
Risk of Exclusion of Older Adults from Access to Medical Services: Findings from a Study Conducted in Eastern Poland

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Abstract:

Purpose: This article presents the findings of original empirical research aimed at diagnosing the level of access to selected medical services among older adults residing in Eastern Poland. The analysis made it possible to identify the factors limiting the use of these services, to determine the frequency of their utilisation by older adults, and to assess the organisation and accessibility of medical care. The results obtained point to significant barriers in the functioning of the healthcare system, particularly in rural areas, where access to medical services is most restricted. The problems identified indicate the need to implement measures aimed at improving the healthcare system, both at the level of local government and at the micro-social level, encompassing support for older adults and for those involved in their care.

Design/Methodology/Approach: The study covered 185 older adults aged 65–88 residing in rural municipalities of Eastern Poland. Women predominated in the sample ($N = 100$), constituting 54.1% of all respondents. A quantitative strategy was applied, using the diagnostic survey method and an original questionnaire. The survey was administered in person by the authors of the article, which allowed for the efficient organisation of the research process, direct contact with respondents, and a high return rate of correctly completed questionnaires. The study was conducted between 5 March and 30 June 2026, in accordance with the principles of research ethics, in particular voluntary participation, respondent anonymity, and confidentiality of the data obtained.

Findings: The study demonstrated the existence of a problem of exclusion of older adults from access to certain medical services. Significant difficulties were identified in accessing the care

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of medical specialists, physiotherapists, and psychologists. These limitations also stem from insufficient availability of public transport (bus and rail), a low level of digital competence, and a lack of intrinsic motivation to use the health services needed. The factors listed contribute to a deterioration in the health status of older adults. This problem is of particular importance in the context of the ongoing ageing process, which is often accompanied by chronic and coexisting diseases as well as a gradual decline in physical functioning, thereby increasing the demand for medical services.

Practical implications: The findings of the study conducted among Polish older adults demonstrate the need for systemic action within the healthcare sector to improve their access to medical services, particularly in rural areas, both at the level of local government and at the micro-social level. It appears advisable to develop and finance support programmes for older adults, including improving access to health services, developing transport to medical facilities, health-promotion initiatives, and support in the use of e-health services. The importance of psychological services and the organisation of support groups, which may foster increased motivation among older adults to engage in health-promoting behaviours, should also be recognised.

Originality/Value: The authors present the results of original and up-to-date research demonstrating the scale of the risk of exclusion of older adults from access to medical services in rural areas of Eastern Poland. The study identified the factors that, in the opinion of the older adults surveyed, most severely limit their ability to use selected health services. The issue addressed is of particular relevance in the context of the ongoing ageing of societies, observed both in Poland and worldwide, and the consequent increase in demand for medical services. The results obtained constitute a valuable empirical resource that may be used to design organisational and social interventions aimed at reducing the phenomenon of health-related exclusion among older adults, thereby improving their quality of life.

Keywords: Older adults, health, medical service, health-related exclusion.

JEL codes: I18, J81.

Paper type: Research article.

1. Introduction

Contemporary societies are experiencing a demographic phenomenon of continuous population ageing, affecting Poland, Europe, and other countries worldwide, albeit to varying degrees. The ageing of Polish society results from the convergence of several demographic, social, and economic phenomena.

It denotes not merely an increase in the absolute number of older people, but above all a growing share of this group within the total population. The most important causes include: increasing life expectancy, low fertility rates, the migration of young people, changes in family models, and the entry into old age of the numerous post-war baby-boom cohorts-individuals born in the 1950s and 1960s are now reaching

retirement age, which increases the proportion of older people within the population structure.

In the case of Poland, it is particularly significant that the ageing process is proceeding relatively rapidly: the share of people aged 65 and over is growing faster than the number of young people, which constitutes one of the greatest social and economic challenges of the coming decades.

According to the World Health Organization (WHO), old age is divided into three sub-stages: young-old age (65-75 years), old age proper (75-90 years), and advanced old age (over 90 years) (Cieplińska, 2022). Researchers consider 65 years to be the threshold of old age, although this period of life differs across occupational groups, as individuals who have reached retirement age frequently do not withdraw from professional life, continuing to display good psychosomatic well-being and strong occupational performance (Górecki, 2019).

