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Mgr Jan Neugebauer, Ph.D., MBA[1]
University of Jan Evangelista Purkyně in Ústí nad Labem, Czech Republic

Mgr Ivana Lovětínská, MBA[2]
University of Jan Evangelista Purkyně in Ústí nad Labem, Czech Republic

Ing. Marek Vokoun, Ph.D.[3]
University of Jan Evangelista Purkyně in Ústí nad Labem, Czech Republic

Ing. Bc. Jiří Rotscheld, Ph.D.[4]
CEVRO University, Prague, Czech Republic

Economic barriers and their impact on access to healthcare facilities[5]

Abstract

Healthcare access is very standard nowadays. Healthy people generally do not prioritize how they access healthcare facilities. However, the most common client of a healthcare facility is not a healthy person, but one who is suffering. In this case, many limitations can impact access to proper care.

The study's primary objective was to identify all potential economic barriers that affect access to healthcare facilities. We established the theoretical basis using the PRISMA-PICOT approach, then focused on the qualitative approach, using semi-structured interviews to test our theories.

Results show that a few spectrums of people are in different conditions, making them vulnerable. Based on the group's vulnerability and specific needs, there are various economic barriers, ranging from low income to inadequate travel approaches. For example, people from rural

[1] Correspondence address: Jungmannova 28/17, 110 00 Praha 1, Czech Republic; e-mail: Jan.Neugebauer@cevro.cz. ORCID: 0000-0001-5216-1015.

[2] Correspondence address: Jungmannova 28/17, 110 00 Praha 1, Czech Republic; e-mail: Ivana.Lovetinska@cevro.cz. ORCID: 0009-0006-7203-5415.

[3] Correspondence address: Jungmannova 28/17, 110 00 Praha 1, Czech Republic; e-mail: Marek.Vokoun@cevro.cz. ORCID: 0000-0001-5659-3085.

[4] Correspondence address: Jungmannova 28/17, 110 00 Praha 1, Czech Republic; e-mail: Jiri.Rotschedl@cevro.cz. ORCID: 0000-0002-0117-3427.

[5] The authors thank the University of Jan Evangelista Purkyne, Faculty of Social and Economic Studies, in Usti nad Labem. Project No.UJEP-SGS-2024-45-005-2 was supported by a grant within the Student Grant Competition at UJEP.

areas often have limited transportation options, and many are unable to use their mobile phones to call for an emergency. Social services in the Czech Republic provide support to individuals in managing specific situations. However, it does not resolve the financial crisis or the health issues of vulnerable patients. Some knowledge should be spread to this group to reduce risks. It can lead to a better understanding of one's health and access to healthcare when needed.

Keywords: barriers, healthcare, needs, vulnerability, people.

Bariery ekonomiczne i ich wpływ na dostęp do usług ochrony zdrowia

Abstrakt

Dostęp do opieki zdrowotnej jest obecnie bardzo powszechny. Osoby zdrowe zazwyczaj nie przywiązują wagi do sposobu dostępu do placówek opieki zdrowotnej. Jednak najczęstszym klientem placówki opieki zdrowotnej nie jest osoba zdrowa, lecz cierpiąca. W takim przypadku wiele ograniczeń może wpływać na dostęp do odpowiedniej opieki.

Głównym celem badania była identyfikacja wszystkich potencjalnych barier ekonomicznych, które utrudniają dostęp do placówek opieki zdrowotnej. Stworzyliśmy podstawy teoretyczne, wykorzystując metodę PRISMA-PICOT, a następnie skupiliśmy się na podejściu jakościowym, wykorzystując wywiady półustrukturyzowane do weryfikacji naszych teorii.

