FINANCIAL STATUS OF PATIENTS WITH CHRONIC MUSCULOSKELETAL DISEASES AND LIMITED WORKING ABILITY

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Summary
Aim. The aim of the study was to assess the financial status and perspectives of patients with chronic musculoskeletal diseases and limited working ability.
Patients. 200 inpatients under rheumatology rehabilitation in the National Institute of Rheumatology and Physiotherapy, Budapest, Hungary were interviewed and assessed; 150 females (mean age: 52 years) and 50 males (mean age: 49 years); 95% of them suffered from rheumatoid arthritis, 5% from degenerative joint diseases.
Methods. Personal interviews were made with the patients about their financial status, and the per capita income in the family was calculated
Results. Of the interviewed patients, 55% had a regular employment income and 7% had both an employment income and a old age pension). 21% received a disability pension and 14% a retirement pension only. 17% survived on social benefits.
The disability pension was less than 57.000 HUF/month for 14% of the subjects, and the per capita family income was less than 28.500HUF/month in 9%. 76% had a per capita family income between 28.500HUF/month and for 15% this was over 100.000HUF/month.
Conclusions. The income of disabled persons is very low in Hungary. In spite of this – thanks to the National Health Insurance – the disabled can take part in full medical and social rehabilitation.

Key words: financial status, social benefits, disability benefits

The European Committee accepted the following objectives: promotion of full employment; universal access to medical treatment and rehabilitation access to resources; universal access to social services; the prevention of social isolation; assistance for the most disabled and aided mobility for all. If these goals were to be fully implemented, many of the most socially isolated and physically handicapped people with limited work capacity might be able to find employment (1). With these goals in mind in Hungary, we have carried out a preliminary survey of the economic and social burdens of people with limited work capability. The aim of this study was to elucidate the financial situation and the aims and goals of 200 patients with chronic musculoskeletal disease, focussing especially on rheumatoid arthritis. The authors know of no such previous study.

PATIENTS

The subjects of our investigation were 200 in-patients of the rheumatic rehabilitation service who had been presented to psychosocial English services of the National Institute of Rheumatology and Physiotherapy. The period of the study was from 1 July 2007 until 31 July 2008. There were 150 females and 50 males among the interviewed patients. The average age of women was 52 (30-70) and that of men was 49 (33-69). A summary of the age distribution is seen in table 1.

Regarding their social status, it was considered important to know if a patient lived in the capital city, Budapest or in a more rural setting. 96 persons lived in rural villages, 54 in towns and 50 in the capital city.

The great majority of these patients suffered from rheumatoid arthritis (95% of the patients), while 5% were being treated for other degenerative joint diseases, 80% of these subjects were suffering from clinical depression at the time of the study.

Table 1. The age distribution of the examined patients.

Age groups	Women: 75%	Men: 25%	Rate
30-40 years	66 persons	18 persons	42%
41-50 years	40 persons	20 persons	30%
51-60 years	20 persons	8 persons	14%
61-70 years	24 persons	4 persons	14%

METHODS

All patients in the study were interviewed regarding their current financial situation and their hopes and goals for the future. Regarding finances, only the data provided by the patients themselves was considered. The per capita income in a family was calculated according to this information.

RESULTS

Financial situation

The monetary income of this group of patients with limited working abilities is summarised in table 2. It is tabulated according to age and sex.

It can be seen from this table that 55% of the patients interviewed were younger than the retirement age and had employment income. A further 7% had a retirement pension in addition to income from employment.

21% of the study subjects were receiving disability pensions because of limited work capacity, 17% were surviving on social benefits alone and 14% were on retirement pensions alone. It should be noted that according to the National Institute of Medical Expertise, 5% of the patients were on final retirement as a result of their disability. For 14% of the studied patients, the disbursed disability pension was less than the 57.000 HUF considered the minimum living income.

14% of the study patients had retirement pensions and 7% were still part of the active work force receiving both retirement pensions and an employment income. For 4% of this 7% it was reasonable to give a pension rise based on equity. Therefore, it was suggested that they are provided with an equity-based pension rise, while 8% were encouraged to apply for a single aid. (Equity-based pension rise can be required by people with disability pension and by pensioners on their own rights; and single aid by those who have not yet applied for any temporary aid at the relevant local government.

Out of the 200 examined patients, 17% depended solely on social benefits.

The minimum level of the full retirement pension was established in 2008 in the amount of 28.500 HUF by the KSH (Központi Statisztikai Hivatal, i.e. Hungarian Central Statistical Office) and the Ministry of Finance, while the regular social allowance must be no lower than 26.420 HUF.

The monthly per capita net incomes – based on the patients' admittance – are summarised in figure 1.

