH WOMEN CURED FOR BREAST CANCER
# KORZYSTANIE ZE ŚWIADCZEŃ PODSTAWOWEJ OPIEKI ZDROWOTNEJ PRZEZ CHORE LECZONE Z POWODU NOWOTWORÓW PIERSI

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## Streszczenie

Wstęp. Leczenie chorych z powodu raka piersi na przestrzeni lat znacząco się zmieniło. W związku z powyższym coraz częściej chore te są długoletnimi pacjentkami nie tylko poradni onkologicznej ale również POZ.

Cel: Ukazanie opinii kobiet leczonych z powodu raka piersi na temat korzystania ze świadczeń POZ.

Materiał i metody: Badanie przeprowadzono na grupie 95 pacjentek poradni onkologicznej. Narzędzie badawcze stanowił autorski kwestionariusz ankiety, GSES - Skala Uogólnionej Własnej Skuteczności. Wyniki z uzyskanych danych zostały poddane analizie statystycznej.

Wyniki: Częściej z POZ korzystają pacjentki starsze, leczone z powodu dodatkowej choroby poza chorobą nowotworową, o niskim poziomie własnej skuteczności, z wykształceniem podstawowym lub zawodowym. Natomiast z usług pielęgniarki POZ częściej korzystają chore z wykształceniem wyższym. Pacjentki poradni onkologicznej nisko oceniają świadczeniodawców POZ za edukację onkologiczną.

Wnioski: Niewielki udział pracowników POZ w edukacji chorych leczonych z powodu nowotworu piersi sprawia że pacjenci poradni onkologicznej do POZ zgłaszają się głównie po: uzyskanie recepty, orzeczenia lub wykonywanie badań diagnostycznych.

Słowa kluczowe: podstawowa opieka zdrowotna, rak piersi

**Abstract**

Admission. The treatment of patients with breast cancer over the years has changed significantly. In view of the above, these patients are more and more often long-term patients, not only oncological but also PHC.

Aim: To present opinions of women being treated for breast cancer on the use of PHC services.

Material and methods: The study was conducted on a group of 95 patients of oncological counseling. The research tool was the original questionnaire, GSES - Scale of Generalized Own Efficiency. The results from the obtained data were subjected to statistical analysis.

Results: Older patients treated more often with PHC are treated for additional disease, apart from cancer, with a low level of their own effectiveness, with basic or vocational education. However, the services of PHC nurses are more often used by people with higher education. Patients of the oncological counseling center assess lowly the healthcare providers for oncology education.

Conclusions: A small share of PHC employees in education of patients treated for breast cancer causes that oncologic outpatient clinic patients for PHC apply mainly for: obtaining a prescription, ruling or performing diagnostic tests.

Key words: Primary Health Care (PHC), breast cancer

Admission.

Breast cancer is perceived by the general public as a serious life-threatening disease and forcing a sick person other than the lifestyle to date. The therapeutic process forces, on patients with the above diagnosis, frequent contact with health care facilities. It is related to the progress of medicine and related sciences, which extend the possibilities of anti-cancer treatment, prevention of side effects, while shortening the time of hospitalization. In this situation, the first level of the health care system, which is Primary Health Care (PHC), should play an important role for every patient regardless of where they live.

Breast cancer patients are struggling with many negative symptoms resulting from anticancer treatment, and they must learn to live with cancer in their living environment. Primary Health Care should meet the needs of the patient, so that he / she feels that the medical care exercised over him / her is truly an integral whole and is not left alone outside the oncological unit. The PHC team therefore has to provide health services so that the patient with breast cancer receives support in the living environment and has the opportunity to overcome the disease and live in good quality.

Purpose of research:

The aim of the research described in this paper is to show the opinions of women being treated for breast cancer on the use of basic health care. The main problem at work can be summarized in the following questions: What basic health care services do patients treated for breast cancer have and what factors influence this?

Specific problems:

1. How often do women treated for breast cancer use the services of individual PHC service providers?
2. What kind of PHC services did you use most often?
3. How do you rate individual service providers?
4. To what extent women with breast cancer were educated by employees of PHC, and in which by the Oncology Clinic employees?
5. Does the level of self-efficacy affect the style of using PHC?

This work includes independent variables such as age, education, place of residence, time of antineoplastic treatment, occurrence of comorbidities and the level of generalized self-efficacy.

Material and Method

For the purposes of the work undertaken here, an original questionnaire was created to gather information on the use of PHC services by women treated for breast cancer.

In order to determine the variable, which is the level of self-efficacy, a standardized tool called the Generalized Self-Efficacy Scale (GSES) was used.