Wyniki pokazują, że różne grupy osób funkcjonujące w odmiennych uwarunkowaniach są podatne na zagrożenia. W zależności od podatności danej grupy i jej specyficznych potrzeb istnieją różne bariery ekonomiczne – od niskich dochodów po niewystarczające możliwości podróżowania. Na przykład osoby z obszarów wiejskich często mają ograniczone możliwości transportu, a wiele z nich nie jest w stanie skorzystać z telefonu komórkowego, aby wezwać pomoc w nagłych wypadkach. Służby socjalne w Czechach zapewniają wsparcie osobom w radzeniu sobie z konkretnymi sytuacjami. Nie rozwiązuje to jednak kryzysu finansowego ani problemów zdrowotnych pacjentów w trudnej sytuacji. Żeby zredukować ryzyko występujące wśród tej grupy osób, należy edukować i upowszechniać wiedzę. Może to prowadzić do lepszego zrozumienia własnego zdrowia i dostępu do opieki zdrowotnej, gdy jest ona potrzebna.

Słowa kluczowe: bariery, opieka zdrowotna, potrzeby, podatność, ludzie.

JEL: I11, I13, I14, I18, J15.

Introduction

The healthcare sector in Central Europe and worldwide is diverse and influenced by several factors. It is typically appropriate to consider which perspective we want to use to understand the whole concept. Understanding the dynamics requires a deeper examination of multiple perspectives, such as health economics (Franco, Lima, Giovanella, 2021).

Within the framework of defining the cornerstones of factors influencing access to healthcare, its very anchoring and philosophy belong. There is a strong belief that universal access is an appropriate solution to cover the highest level of patients, promoting and maintaining the population's health (Maarse, 2006; Matin

et al., 2021). This universal approach offers comprehensive public healthcare systems financed by the taxes of the state's citizens. This therefore aligns with the philosophical and political belief that healthcare is a fundamental human right (Preker, Cotlear, Kwon, Atun, Avila, 2021). Global perspectives differ, particularly in privatized systems that emphasize market-oriented solutions and personal responsibility in healthcare (Garcia-Subirats et al., 2014). This concept, therefore, relies on the residents' sense of responsibility for their health, and, in the event of illness, they must be adequately protected by other institutions, such as insurance, against imminent financial expenses, or have sufficient funds saved for these needs (Politzer, Shmueli, Avni, 2019). According to research, it is evident that privatized systems are less humane towards the masses (there is no possibility of comprehensive examinations for each person), but in return, there are shorter waiting times, more friendly treatment options, and the residents themselves place great emphasis on personal prevention (Reilly, 2021; Garcia-Subirats et al., 2014).

Healthcare is a concept that evaluates and continuously develops one field at a time – the person. It consistently focuses on ensuring that healthcare meets patients' individual needs and preferences, and recognizes them as active participants rather than passive recipients (Franco et al., 2021). For these reasons, the health concept is developed in great detail into systematic fields that always strategically focus on the relevant part of the body and health philosophies. The socio-economic perspective and health economics see the intersection of possibilities in preventing diseases, acute care, planned care, and long-term care (Kehr, Muinde, Prince, 2023; Matin et al., 2021).

Healthcare as a scientific discipline is no longer described in this general way. However, it is systematically divided into sub-parts that form not only the core itself, but also shape the circumstances and encourage society to common goals, such as the eradication of diseases, prevention of transmission, prevention of the onset or development, repair of already dispensarized parts, etc (Matin et al., 2021; Garcia-Subirats et al., 2014). Here, ethical and moral dilemmas are often discussed, confronting healthcare professionals and patients with topics such as long-term care, irreversible changes, neglected or missing care, incurable diseases, or death (Kehr, 2023; Politzer et al., 2019). For these reasons, the entire perspective is not limited to patients, although the concept primarily focuses on patient care (Reilly, 2021). It is also about healthcare professionals, who within individual systems can be significantly overburdened by the large number of patients demanding healthcare in a universal system (Franco et al., 2021). Healthcare professionals often have to respond to legal complaints. They are compelled to speak out publicly against changes that would only entail additional work responsibilities, although they should also consider protecting themselves (Neugebauer, 2023).

