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MANAGEMENT OF CUSTOMER WITH DYSFUNCTION OF SOCIAL IN HEALTH ORGANIZATIONS

Any of health organization must be create a good relation not only inside of organization but mostly with all of them from outside of organization. One of them is a patient, by author is named "customer" because for every person for health organization is going money that affects the proper functioning of the hospital. Decision makers within the system are constantly required to make choices, as well as seek alternative ways to measure the unit costs of illness. One of the factors that makes it difficult to optimize the scope of health services is the phenomenon of social exclusion, which is increasingly affecting society. The author intends to demonstrate the links between social exclusion and the higher costs of treating customers belonging to this social sector, unlike other customers who are neither unemployed nor live in poverty.
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1. INTRODUCTION

The healthcare system in Poland is an organism that requires continuous monitoring by the management decision-makers. This action is necessary, even if only because of the varying structure of supply of customers which has an increasingly negative effect on customers needs and expectations with respect to health services. Therefore, the demand for health services will continue to be evaluated as a market phenomenon growing not only in quantitative, but also, as shown in earlier observations, in qualitative terms.

We can conclude that customers awareness is increasing, which in turn increases the demand for healthcare and medical services. Customers expect a higher level of service to be provided by medical personnel through better and more accurate diagnosis, positive interpersonal relationships and improved speed of service, taking place on the basis of service "without queues" [1].

Another problem that has been diagnosed in the healthcare system is the phenomenon of social exclusion, which is occurring more frequently and reaching a mass character. A customer with disfunction who has smaller financial possibilities, other illnesses, and it need more attention and time on the part from medical staff.

2. ANALYSIS OF RECENT RESEARCH AND PUBLICATIONS

This is a consequence of the economic crisis, the low level of per capita income and an increasing unemployment rate recorded by the BEAL method.

One of the factors impeding the process of optimizing the provision of services in the field of public health is the phenomenon of poverty in society, which is one of the most important public

policy objectives [2]. With the development of economy, the phenomenon of poverty has become a component of public intervention at a time when interest in policies to improve the situation of the poor is not only the result of moral arguments, but also relates to the political and economic aspects of the analyzed phenomenon.

Dynamic changes in the health system from the early 1990's to the present day have brought about a significant number of modifications on the plane of legal and formal, organizational, staffing, competence, insurance and financial sectors. The most important factor in determining the evolution of the health care system is the form and method of financing of the health system. The aim is to meet the needs of people using medical services and at the same time account for a stable source of income for employees of the system and systematic investments in fixed and mobile assets.

3. SPECIFICITY OF A SOCIALLY EXCLUDED CUSTOMER

Social withdrawal from various aspects of life leads to a person becoming poorer and less socially active than those who are free of social exclusion.

It should be remembered that the poor do not have to be excluded, and the excluded do not necessarily have to be poor, although both of these phenomena are often seen to accompany each other [2].

This statement is identical to the insights of A. Smith, who saw poverty not only in the material realm, but also in the immaterial.

The above statement concurs with the insights of A. Smith (late eighteenth century), who recognized that poverty existed not only in the material realm, but also in the immaterial. He identified the concept through welfare, the possession of which allows one to feel worthy (without a sense of shame) in a public space [3] and exist in a dignified and financially self-sufficient manner.

Poverty must not be seen as a solely economic problem, but rather as a multidimensional phenomenon that includes both a lack of income and the opportunity to live in decent conditions [4]. Such welfare thus depends on the socio-economic context and the economic environment [5].

In relation to this phenomenon, the concept of marginalization is often used, which is defined as exclusion from participation in the social life of individuals, groups or societies on a global basis in relation to their social environment [6].

It is understood that two main factors contribute to exclusion, frequently occurring simultaneously or in a sequential fashion.

It concerns the phenomenon of unemployment and poverty [7], which can occur in a variety of configurations and relationships. Different situations may occur in which a person who is employed and receiving a salary sufficient for at least a decent life will be released, and will fall into the group of unemployed persons as a consequence of the use of savings, resulting in a need to lower the standard of living which may degenerate into a state of poverty.