The results from the obtained tests were subjected to statistical analysis. The values of the measurable parameters analyzed are presented by means of mean value, standard deviation, and for non-measurable by means of abundance and interest. Pearson's Chi square test was used. The database and statistical surveys were based on the STATISTICA 10.0 & # x2013; StatSoft Polska computer software.

The study included 95 women treated for breast cancer. The respondents were patients of the Oncology Clinic in Lublin. The research was carried out in April 2014. Participation in the study was voluntary and anonymous. The study obtained the consent of the Bioethics Committee of the Medical University of Lublin.

## Results

The respondents were aged 36 to 77, with more than half of them over 56 (52%). Most women were with secondary / technical education (44%) and the least with higher education (22%). The respondents were urban resi- dents (78%), and every fourth was a resident of the village.

45% of women declared that they were treated for 2 years, 18% for 2 to 5 years, and 37% for 5 years and more. In the study group of women (10.5%) only 1 method of treatment was used, the others had combined treatment.

65% of the respondents indicated that they had a coexisting disease. The most frequently mentioned diseases are hypertension (47%) followed by diabetes (32%) and osteoporosis (31%).

The scale of Generalized Self-Efficacy Scale (GSES), which has been completed, reveals that 62% of patients treated for breast cancer assess their own effectiveness at a high level, 21% at the medium level, and 17% respondents at the low level.

As a result of the analysis of the obtained data, 99% of patients use the services of a PHC doctor, every second woman took advantage of night and holiday healthcare, 37% of the services of a PHC nurse, and 12% of the services of a midwife PHC.

32.6% of respondents use PHC services "once every 6 months" and "more often than once a month" is used by 8.4% of respondents. The services provided by oncology clinics received similar results "once every six months", 40% visited and 2.1% "more often than once a month". 37% of respondents use services, PHC nurses, 54% of respondents use night and holiday medical care, and 11% of midwife services, 5.2% of respondents use emergency medical services .

Age determines the frequency of using PHC services. Women aged over 55 use POZ services most often, because the variant "more often than once a month" (12%) and "once a month" (33%) is chosen by those respondents more often than by younger ones. Women aged <45 years (33%) and those aged 45-55 (42%) most often "once a year", but less often at the age of > 55 years (14%). The oncological clinic is most often used by patients aged <45 years ("once a month" by 60% of respondents). In the age group> 55 years, almost half of women (47%) used the services of oncological counseling "once in 6 months".

The frequency of using PHC benefits is determined by education. The respondents who have lower education, the more they use PHC services. The frequency of using the Oncology Clinic increases with the higher education of the respondents.

The conducted research has shown that the place of residence also determines the use of PHC benefits. The most frequent answer given by women living in the countryside was the frequency of using "once every six months". The responses of the inhabitants of large cities were evenly distributed between "once a year" (23%), "once a month" (25%), and "once every 6 months" (29%). The frequency of using the oncological counseling services does not depend on the respondents' place of residence.

The research shows that patients treated for additional disease are more likely to benefit from PHC services than patients without comorbidities.

The analysis of surveys shows that respondents with a low level of self-efficacy more often use PHC services. "Every month, more than every month," every fourth woman with a low level of self-efficacy, "once a month" uses 31% of respondents, and every third woman "once in 6 months". Women with an average level of self-efficacy most often corresponded to "once in 6 months" (40%), $p = 0.2$.

The services of PHC nurses are more frequently used by older patients (49%) over 55 years of age, as well as in the menopausal age of 32% (45-55 years) than women under 45 years of age. (7%). This relationship is statistically significant, $p < 0.01$. A similar relationship was observed among patients using midwife services, the older women are, the more often they use their services (<45 yo - 0.0%, 45-55 - 9.7%,> 55 - 16.3 %), $p = 0.21$. The opposite tendency can be seen among patients using night and holiday healthcare, most often it was used by younger women aged <45 years old. (60%) and 45-55 (58%).

The higher education the researched patients have, the more often they use the services of a PHC nurse. The opposite tendencies can be observed in the case of night and holiday health care, the more advanced education they have, the less often they benefit from it. This relationship is statistically significant, $p < 0.02$.

Based on the conducted research, it can be observed that the majority of patients living in small towns use night and holiday health care services, this relationship is statistically significant $p = 0.03$.

The comorbid condition determines the benefits of the PHC nurse. Patients with comorbid illness use her services twice as often as women treated only for cancer. It is a statistically significant relationship $p = 0.02$.