General barriers to access to healthcare

A barrier in this context is any activity, situation, or condition that negatively impacts the standard achievement of adequate healthcare. These barriers undoubtedly include models of financing healthcare facilities, which can be public or private systems (Matin et al., 2021). The allocation of resources is also significant, as investments in healthcare infrastructure are a major phenomenon, and healthcare technology receives more substantial support in Central Europe than in other parts of Europe (Neugebauer, Vokoun, 2024). These technological advances primarily focus on the potential for significantly faster treatment and increased access to professional care for individuals in both urban and rural areas (Garney et al., 2021; Neugebauer, Vokoun, Lovětínská, 2024).

Both systems discussed have advantages and negative impacts; another topic addressed is the trade-off between cost and quality (Kyriopoulos et al., 2014). There are trade-offs between maintaining quality of care and controlling costs, which underlines the significant importance of efficient management. However, it is always true that higher quality is also associated with higher costs. In healthcare, this rule applies more than anywhere else, because the quality of care includes not only the treatment itself, but also the equipment used, materials, premises, medical team, dispensary, education, staff approach, waiting times, list of possible examinations/treatments, and much more (Kyriopoulos et al., 2014).

Commonly discussed issues focusing on the economic aspect of access to healthcare facilities include insurance options, unexpected expenses, low income or low family budgets, language, acute and chronic limitations in movement, mental deficits, changes in social role or identity, cultural differences, and poor accessibility (Ahmed, Lemkau, Nealeigh, Mann, 2021; Carrillo et al., 2011; Doležalová, Tóthová, Neugebauer, Sadílek, 2021; Neugebauer et al., 2021; Neugebauer et al., 2024; Sheikh-Mohammed, Macintyre, Wood, Leask, Isaacs, 2006). Numerous studies have shown that high healthcare costs deter individuals from seeking medical care. This includes both direct costs, such as service fees, and indirect costs, including transportation and lost earnings. It is also directly related to the country in which the population is located (Neugebauer, Vokoun, 2024). In low-income countries, even small health care costs can be unaffordable (Sheikh-Mohammed et al., 2006). In middle- to high-income countries, significant costs are often associated with specialized and chronic care (Ahmed et al., 2001). Insurance is a frequently discussed issue, as evident from various sources, which indicate that the presence and type of health insurance significantly influence access to care. Individuals with comprehensive insurance are more likely to seek and receive care promptly than those who are uninsured or underinsured. For example, in the United States, studies have highlighted significant access problems related to underinsurance, whereas European countries with universal insurance systems report lower barriers related to

insurance status (Carrillo et al., 2011; Politzer et al., 2019). High out-of-pocket costs remain a critical barrier, particularly affecting low-income groups. Studies highlight that these costs often lead to delayed care or missed treatment. In countries without public health systems, out-of-pocket costs can push families into poverty, a trend commonly observed in regions of Africa and parts of Asia (Neugebauer et al., 2024; Sheikh-Mohammed et al., 2006). Research also continues to link high-income inequality to disparities in healthcare access. Individuals from lower socioeconomic backgrounds face greater challenges in accessing healthcare (Neugebauer et al., 2024; Carrillo et al., 2011; Kyriopoulous et al., 2014; Garney et al., 2021).

Materials and methods

We established the theoretical basis using the PRISMA-PICOT approach and subsequently focused on the qualitative approach, utilizing semi-structured interviews to validate our theories. The study design is guided by a combination of anchoring theoretical concepts and standardized search strategies. That is why the first phase outlined theoretical concepts and anchored them using the qualitative method of semi-structured interviews, which was employed in subsequent phases.