In another case, a person employed as a low-paid worker and supporting several children may be known to be poor or living in poverty. According to legal and formal regulations, Polish law distinguishes different definitions of the concept of poverty; the so-called subsistence level (defined in 2017 in the amount of 31,24 zloty per person per day) [8] as opposed to the so-called subsistence minimum (this is the amount of PLN 16,11 per person per day. In 2015, the social group classifying for the minimum subsistence level represented a volume of 33% of society on the world. Such a mass phenomenon indicates the significance of the problem and points to the aspects that have to be resolved.

The category of social exclusion is broader and more complex than poverty, and at the same time vaguely covered in literature. This term is derived from the definition of relative deprivation formulated by J. Townsend, and refers to a standard of living below which one is not guaranteed to play social roles and participate in social relations and customary behaviour characteristics and find value in membership in the society [9].

On the basis of secondary data derived from research conducted by the Public Opinion Research Centre (abbreviation: CBOS) in September of 2013, it can be seen that the factors which most affect the growth of the risks of exclusion in society are:

- material situation,
- health [10, 12, 13].

In the case of social groups affected by exclusion, at greatest risk are those in which deteriorating financial situation and health status are experienced. Consequently, this has an impact on the growth of the total cost of

treatment. In Poland, studies have been conducted that indicate a link between social exclusion and an increase in the unit cost of treatment of persons classified in this group.

By following a query in the area of scientific publications and research reports conducted at the level of a country or region, it can be said that in recent years studies were carried out whose interest were the following phenomenon: poverty, unemployment, the level of society and social exclusion. However, the impact of these phenomena in the context of the rising unit cost of treating customers in the healthcare system has not been generally analyzed.

The analyzed data shows that social problems associated with poverty and social exclusion are present in Poland.

According to those surveyed, groups at risk of marginalization (an intermediate state of social exclusion) include the unemployed, the sick, the disabled and the poor. As many as 43 percent of respondents believe that the unemployed have least chance of achieving their needs; 20 percent of respondents indicated that the sick and the disabled are persons who are at risk of marginalization. However, according to 18 percent of respondents, this phenomenon may also apply to the poor and impoverished.

These results indicate that the phenomenon of marginalization in social perception is related to the state of unemployment, poverty and poor health.There are also other important results, which show that every eleventh respondent stated that they felt excluded. In this group, the majority pointed to economic factors and their health situation. A total of 46 percent of respondents said that they were excluded because of their financial situation, and 31 percent pointed to health reasons.

This indicates that a large group of people who are ill, often with low-income and requiring additional care, are already excluded.

In summary, it can be stated emphatically that in Poland, research has been conducted on the measurement of the number of excluded people, the causes of marginalization, unemployment, and methods for their limitation, but an in-depth analyzes of the social impact of these negative socio-economic phenomena that involves the greater element of Polish society has not yet been carried out.

4. METODOLOGY AND RESEARCH RESULTS

In the external study, a survey method was used, supplemented with a method of observation at the study site. The author of the publication carried out research using the qualitative method, formalized interview with medical staff. This research was done in University hospital in Wroclaw in 2018.

In this publication the author cites borrowed research data, which is used to demonstrate the links between social exclusion and the costs of treating customers. The results were based on a survey questionnaire method performed on a composite sample of about 2,500 people, which were tested in two stages of research. The considerations took into account in several areas: health, financial situation, cultural integration, relations with other people, resources, property and inheritance.

The data presented in Table 1 shows the structure of respondent situation, in which the dominant group of respondents were derived from two groups belonging to the wider labour market; people with jobs, that is, economically active and those made redundant, i.e. inactive.

Table 1

THE STRUCTURE OF RESPONDENTS

	Survey 1		Survey 2	
	Number	Percent	Number	Percent
Professionally active	284	56,3	305	43,8
Registered unemployed	27	5,4	59	8,5
Unemployed not registered	16	3,2	24	3,2
Students	16	3,2	19	2,7
Dismissed	113	22,4	181	26,0
Housewives	25	5,0	40	5,7
Other inactive	23	4,5	59	8,5
Unknown	0	0,0	9	1,3
Total	504	100,0	696	100,0

Source: Compiled on the basis of studies in the "Avicenna" group

Together, these two groups represented 78.7% of customers in the first stage and 69.8% in the second stage. This information shows that a pool of 90% of respondents are persons of working age, and only a fraction - less than 10% - of those work in pre or post-production.