In the conducted studies, patients treated for breast cancer were to assess individual providers in terms of 5 criteria: access to services, reliability of information, cooperation with a specialist, patients and their families, and whether patient rights are respected. The ratings were based on a five-point scale, where 1 is the lowest and 5 the highest. After calculating the arithmetic mean and the standard deviation, the following results were obtained. Among all service providers, the respondents are best rated by midwives, who received an average score of 4.3 with a standard deviation of 0.47, but this may be due to the fact that a small number of respondents use midwife's services. A doctor and a PHC nurse received an average score of 3.8, with a standard deviation of 0.79 for a nurse and 0.90 for a doctor. The PHC doctor was assessed worst in terms of cooperation with a specialist (3.2) (standard deviation 0.95) and the nurse in terms of cooperation with the patient and his family (2.9), but the dispersion was the greatest (1.11). Results for midwife PHC may be unreliable due to too few respondents using these services, only (11.6%) among the surveyed. "The access to the services" of the family doctor is best assessed by younger patients - <45 years (4.1), and worst among those aged 45-55 (3.5). "Reliable information" provided by PHC nurses is the worst rated by patients aged <45 years old. (2.0), "Respect for patient rights" by PHC nurses is also the worst rated by younger patients <45 years of age. average (3.0), and preferably at the age of 45-55 (3.6). As a result of the conducted research, it can be noticed that patients with lower education better assess the family doctor than those with higher education. A similar relationship can be noticed in the context of cooperation with a PHC nurse. After calculating the average of all the criteria, a similar assessment is made for individual healthcare providers, which is: 3.74 for the midwife, 3.45 for the doctor, 3.38 for the nurse.

Respondents with a high level of self-efficacy evaluate providers better than women with an average level of self-efficacy, which were rated lower. The PHC nurse received the lowest marks for "cooperation with the patient and his family" from all women regardless of the level of their own effectiveness.

What kind of PHC services are used by respondents was also the subject of research. The analysis shows that almost everyone (94%) used the examination and medical advice to obtain a prescription or certificate / certificate was used by the same number of respondents (75%), a large number of people representing 66% also used diagnostic tests. The most rarely mentioned services were services provided at the patient's home, which was used by one person. The benefits of care services and referral to long-term care were used by 3% of respondents. One in five respondents (22%) in PHC controls their non-cancerous disease. The most frequently mentioned co-morbidities are arterial hypertension (10%) and osteoporosis (6%).

With the age of the respondents, the number of services in PHC increases, such as diagnostic tests, treatments in the treatment room, referrals for rehabilitation and spa treatment, the number of prescriptions for medicines issued. With the age of the respondents, the number of using services such as the number of medical examinations and consultations, preventive vaccinations and issued judgments / certificates decreases.

Health education

With the age of the respondents, the number of educational services provided by oncology workers is increasing, especially in the field of education about living with cancer, diet, physical activity and post-operative and anti-edematous procedures. However, the number of services in the field of skin and hair care as well as the side effects of the treatment is decreasing.

Out of the respondents, 75% declared that they had received education from the employees of PHC. For 21% it was education in the field of living with cancer, to a lesser extent education about the way of eating (6%), physical activity (3%)

Age does not determine the educational services that are provided by employees of PHC in favor of patients.

As a result of the analysis of the conducted research, the smallest share in the knowledge gained by the respondents is the PHC nurse, who received a score of 2.2 (5-point scale where 1 is the lowest), the PHC doctor did not get much better (score 2.4). According to the respondents, regardless of their age group, the oncologist (3.8) and support groups (3.7) have the largest share in education.

A significant group (82%) of surveyed women participate in at least one support group. The majority (68%) attend "Amazons" meetings. Over half (56%) consider the family to be a support group that helps them fight the disease. One in five women (18%) did not declare their participation in any form of help.

The higher education the patients have, the more often they use the support group, which is the club "Amazons", $p < 0.01$. Educated women less often use social welfare. The family is a source of support for respondents regardless of their education.

Respondents living in small and big cities more often than those who live in the villages use the support group "Amazons". This dependence is statistically significant $p = 0.02$. Women living in villages more often admit that it is the family that helps them fight the disease.

The analysis of the conducted research shows that the most women with low levels of their own effectiveness belong to the club "Amazons", 12% of women with high levels of self-efficacy benefit from social welfare and this is the highest percentage of women.

The place of residence, the duration of cancer treatment and the level of generalized self-efficacy do not affect the membership of the "Amazons" support group.