Available data indicate that, until the mid-nineteenth century, global mortality rates ranged from 5–50 deaths per 1,000 population and were caused primarily by infectious and parasitic diseases that were difficult or impossible to treat, meaning that only a small proportion of the population survived to advanced old age (Gawron *et al.*, 2011).

It should be noted that, despite this adverse phenomenon, the "survival" of societies was determined by a birth rate exceeding the mortality rate. In 2018, there were 4,063,276 women and 2,669,084 men aged 65 and over in Poland—a manifestation of the "feminisation of old age," a global trend resulting from the biologically longer lifespan of women (Górecki, 2019). Projections indicate that, after 2025, the number of older adults in Poland will exceed the number of people aged under 18 (Fabiś *et al.*, 2015).

It is worth noting that demographic ageing is a process that entails changes not only within social structures but also across other dimensions of life; ageing societies have consequently become a particular challenge for most countries worldwide (Gawron *et al.*, 2011; Yu *et al.*, 2023). High- and middle-income countries are currently experiencing continuous demographic ageing, typically characterised by a steady decline in birth rates alongside low mortality rates.

The process of depopulation, and the associated process of demographic ageing, may increase demand for medical services and create difficulties in ensuring an adequate level of access to these services (Thiede *et al.*, 2017). The level of accessibility of medical services responds both to quantitative population changes (a shrinking population base—i.e., the size of the pool of potential service users—may reduce the supply of services) and to structural transformations (changes in the age structure of the population may increase or decrease demand for certain types of services, since demand patterns for various services differ by age) (Klimczuk, 2010).

One worrying phenomenon, observed not only in Poland, is the "urbanisation" of certain medical services (Norris *et al.*, 2014), which reduces accessibility in less-developed or peripheral rural areas and may result in health-related exclusion of entire social groups. In the Polish context, the adverse impact of a reduced supply of these services in peripheral areas is partially mitigated by the parallel outflow of population from those areas.

This does not, however, change the fact that the less mobile population must contend with declining levels of access to various public services, including medical services. Subjective assessments of the level of accessibility of medical services may be influenced by numerous factors, such as transport-related, economic, spatial, or individual factors (Heenan, 2006; Banerjee and Duflo, 2007; Thiede *et al.*, 2017).

The economic factor is highly significant (the financial affordability of a service, i.e., the population's income level), as is the individual factor (relating, among other things, to the differing needs of individuals and their satisfaction with the quality of services offered) (Heenan, 2006). Assessments may also be influenced by the degree to which services are adapted to residents' needs, such as the days and hours of patient reception.

Researchers studying the ageing phenomenon have identified a significant problem concerning the social isolation of older adults and their access to medical services. The considerations outlined above motivated the development of a research concept aimed at examining access to medical services among older adults residing in the Eastern Poland region.

The problem observed may stem from numerous factors—particularly the interplay of geographic, demographic, organisational, economic, and digital barriers—rather than from a single cause. Eastern Poland is among the regions with a relatively high share of older people. Growing demand for health services increases the burden on the existing care system. Limited access to medical services may lead to: delayed disease diagnosis, deterioration of health status and functional capacity, an increased number of hospitalisations, reduced quality of life, and a growing sense of loneliness and health-related exclusion (Calderón-Jaramillo and Zueras, 2023).

2. Factors Limiting Older Adults' Access to Medical Services: A Review of the Literature

As noted above, the problem of restricted access to medical services experienced by older adults must be examined from multiple perspectives. An important factor is health literacy, understood as the degree to which an individual is able to obtain, process, and use acquired information to make health-promoting decisions. The level of health literacy is linked to individual skills in reading, understanding, and evaluating health information, the capacity to undertake preventive action, self-care

and the promotion of positive health behaviours, communication, informed health decision-making, and the ability to advocate for one's own health and that of others.

The European Health Literacy Survey, conducted among a sample of 1,000 individuals between 2009 and 2012 in Austria, Bulgaria, Germany, Greece, Spain, the Netherlands, and Poland, revealed alarmingly low levels of health literacy in almost half of respondents (47%) (Sørensen *et al.*, 2015). Within this group, the proportion of individuals aged 65 and over with inadequate health literacy stood at 61.3% (Słońska *et al.*, 2015). It is estimated that, within the population of the United States, this problem affects one-third of residents, including two-thirds of older adults (Kutner, Jin and Paulsen, 2006).