Within the area of health, three indicators were taken into account: mortality rate (*Morbi*), risk index (*RISIKI*), including the terms of indication, e.g. concerning working conditions (*Risk*) (*IDEM*) and, in the second stage, the rate of disability (*INCAP*).

In terms of health, the individual subjects reported a greater handicap status in the first study than in the second. As many as 58.2% of respondents were affected by impairment to at least a moderate degree in the first study, whereas in the second study this was a smaller group of subjects and represented 14.5% of the surveyed customers. This factor has a significant impact on the phenomenon of exclusion only among respondents from the first stage of research. In the second stage, the relationship between social exclusion and quality of health was not established.

Table 2

THE SITUATION OF THE RESPONDENTS IN THE AREA OF HEALTH

Exclusion level	Survey 1		Survey 2	
	Number	Percent	Number	Percent
No impairment	144	28,6	595	85,5
Moderate impairment	274	54,4	90	12,9
High degree of impairment	19	3,8	11	1,6
Unidentified class	67	13,2	0	0,0
Total	504	100,0	696	100,0

Source: Compiled on the basis of studies in the "Avicenna" group.

Table 3 presents data showing the state of impaired respondents in terms of the so-called resources with the following indicators: quality of life based on the amount of income (revenue) and uncertainty, which is the so-called poverty rate (PRECAT).

Table 3

THE SITUATION OF THE RESPONDENTS IN TERMS OF RESOURCES

Exclusion level	Survey 1		Survey 2	
	Number	Percent	Number	Percent
No impairment	97	19,2	185	26,6
Moderate impairment	147	29,2	345	49,6
High degree of impairment	140	27,8	166	23,8
Unidentified class	120	23,8	0	0,0
Total	504	100,0	696	100,0

Source: Compiled on the basis of studies in the "Avicenna" group

In this area of research, most subjects demonstrated a moderate or high degree of deprivation. This indicates that income is an important factor that affects the degree of social exclusion.

In another area, the author analyzed relationships with other people, based on two indicators: the index of family relationships and relationships with related indicators, in particular contact with neighbours. Just as in the case of cultural integration, the area of analysis also can be defined as an average range of topics related to social exclusion.

Table 4.

THE SITUATION OF THE RESPONDENTS IN THE AREA OF RELATIONSHIPS WITH OTHER PEOPLE

Exclusion level	Survey 1		Survey 2	
	Number	Percent	Number	Percent
No impairment	217	43,0	308	44,2
Moderate impairment	183	36,3	176	25,3
High degree of impairment	55	11,0	212	30,4
Unidentified class	49	9,7	0	0,0
Total	504	100,0	696	100,0

Source: Compiled on the basis of studies in the "Avicenna" group.

We spend our lives surrounded by family, friends, acquaintances and people we meet or pass on the street. Public, professional and personal life largely depends on the impact of the behaviour of other individuals, groups and communities [11].

Effective communication allows the existence of the due process of interaction between people, which is not only advisable but even necessary for the proper functioning of an organization. Of particular significance is the communication process in organizations becoming "open" to the environment in which employees maintain permanent relationships with their customers. It should be noted that due to the stability of the composition of personnel (small

changes in employment) it is easier to manage internal contact, a situation that is different in the case of relations with the public.

Table 5 presents data showing the level of residential involvement in the area of disability relating to social exclusion, taking into account the interior comfort index (CI), relating to the quality of domestic appliances and the housing location indicator (LOCA), which is a measure of location relative to places of cultural, labour and other significance.

In analyzing the two indicators identified for use in this area, it was noted that in the first stage test there was a large correlation between exclusion and the housing. In contrast, in the second stage, an average degree of relationship was demonstrated.

Table 5.

THE SITUATION OF THE RESPONDENTS IN THE AREA OF HOUSING

Exclusion level	Survey 1		Survey 2	
	Number	Percent	Number	Percent
No impairment	62	12,3	321	46,1
Moderate impairment	252	50,0	297	42,7
High degree of impairment	127	25,2	78	11,2
Unidentified class	63	12,5	0	0,0
Total	504	100,0	696	100,0

Source: Compiled on the basis of studies in the "Avicenna" group.

The results of research in the field of inheritance are presented in Table 6. The analysis included two evaluation criteria: tangible assets (IMMO ratio) and movable assets (ratio MOBI).