Discussion

The conducted studies have identified certain dependencies that condition the use of PHC services. The most important determinants of PHC are such factors as age, education and place of residence of the respondents. For example, patients> 55 years of age treated for breast cancer, they usually go for medical advice to the family doctor, younger patients look for other alternatives to meet their medical needs. Similarly, in the case of women with higher education, these patients are less likely to attend the GP Practices in comparison to patients with lower education. The respondents living in rural areas less often use PHC services than women living in big cities. This is most likely caused by the distance between the place of residence and the PHC office. An important variable for the frequency of using PHC benefits is the occurrence of a comorbid disease with cancer. These patients more often go to the PHC counseling center. Another important variable is the level of generalized self-efficacy. It results from other studies that women treated for breast cancer have a high level of self-efficacy [1].

This study confirmed this fact, as 61% of respondents have a high level of self-efficacy. Women with low levels due to worse coping with difficult situations are more likely to go for advice to PHC medical staff. Women with a high level of generalized self-efficacy do not benefit so often from PHC benefits. Generalizing the results of the research undertaken here, women who are treated for breast cancer usually receive PHC once every 6 months. A significant proportion of respondents to PHC are asked to obtain a prescription, ruling or certificate. This is due to the ability to cope independently with the effects of anti-cancer treatment. Some studies emphasize the need for greater support from the PHC for women who are being treated for breast cancer, who are residents of villages and smaller cities [2].

The majority of respondents rated the PHC doctor and nurse for an average rating slightly below 3.5 in terms of availability of services, reliability of information, cooperation with a specialist, patients and their families, and in respect of patient rights. In the Miller study, the results were higher, 70% of patients rated the benefits positively [3]. Access to family doctor services in the Kowalczyk study 78% of the respondents rated well and very well [4].

Access to family doctor's services is best assessed by younger patients - <45 yrs. The reverse tendency was demonstrated by Kowalczyk's research, where the elderly patients rated the access the best - after 79 years of age [4].

In the present study, patients with lower education better assess GP and GP nurse than higher education. In research, Kowalczyk was similar [4].

Patients with a high level of self-efficacy are better rated by individual providers than women with medium and low performance levels. Out of the respondents, 75% declared that they had received education from the employees of PHC. For 1/5 of the respondents, it was education about living with cancer. According to Cianciara's research, 44% of patients are always educated at the medical visit. According to 8.5% of doctors, nurses are responsible for education [5], and in this study, nurses for oncological education received a low score from PHC patients.

Health care workers, in accordance with the Act, have the obligation to carry out educational activities [6]. In the present research it has been shown that the PHC doctor and nurse educate patients treated for breast cancer, but their education has been much lower rated than the education of oncologist and support groups. The conclusion of this conclusion is the Humeniuk study which showed high expectations of patients regarding health education conducted in primary care [7].

When comparing the self-efficacy indexes of several clinical groups, significant differences can be observed. Women after mastectomy are characterized by the highest level of self-efficacy in comparison with other clinical groups. This gives a positive picture of the clinical group that can and wants to ensure the best possible quality of life despite a serious disease, which is breast cancer [1]. This study confirmed the above thesis.

Own research shows that for over half of the respondents, the family is a reliable support group, which is also reflected in other studies [2].

## Conclusions

Based on the tests carried out, it was found that:

1. Women who are being treated for breast cancer generally receive PHC once every six months. The largest group are those using family doctor services, less overnight and holiday health care and a PHC nurse. The frequency of use is influenced by: age, place of residence, education and level of self-efficacy. Patients with comorbidity are twice as likely to use PHC nurse services than women treated for cancer alone. It is a statistically significant relationship.
2. Respondents with a high level of self-efficacy are rated higher by primary care providers. The benefits they use most often include: a medical examination to obtain a prescription or certificate / test and diagnostic tests.
3. Women aged> 55 years, more often use the outpatient clinic, and women aged <45 years from oncological counseling.

4. Women> 55 years old, with lower education, with a low level of generalized self-efficacy, more often use PHC services. Women with a high level of generalized self-efficacy are better rated by primary care providers than women with middle and lower levels.
5. Among respondents, the PHC service providers rate the employees of the POZ on over 3 in a five-point scale. The standard deviation is the highest in the opinion of the family doctor (0.90). The POZ nursery was rated the lowest for cooperation with the patient and his family, and the lowest for the cooperation with the specialist. Women with a higher level of self-efficacy are better rated by primary care providers.
6. In the respondents' opinion, 21% of them received education about living with cancer from PHC staff. Oncological education conducted by a PHC doctor and nurse was rated lower than in an oncological clinic or support group.

This work showed a small share of PHC employees in education of patients treated for breast cancer. They operate mainly "at the patient's request" by providing services in the field of prescriptions, judgments / certificates. They do not meet the educational needs of an oncological patient. Taking into account the above-mentioned conclusions, it seems that employees of PHC should more frequently provide educational support to their patients functioning in the environment of living with a chronic disease, which is cancer.

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