The literature identifies a range of adverse health consequences associated with inadequate health literacy, including poorer health outcomes, repeated hospitalisations, frequent use of hospital emergency departments, and less frequent uptake of preventive measures such as screening tests, mammography, or vaccination (Berkman *et al.*, 2011).

The level of health literacy is particularly important for older adults suffering from chronic conditions—such as hypertension, atherosclerosis, or diabetes—since it influences the process of chronic disease self-management (recognising symptoms, the ability to take corrective action when a condition worsens, adherence to medical recommendations, and much else besides). Low health literacy increases the risk of frequent emergency hospitalisations and premature death (Chesser *et al.*, 2016; Baker, 2007).

A further factor concerns digital barriers. An increasing number of medical services require internet access (online registration, the Online Patient Account, teleconsultations). Some older adults have difficulty operating new technologies or lack appropriate equipment and internet access. Not everyone is able to keep pace with the rapid development of ICT. Moreover, even highly proficient ICT users sometimes become lost amid the flood (noise, overload) of information, unable to locate what they were seeking (Fazlagić, 2014; Popiołek, 2013).

In this context, it is worth noting the findings of the report *Information Society in Poland in 2018* (GUS, 2018). It emerges that the main reasons for households' lack of internet access are a perceived lack of need to use the internet (65.7% of responses) and a lack of skills (51.3%). Excessive equipment costs (22.6%) and the cost of internet access (17.4%), as well as an aversion to the internet (11.7%), were cited considerably less frequently (GUS, 2018). The greatest disparities occur in relation to education and age: the older an individual, the less frequently they use new technologies (Batorski, 2015; CBOS, 2015; Duplaga, 2017).

Given the very high proportion of pensioners using various healthcare facilities, the ongoing ageing of the Polish population—which poses an increasing challenge for the

healthcare system (GUS, 2015)—and the low proportion of internet users aged 65 and over (CBOS, 2015), older adults must be identified as the patient group most exposed to digital exclusion. It should be added that, in many cases, older people lack not only access to ICT and the relevant knowledge and skills, but frequently also the willingness, motivation, or conviction to make use of such solutions.

A shortage of medical personnel in the eastern voivodeships of Poland (e.g., Lubelskie, Podlaskie, or Podkarpackie) means that the number of specialist physicians, nurses, and physiotherapists is often lower than in large urban centres. This results in longer queues and waiting times for services. Poland remains one of the EU countries with the lowest ratio of medical practitioners per capita.

According to OECD data (2020), in 2017 there were only 2.4 physicians per 1,000 residents in Poland, compared with an OECD average of 3.6 physicians per 1,000 residents at that time. By 2021, this ratio for Poland had risen to 3.4, yet it remained below the EU average of 4.1 physicians per 1,000 residents (OECD, 2020).

According to Statistics Poland (GUS), the ratio stands at approximately 3.5 physicians per 1,000 residents, against an EU average of approximately 4.0 (GUS, 2024). The ratio for nurses is even lower: Poland has only 8 nurses per 1,000 residents (8.2 nurses per 1,000 residents according to GUS data for 2023).

By comparison, the EU average is approximately 9 nurses per 1,000 residents, while countries such as Germany or Finland achieve 13–14 nurses per 1,000 residents. In 2017, Poland ranked third from the bottom among EU countries in terms of nursing staffing levels, with only Bulgaria, Latvia, and Greece faring worse (OECD, 2020). Previous forecasts suggested that the ratio of nurses in Poland could decline further owing to a wave of impending retirements (NIPiP, 2015).

One of the significant challenges facing the contemporary healthcare system is the ongoing centralisation of specialist services, involving the concentration of highly specialised medical services in large urban centres, primarily in clinical and regional hospitals. Although centralisation may yield measurable benefits from the perspective of health system organisation, it simultaneously becomes a substantial barrier to accessing health services for many older adults.

Older people, particularly those residing in rural areas and smaller localities, frequently encounter difficulties associated with the need to undertake lengthy journeys to distant medical facilities. Limited availability of public transport, deteriorating physical fitness, the coexistence of chronic diseases, and reduced mobility make access to specialist care considerably more difficult for this group. In many cases, the need to travel several tens, or even more than a hundred, kilometres constitutes not only an organisational barrier but also a financial and psychological one.

This is particularly evident in regions with less-developed transport infrastructure, such as parts of the Eastern Poland voivodeships. A limited number of bus or rail connections, restricted availability of medical transport, and dependence on assistance from family members mean that some older adults forgo visits to specialists, postpone diagnostic procedures, or fail to undertake recommended treatment.