The median income is considered the average income, and the poverty threshold is considered to be half of the median amount, namely, 28.500 HUF in 2008. There is no officially declared poverty threshold in Hungary, but the minimum retirement pension that is taken into consideration at social assistance can be regarded as such. According to TÁRKI's (Társadalomtudományi Kutató Intézet, i.e. Social Research Institute) monitoring data-recording and the calculating method of OECD2 (Organisation for Economic Co-operation and Development) (ILO – International Labour Organisation and the

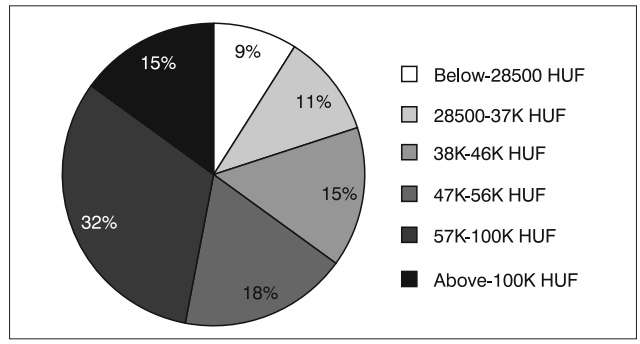

Fig. 1. Monthly per capita income based on paients' admittance.

Table 2. The activity of people with diminished working ability according to age groups.

Age group	Number and percentage of persons with active income		Number and percentage of persons with inactive income (the disabled)		Number and percentage of persons e receiving social assistance		Number and percentage of persons with pension on own right	
	Women	Men	Women	Men	Women	Men	Women	Men
30-40 years	38 (19%)	12 (6%)	16 (8%)	4 (2%)	12 (6%)	2 (1%)		
41-50 years	20 (10%)	10 (5%)	10 (5%)	6 (3%)	10 (5%)	4 (2%)		
51-60 years	12 (6%)	4 (2%)	4 (2%)	2 (1%)	4 (2%)	2 (1%)		
30-60 years	35,00%	13%	15%	6%	13%	4%	No persons with pension on own right btw. 30-60 years	
Altogether	48%		21%					
61-70 years	6 (3%)	8 (4%)	–	–	–	–	24 (12%)	4 (2%)
	Together: 7%							

World Bank), the average monthly per capita income in a household in 2007 was 69.258 HUF, while the annual poverty threshold according to this was 663.429 HUF in the same year (2) (55.276 HUF/Month).

According to this, the overall per capita income of the 200 patients in the study (calculated with OECD2 (measuring numbers: 1, 0.5 and 0.3)), is approximately 60% of the median income.

DISCUSSION

This study presents a dramatic picture about how low the financial situation of people with limited working abilities, and of disabled people, is compared to the general income in Hungary, especially when the poverty threshold level of 28.500 HUF/month is considered. 9% of the study patients survive on an income lower than this, that is, below the poverty threshold level.

A settlement sets its specified forms of social provision to the number of inhabitants. The Social Welfare Act was ratified in 1993 and then introduced as the 1993/III. It has been modified 40 times (!) since then – seemingly not without a reason.

In spite of the benevolent intentions of the central government, the social benefit laws are out of date and ineffective in as much as they do not reach everybody needing social assistance. One example of this, mentioned by all persons questioned, was the constant rise of authority controlled.

Almost half of the study patients lived in rural villages (48%). It is recognised that it is much more difficult to cope with social problems in the rural setting as social services are not available at this level. This is represented by schooling difficulties and the lack of proper work opportunity and infrastructure. However, people living in settlements with 50000 or more inhabitants are in an advantageous situation. According to the 2004 modification of the Social Welfare Acts, they have had access to residual arrears compensation as well as support for accommodation maintenance, while people living in smaller settlements can apply only for accommodation maintenance assistance (3).

The Rehabilitation Allowance Law, accepted in 2007 and taking effect from 01.01.2008 (4), sets the rehabilitation period to 1.3 or 5 years. Patients with physical and psychosocial disabilities need professional social help for this period, as – depending on the length of the period of disability – many such patients have been socially isolated, and they require assistance to re-establish their daily routine and schedule consistent with returning to work. They may need help in adapting to a workplace community, to stress situations and to the management of family and friends. Furthermore, they need time to be integrated into workforce gradually and follow-up is essential to achieve success.

Change in the official approach to disability rehabilitation and financial support is needed especially if Hungary is continuing to pursue EU membership. It should be realised that employing disabled people is an economic need and not only a charitable act.

This study has provided information only but the data acquired demonstrates the necessity of developing better programmes to help people with limited working abilities – and especially with chronic musculoskeletal diseases. These need to include medical, social and employment rehabilitation.

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