Data collection and analysis

The PICOT research question should be the best choice for our kick-off part. The research question was formulated: *What economic barriers have affected patients' access to healthcare facilities in recent years?* Data were collected from the Web of Science and Scopus databases. PRISMA flow was a standardized procedure for all the screening and data analysis. Firstly, we used the following keywords: economic barriers, disparities, healthcare facilities, healthcare, access, and impact. We identified 419 articles from both databases. However, we did include more criteria for the first selection of all articles found. A specific date criterion (a 5-year range, 2024–2020) was applied, and 248 articles were excluded, leaving 171 remaining. Then, we used a particular range of citations in databases (Q1–Q3) and excluded 64 articles, leaving 107 remaining.

Secondly, we employed the PRISMA flow diagram to adhere to a standardized procedure. We screened the remaining articles for duplication (17 excluded), different languages (5 excluded), and inappropriate topic names (9 excluded). After this phase, the 76 articles remain. The next phase was abstract selection and full article reading. This phase reveals additional variables of focus, including vulnerable populations, which are defined by new terminology: *vulnerable populations, vulnerable groups of people, and specific types of vulnerability (e.g., economic vulnerability, social vulnerability, or health vulnerability).* Based on the new variables, we presented

data in other articles (Neugebauer, 2024; Neugebauer et al., 2024). This phase was crucial for gaining a deeper context, although we had to exclude some articles due to the work's aims. The abstract selection excluded 16 articles, and the full text reading excluded 19. Overall, the data presented in this study were collected from 41 articles; however, not all the data collected are presented. Few articles were used just to verify the information already said by other authors.

Thirdly, we prepared all the articles and gathered all the possible data about the economic barriers. We categorized all the data into groups and marketed them using the proper and relevant names in a general sense.

Finally, we consulted with the relevant individuals from each vulnerable population group regarding the economic barriers, drawing on the data and theories we had collected. These semi-structured interviews, which lasted an average of 30 minutes, supported the views of Czech citizens. To better understand, we created a picture as a visual grounding (Figure 1).

Participants' data

We identified seven groups of people typically affected by disparities in healthcare access due to economic barriers. We asked at the beginning of the interviews about characteristic information of our participants (see Table 1 below). We did 21 interviews (3 for each group), which should support or refute our theories. Our priority was to find relevant participants from the group they represent to assess the validity of our theories. Participants were identified on internet websites and in the databases of third-party companies. Choosing was by simple random sampling. After selection, we arrange the meeting with the participants. If they were no longer available (as can happen in individuals with chronic illnesses, pregnant women, and older adults), we would choose the next person based on the same criteria.

Table 1. Characteristic information of participants

	Group of participants	Age	Nationality	Financial income	Job	Region/ area
1	*2*	*3*	*4*	*5*	*6*	*7*
P1	Minorities	27	Iraqis	40.000,- CZK	IT staff	City
P2	Minorities	41	Indians	61.000,- CZK	Team leader IT	City
P3	Low-income people	26	Czechs	21.000,- CZK	Nursing staff	Rural area
P4	Minorities	33	Nigerian	44.000,- CZK	Payroll leader	City
P5	Pregnant women	28	Czechs	15.000,- CZK	Cleaner	Rural area
P6	Older adults	71	Czechs	18.500,- CZK	Pensioner	Rural area
P7	Low-income people	49	Czechs	17.000,- CZK	Factory worker	Small town
P8	Unemployed	36	Czechs	20.000,- CZK	Unemployed	City

1	*2*	*3*	*4*	*5*	*6*	*7*
P9	Chronically ill people	55	Czechs	35.000,- CZK	Unemployed	Small town
P10	Low-income people	51	Slovaks	20.000,- CZK	Unemployed	Rural area
P11	Pregnant women	31	Czechs	21.000,- CZK	Unemployed	Rural area
P12	Older adults	79	Czechs	15.000,- CZK	Pensioner	Rural area
P13	Immigrants and refugees	43	Ukrainians	58.000,- CZK	Company leader	City
P14	Immigrants and refugees	41	Ukrainians	60.000,- CZK	HR leader	City
P15	Chronically ill people	69	Czechs	21.800,- CZK	Pensioner	Rural area
P16	Chronically ill people	71	Slovaks	19.300,- CZK	Pensioner	Rural area
P17	Unemployed	29	Slovaks	28.000,- CZK	Unemployed	City
P18	Unemployed	33	Czechs	16.000,- CZK	Unemployed	Small town
P19	Older adults	74	Czechs	16.700,- CZK	Pensioner	Small town
P20	Pregnant women	26	Czechs	51.000,- CZK	HR	City
P21	Immigrants and refugees	24	Poles	31.000,- CZK	Nursing staff	Rural area

Source: own research.