This, in turn, deepens health inequalities between residents of large agglomerations and those living in peripheral areas (OECD, 2025). Similarly, data from GUS underscore that the accessibility of healthcare facilities is one of the most important factors influencing older adults' quality of life. A decline in the number of outpatient clinics and medical practices means that residents must increasingly turn to facilities located in larger towns, which particularly hinders access for older adults with limited mobility.

The GUS publication *Rural Areas in Poland 2024* reports that: in 2024, there were 4,639 outpatient clinics operating in rural areas; since 2019, the number of rural outpatient clinics has fallen by 10.9%; and the number of medical practices in rural areas has declined by 31.3% compared with 2019 (GUS, 2025).

Although basic health services in Poland are publicly funded, the use of healthcare entails numerous indirect costs that constitute a significant barrier for a considerable proportion of older adults. Limited income, derived primarily from pensions, means that older people are frequently compelled to choose between expenditure on treatment and the satisfaction of other basic living needs. Among the most frequently cited problems are costs associated with travelling to medical facilities.

This applies particularly to residents of rural areas and small localities, where access to specialist physicians is limited (Kocot, 2023). For individuals lacking independence, additional costs arise from the need to secure a carer or specialised medical transport. Expenditure on medicines and medical devices constitutes a further significant economic factor. Older people frequently suffer from multimorbidity, necessitating the simultaneous use of several or more than a dozen preparations.

Despite the existence of a reimbursement system, some medicines remain fully payable or require substantial patient co-financing (OECD & European Observatory on Health Systems and Policies, 2023). The economic situation of older people is further affected by rising costs of living, encompassing expenditure on food, energy, housing, and other basic needs. Under such conditions, health-related expenditure is often deprioritised, particularly where it concerns prevention or check-up examinations whose effects are not immediately perceptible.

Limited financial resources may therefore lead to a reduced frequency of medical service utilisation and to deepening health inequalities. Economic factors thus exert an indirect effect by increasing the risk of health-related poverty (Szczerbińska, 2018; OECD, 2023; GUS, 2025).

Limited public transport constitutes a further factor restricting older adults' access to medical services. In many municipalities, the number of bus or rail connections is insufficient. For older adults who do not drive, this represents a significant barrier to accessing healthcare (Drażek, 2025). This problem is particularly evident in rural and peripheral areas, where a limited number of bus or rail connections forces older people either to rely on family assistance or to forgo medical appointments altogether.

Research indicates that transport accessibility remains one of the key factors determining older adults' ability to access both primary and specialist healthcare, and that its limitation may lead to delayed diagnosis, disruption of treatment continuity, and a deepening of health-related exclusion among older people (Wiśniewski, 2025).

Attention should also be drawn to the ongoing phenomenon of migration of younger rural residents to cities. The outflow of young people to larger cities or abroad means that an increasing number of older adults remain in many localities, while the number of people able to provide them with daily assistance and transport to medical facilities correspondingly declines (Kocot, 2023; Drażek, 2025). Migration does not directly restrict access to medical services, but it weakens the social support network and exacerbates the organisational difficulties older adults face in accessing healthcare.

3. Testing Procedure

The aim of the study was to determine the risk of exclusion of older adults residing in rural municipalities of Eastern Poland from access to medical services. On the basis of a review of the literature and available GUS and OECD reports, the main research problem was formulated as the following question: What factors constitute a risk of exclusion of older adults from access to medical services? This principal problem was further specified through three questions:

RQ1: Which factors most severely limit older adults' access to medical services?

RQ2: How frequently do older adults use selected medical services?

RQ3: How do older adults assess the organisation of access to medical services?

It was hypothesised that the risk of exclusion of older adults from access to medical services may vary depending on the type of service. The study was conducted among 185 individuals aged 65-88. Women predominated among respondents, accounting for 54.1% of the total sample. Researchers consider 65 years of age to be the threshold of old age. The study covered exclusively older adults residing in areas holding rural-municipality status. Fieldwork constituted the core of the research project. The survey was carried out using a quantitative method, employing a diagnostic survey and an original questionnaire comprising 10 questions. The study was conducted between 5 March and 30 June 2026.