Analysis of the resulting findings indicates that in the area of inheritance, there are important links between the indicators and the phenomenon of social exclusion. In the studies, the total impairment was 82.2% in the first study and 79.7% in the second. This was a high rate, confirming the impact of this area on the appearance of marginalization in society, which in turn leads to social exclusion.

Table 6.

THE SITUATION OF THE RESPONDENTS IN THE AREA OF INHERITANCE

Exclusion level	Survey 1		Survey 2	
	Number	Percent	Number	Percent
No impairment	52	10,3	133	19,1
Moderate impairment	161	32,0	298	42,8
High degree of impairment	253	50,2	257	36,9
Unidentified class	38	7,5	8	1,2
Total	504	100,0	696	100,0

Health and cultural integration are planes whose relationship to social exclusion are above average but cannot be classified as factors showing significant interaction with the relationship analyzed. The weakest link was shown to be the area of relationships with other people, which should be treated as a result of the phenomenon of social exclusion, rather than the cause of its occurrence.

5. CONCLUSIONS OF RESEARCH

The author, based on a literature query along with secondary data presented based on analysis by a team led by Camal Gallouj and own research, presented the conclusions in terms of ex-post and ex-ante evaluation.

Ex-post conclusions refer to a past situation, to the historical background; the situation as it was before, and on this basis it is possible to diagnose the impact of that situation on the current state, which is based on the data collected. Conclusions of the second analysis include interpretations of the status quo and form the starting point to predict the situation in the health system in the absence of any interventions in v with those characteristics assigned to the socially excluded. The conclusions of the ex-post analysis show that relationships between the analyzed areas and the phenomenon of social exclusion have a medium and even large dependency and demonstrate cause-effect relationships.

Diagnosing a customer with one of the factors in the area of resources, housing and inheritance can lead to him qualifying for a group of people with deprivation in the field of social exclusion. Those who qualify for this group have the following properties, based on a qualitative analysis carried out in the second stage of the research.

Such characteristics include:

1. Customers with social disabilities remain in hospital longer, increasing the customer's per unit cost to the healthcare system compared to customers without such dysfunction.
2. The study showed a typical need to extend the stay by 1 to 2 days, In terms of the number of Poles belonging to socially excluded groups, assuming that 1 in every 100 Poles will be hospitalized once a year, the annual effect on hospitals will be in the region of 43.000 people hospitalized with this dysfunction, which amounts to between 43.000 to 86.000 man-days. This is a significant amount of extra working time and consequently spent funds.
3. In terms of the total for the entire study sample, this represents a total of 21.345 more days in hospital per annum days than for

customers not affected by impairments in the area of social exclusion.

4. This value translates into additional costs, or the equivalent of approximately 3.300 additional hospital admissions, which is already a considerable expense. The cost, estimated on the basis of this data, totals an average of 11.000.000.000 Euros annually across the whole of the French health system. In Poland, this cost will be lower in financial terms, however, in relation to per capita expenditure it is certainly higher, and thus more important for the balance and realignment of supply to meet the needs of customers.

Table 7.

ROLES OF MEMBERS OF A PATERNALISTIC MODEL

Role of the medical staff	Role of the customer (patient)	Role of the family
principal	passive	No action
authority	submissive	
decisive	imitative	

Source: [14].

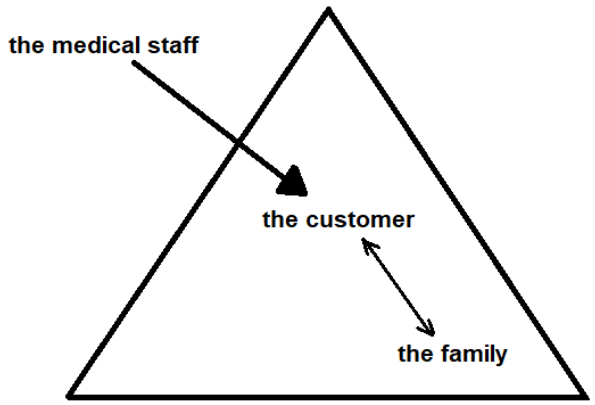

Fig.1. Relation between participants in a paternalistic model (*Source: [15]*)

Management of customer with disfunction of social requires of medical personnel to use other means of communication and build relationships on a facts. Model of communication between medical staff and the customer is should founded on a moderate paternalistic model which is build on facts and documents. The result will be a reduction in service time, which will affect consultation time, financial savings and an increase in the efficiency of medical staff.