Results

Our results were categorized into three categories, with the theoretical concept supported by the participants' data. For a better understanding of the relationships between, see Figure 1.

Low economic status

This category includes individuals who are dissatisfied with their income. On a basic level, it includes people with a low income or a limited family or personal budget. Due to changing financial situations, pregnant women and older adults are also included.

Theories refer to the insurance system as one of the barriers for selected groups of people. This was also mentioned in the interviews with the participants. It is not about whether they can or cannot have the insurance. However, there is more to all the participants than not having the money to cover those risks. If they would like to have it, the answer was: "*I love to have it, but we would rather choose food and some cultural aspects to stay in the social environment than cover risks that cannot happen now.*" Supporting information was mentioned: "You never know what will happen to you, and I know the people who cover their risks and spend thousands of crowns on *it. I prefer to improve my children's lives by buying things for their happiness*." As we can see from this category, it is more about choosing between stuff, because they do not have enough money to cover both.

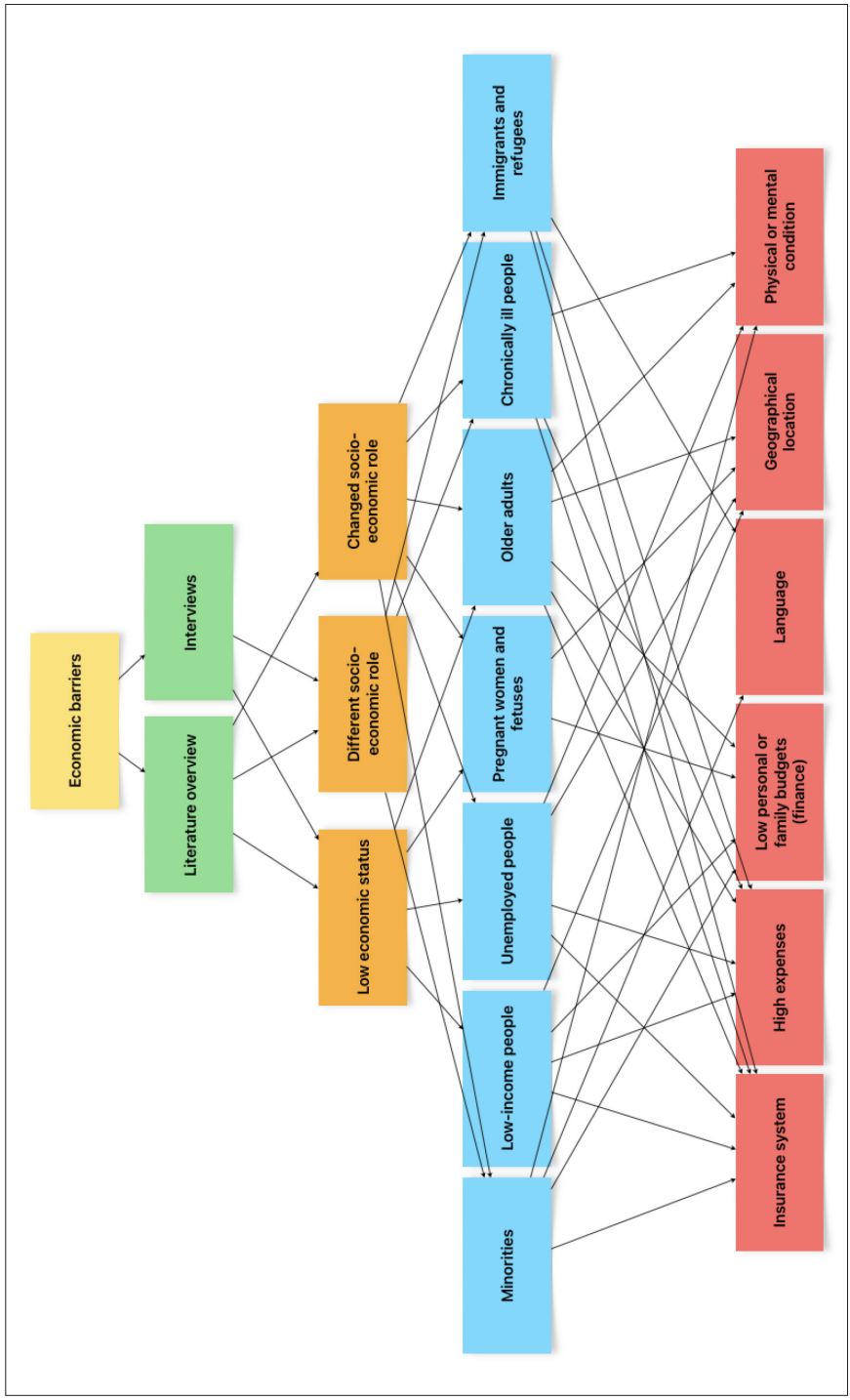

Figure 1. An overview of selected participant groups and their barriers

Source: own research.

The following situation concerns the age or health condition that excludes the clients from the opportunity to pay for it. Our participants refer to it as: "*I do not know the people my age who already have insurance. At this age, you only have a pension and little energy for another job. To be honest, I don't want to spend more time at work. I accept the statement that I cannot have personal insurance*." We should note that the participants were from the Czech Republic, where the country provides comprehensive health insurance, and personal insurance is an optional, additional coverage that includes aspects such as injuries or specific diseases requiring long-term treatment. They continued with their living situation: "*We sometimes don't have money for the bus or train. It's expensive to go there, and I sometimes don't feel bad enough to call the ambulance car*." It also refers to rural areas with no available buses or trains; people would prefer to stay home if it is expensive.

The last situation was mentioned as part of a different culture that is unfamiliar with its workings. Typically, it occurs in minorities, immigrants, and refugees: "I do not have any idea how it works practically. I already read all the information, but I'm still terrified about copayments." Other participants supported this by saying, "*I am terrified of how much I will pay there. And I cannot argue based on my poor Czech language*."

Different socio-economic status

This category refers to people with a different socio-economic status from most people in the country (typically minorities, immigrants, refugees, and chronically ill people). Our theories did not mention chronically ill people, but from their perspective, it was part of the new lifestyle that leads to different socio-economic status. "*We lived much more easily before the chronic pain and other symptoms started. After that, we had to cancel the job and stay home to receive a disability pension. I can't go to work and get more money, or live with the same values as before*." The disease can impact the patient's overall health, sometimes rendering them unable to attend the hospital. Participants supported this theory: "*If I feel bad, I do not have the choice to do anything. I can call my son to help me, or if I cannot move and do not have my phone around, I have to wait till someone comes*."

The next people were discussing the various languages and treatment styles. Different treatment methods and diagnostic systems make them vulnerable, and more education is needed. They support our theories with: "*It is bad to say it, but we do not know how it works here. I don't have the opportunity to go to the hospital. Or should I go to the healthcare facility you call Poliklinika? Many healthcare staff do not speak English and often make unusual facial expressions and comments. So I prefer to look at the internet and use online physicians*." All the participants also mentioned the high expenses, co-payments, or bad conditions.

The people of different nationalities stay consistent: "*I am afraid of what will happen. We have to go to work and pay our bills. There is no chance of being ill*."