References

1. Gallouj C., Kaabachi S. (2011) *Innowacja i organizacja w szpitalu: perpektywa francuska*, (in:) Innowacje organizacyjne w szpitalach, ed. J. Stępniewski, P. Karniej, M. Kęsy, Wolters Kluwer, Warszawa, p.98.
2. Bukowski M., Magda I. (2013) *Employment in Poland 2011. Poverty and labour, Human Resources Development Centre,* Warsaw, Poland, p. 13, 24 i 25.
3. Malloy R. P., Evensky J. (1994) *Adam Smith and the Philosophy of Law and Economics*, Kluwer Academic Publishers, Dodrecht, Holland, p. 158.
4. Wrzesiński J. (1987) Report entitled “extreme poverty and socio-economic instability”, the Commission on Human Rights.
5. Sen R. K., Roy K. C. (1996) *Sustainable Economic Development and Environment. India and other Low Income Economies*, Atlantic Publishers and Distributors, New Delphi, p. 72-73.
6. Rhoads R. A., Szelenyi K. (2011) *Global Citizenship and the Univeristy. Advancing Social Life and Relations in an Interdependent World*, Stanford Univeristy Press, Stanford, p. 17-20.
7. Nowak A. (2012) *Education and marginalization and social exclusion,e Published by the University of Silesia,* Katowice, p. 110.
8. *Starzenie się i Polityka Zatrudnienia. Polska lepsza praca wraz z wiekiem*, Ministerstwo Pracy i Polityki Społecznej (2015), Centrum Rozwoju Zasobów Ludzkich, Warszawa.
9. Townsend P. (1979) *Poverty in the United Kingdom. A survey of household resources and standards of living*, University of California Press, Berkeley and Los Angeles, p. 567.
10. *Evaluation and prediction of the material conditions of life of Poles (2013), Center for Public Opinion Research*, Warsaw.
11. Aronson E. (1998) *People as a social being*, PWN, Warsaw.
12. Spaaij R., Magee J., Jeanes R. (2014) *Sport and Social Exclusion in Global Society*, Routledge, London and New York? p. 21.
13. Green J., Tones K. (2010) *Health Promotion. Planning and Strategies*, Sage, London, p. 105.
14. Anna J. (2018) *In our best interest. A defense of paternalism*, Oxford University Press, Oxford, p.246-247.

15. Vastag G. (2015) Reaserch in the decision sciences for global biznes. Best papers from the 2013 annual conference, Person Education, NJ, p. 172-174.

Анотація

КЕСІ Марчін, СТЕЛЕЖУК Мілош Лукаш

Управління клієнтами з соціальними дисфункцями в закладах охорони здоров'я

Будь-який заклад охорони здоров'я повинен створити добрі стосунки не лише всередині організації, а й здебільшого з зовнішнім середовищем. Одним із представників зовнішнього середовища є пацієнт, якого автор назвав «замовником», тому що за кожну людину для організації охорони здоров'я йдуть гроші, які впливають на нормальне функціонування лікарні. Особам, які приймають рішення в системі, постійно доводиться робити вибір, а також шукати альтернативні способи вимірювання одиничних витрат на хворобу. Одним із факторів, який ускладнює оптимізацію обсягу медичних послуг, є явище соціальної ізоляції, яке все більше впливає на суспільство. Автор має намір продемонструвати зв'язок між соціальною ізоляцією та вищими витратами на лікування клієнтів, що належать до цього соціального сектора, на відміну від інших клієнтів, які не є ані безробітними, ані живуть у бідності.

Управління клієнтом із соціальними дисфункціями вимагає від медичного персоналу використання інших засобів комунікації та побудови стосунків на фактах. Модель спілкування між медичним персоналом і клієнтом має ґрунтуватися на поміркованій патерналістській моделі, яка базується на фактах і документах. Результатом стане скорочення часу обслуговування, що вплине на час консультації, економію коштів та підвищення ефективності роботи медперсоналу.

***Ключові слова**: менеджмент, клієнт з дисфункцією, організація охорони здоров'я, соціальне відчуження*

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