Changed socio-economic role

This category refers to individuals who have changed their socio-economic role, allowing them to return to their previous position. Czech pregnant women did not support our theories, who said: "*I do not feel any discomfort in this area. I am pregnant, but my job is very stressful, and I can do it in this condition as well*." Some women work as long as possible to prepare the budget. One of them had a bad condition during the pregnancy and described to us: "*Sometimes there is a painful stomachache, and you have fear about your baby. It makes you panic and forces you to spend a lot of money to reach the hospital. I have no idea what I should do if I were somewhere in the countryside*." Some people also refer to money for extra technical support and treatment. They told us: "*We wanted the 3D picture of our baby or any other technical screening. But it was for extra payment, and we are happy to travel to the hospital and find some cheap furniture at home before the baby comes*."

There was also some information about geographical preferences that supports both groups, pregnant women and older adults: "*In this condition, you have to predict what happened and whether you can reach the hospital. We are saving money for a taxi, in case there is nobody around to take me there*." Older adults prefer to stay home if symptoms appear and they cannot accurately assess them. Most say, "*We have had this condition for years, so we know what can happen. There are no symptoms that we do not expect or did not have before*."

Discussion

Based on the study's selected objective, we wanted to identify the economic barriers that can lead to disparities in access to healthcare facilities and proper care. Our results reflect six potential obstacles that can be linked to a specific group of people.

The first barrier is the insurance system, which is problematic and a barrier to healthcare access. Results also suggest that misunderstandings exist in the education of foreign citizens in Central Europe, where universal insurance is funded through taxes (Garney et al., 2021). Ahmed et al. (2001) support this domain as a barrier, but used the American system as an example. Those who need to undergo treatment cannot afford it if they do not have the necessary funds. Insurance is the best choice for people who cannot afford the payment (Juarez, 2023). On the other hand, some information is available about how insurance works in the Czech

Republic and European countries, which can help prepare individuals who plan to live in different countries (Lewandowska, Kowalski, Majcherek, Hegerty, 2024; Šlegerová, Bryndová, Michenka, Kočí, 2025). Tkachenko and Kyrylenko (2023) support the information about the insurance companies and their work in each country. They also reveal information about investment strategies that everyone can apply. Some people use a combination of insurance, where they pay for the "money pillow" if they do not yet have sufficient funds. With this insurance, they also create investments that create this extra budget for unexpected expenses. After a few years, they reach the budget for covering the health problems, and paying for that "money pillow" is unnecessary (Thomas, Diclemente, Snell, 2013; Gordon, Booysen, Mbonigaba, 2020).

The second barrier is connected to the first and refers to the high expenses associated with treatment or healthcare. Our results support that people fear spending money in healthcare facilities or buying medication in pharmacies. We must mention examples from other countries, where people pay for visits to the physician, physical examinations, technical assessments, blood tests, and therapeutic plans (Carrillo et al., 2011; Gordon et al., 2020). Compared to this system, European treatment is significantly less expensive (Lewandowska et al., 2024). There is also a co-payment, but only for medications or additional treatments not covered by general insurance (Maarse, 2006; Neugebauer, 2024, Neugebauer, Vokoun, 2023).

The third barrier is a low family or personal budget. Our results support this domain as a significant barrier in non-European countries. The universal system is well-suited for individuals who cannot afford treatment, but still require it. Maarse (2006) describes this situation and notes that people from other countries also come for acute treatment to pay less than they would in their home country. It makes sense why we still have a lot of work to do, given the shortage of employees in healthcare facilities (Thomas et al., 2013). Ahmed (2001) used the American system as an example of how much people must pay. It makes sense for the people there to create an extra budget of money without the panic about what will happen. However, it does not make sense in European countries to create an additional budget or be afraid about what will happen if more than 90 % of the budget is covered by health insurance, and social insurance can also support some money loss because of the treatment (Lewandowska et al., 2024; Neugebauer, 2024; Šlegerová et al., 2025).

Language is the fourth barrier to accessing healthcare; therefore, all hospitals and healthcare facilities should have a translator available. Our results support the theory that language can act as a barrier. People are hesitant to visit healthcare facilities for proper care due to negative past experiences. Sheikh-Mohammed, Macintyre, Wood, Leask, and Isaacs (2006) discuss language as a significant issue in small countries with their languages, such as the Czech Republic. There can be more than a misunderstanding that can lead to improper care, missing care,

or delayed care. It can also lead to unnecessary tests, repeat visits, and incorrect treatments. All of these factors contribute to increased healthcare costs for patients and providers. It disproportionately affects minority and immigrant communities, exacerbating existing economic disparities and limiting their access to quality healthcare (Juarez, 2023; Neugebauer, 2024; Thomas et al., 2013). This type of barrier also encompasses some religious or culturally diverse preferences, which can lead to discrimination or unusual behavior from healthcare staff (Rapp, Volpe, Hale, Quartararo, 2021).

Geographical location is the fifth barrier on the list. Results indicate that individuals from rural areas have less access to healthcare compared to those in cities. This is due to the proximity of their residence to the healthcare facility. Many of them must travel more than 30 minutes to visit the physician. Neugebauer, Vokoun, and Lovětínská (2024) and Neugebauer, and Vokoun (2023) demonstrate in their studies that there are more connections with this barrier, and the distance from the healthcare facility can have a profoundly detrimental impact on the rest of the person's life. Local bus companies or healthcare services can help address the transportation issue (Juarez, 2023). Reilly (2021) described this as a factor that can lead to an increase in the co-payment. Imagine that some people rely on healthcare transportation services because they lack access to transportation or other alternatives. They must include the money for transport in the budget, and as Ahmed, Lemkau, Nealeigh, and Mann (2001) note, the treatment and examination are often cheaper than the transport (Yu, Meng, 2022). It is also about the facility preferences in connecting with the staff's behavior. Some people, mostly from different countries, prefer culturally sensitive facilities (Rapp et al., 2021).

These barriers are connected with the last one, the patient's health condition. Our results support the theories and environmental research. The patient relies on other services to transport them to the healthcare facility, depending on their physical condition. This condition makes them very vulnerable, and we can discuss many changes based on actual diagnoses, mental or physical status. Reilly (2021) refers to some people who cannot pay for themselves because they are in pain or under the control of the disease. It can also be very uncomfortable for both healthcare workers and patients to discuss payment before they begin treatment. Let us focus more on European style, where we do not have these issues due to a universal healthcare payment system (Lewandowska et al., 2024). Neugebauer et al. (2024) described some of these disabilities that can be caused by the lack of care or an unreachable healthcare facility. Their results contain information about healthcare facilities prepared for all transportation possibilities in big cities, including helicopters. In the Czech Republic and other countries with similar healthcare systems, people can be transported without a mandatory copayment. As Neugebauer (2024) reflected, if there is any suspicion of misdiagnosis or delayed care, the healthcare facilities communicate with each other and provide the fastest care for the patient.

Conclusion

The economic concept of barriers that lead to different access to healthcare is numerous and interconnected. Patients often encounter multiple barriers that affect their access to a healthcare facility. In addition to other health financing systems, co-financing or choice of transport is more dominant.

Six fundamental barriers were identified, including language barriers, a limited budget, an inadequate insurance system, geographical location, health status, and high healthcare costs.

In addition to this list of fundamental barriers, it was also found that patients are hesitant to seek medical help due to previous experiences or references from their home countries. One of the common barriers is also living in the countryside, which can signal that a person may be far from medical assistance. In the Czech Republic, social services are available to help individuals cope with specific situations. However, this does not solve the financial crisis and illnesses of vulnerable patients. Some knowledge should be disseminated to this group to reduce risks. This can lead to a better understanding of one's health and access to healthcare if necessary.

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