Participants were informed of the study's objectives and guaranteed full anonymity, which ensured the quality and reliability of the data. The survey was administered in

person, in accordance with ethical principles. A purposive sampling procedure was applied, as it allows for a critical examination of the indicators present within the population under study and identifies where the phenomena or processes of interest are most likely to occur. A total of 185 completed questionnaires were selected for analysis. The results obtained were analysed using numerical measures and percentage indicators.

4. Factors Limiting Access to Medical Services Among Older Adults

To verify the hypothesis positing that the risk of exclusion of older adults from access to medical services may vary depending on the type of service, respondents were asked which factors most severely limited their access to selected medical services. The factors cited by older adults are presented in Table 1. Given that differences between women and men were observed in certain responses, sex was included in the table.

Table 1. *Factors limiting older adults' access to medical services*

Limiting factors	Women (%)	Men (%)
Access to a primary care physician	78.0	73.0
Home visit by a physician	38.0	32.0
Access to specialist physicians	38.0	35.0
Access to dentists/prosthodontists	25.0	20.0
Access to public transport	42.0	57.0
Access to a pharmacy	82.0	78.0
Access to physical rehabilitation and physiotherapy	55.0	44.0
Ability to book a physician appointment by phone/internet	35.0	28.0
Access to laboratory tests and/or X-ray/ultrasound	65.0	66.0
Participation in disease-prevention programmes	5.0	3.0
Access to a day-care centre for older adults	8.0	6.0
Psychological support for isolated older adults via regular home visits	3.0	0.0
Digital competence	15.0	12.0
Intrinsic motivation	50.0	45.0

Note: Percentages do not sum to 100%, as the question allowed multiple responses.

Source: Own elaboration.

The large majority of medical services used by older adults are located within their municipality of residence; accordingly, access to a primary care physician was confirmed by the largest number of respondents. Similarly, no problems were reported with access to pharmacies. By contrast, the use of specialist physicians' and dentists'/prosthodontists' services fared considerably worse, owing to the location of specialist outpatient clinics or hospitals in county (powiat) towns, away from older

adults' places of residence. Older adults' travel to specialist physicians and physiotherapists is hindered by a limited public transport network (bus, rail), and in some cases by its complete absence.

This transport barrier restricts older adults' access to specialist medical services, which they consequently use only rarely. The effects of this situation are particularly severe for individuals with limited mobility and for older women, who are significantly less likely than men to hold a driving licence—hence the observed differences between women and men. Rural areas lack specialist physicians and physiotherapists (rehabilitation practitioners); dentists practised in only a small number of municipalities.

This is undoubtedly a consequence of structural staffing problems within the Polish healthcare system, which are exacerbated in rural areas—possibly owing to the lower attractiveness of working in a rural environment from the perspective of professional development within medical occupations. This accounts for the restrictions/difficulties in access to specialist medical services reported by older adults.

The findings also revealed a barrier in the form of low digital competence among the great majority of older adults, resulting in their exclusion from information disseminated online, an inability to book physician appointments via the internet, and a lack of information about prevention programmes—hence the severely limited access of older adults to psychological services and prevention programmes.

The results further identified "intrinsic motivation" to use a given medical service as a significant factor: approximately 50% of respondents reported a lack of motivation to use services, with older adults commonly responding "I do not use it because I have no such need." A lack of intrinsic motivation to make health-promoting decisions constitutes an indirect factor contributing to a deterioration in their health.

The next issue examined was the frequency with which older adults use selected medical services. The responses most frequently given by surveyed older adults are presented in Table 2. As these patterns of behaviour were similar across the majority of respondents, percentages were not broken down by sex.

Table 2. *Frequency of medical service use among older adults*

Frequency of use/ Type of medical service	Once a week (%)	Once a month (%)	Once a quarter (%)	Less often (%)
Primary care physician	2.0	19.0	30.0	49.0
Pharmacy	8.0	50.0	30.0	12.0
Specialist physician outside primary care	0.5	4.5	15.0	80.0
Dentist/prosthodontist	0.0	3.6	8.4	88.0

Frequency of use/ Type of medical service	Once a week (%)	Once a month (%)	Once a quarter (%)	Less often (%)
Laboratory tests	0.0	4.5	22.0	73.5

Source: Own elaboration.

The highest utilisation rates were recorded for access to pharmacies. Their relatively even spatial distribution and market-based mode of operation mean that older adults find their availability, opening days, and hours convenient. The lowest ratings concerned access to specialist physicians outside primary care—i.e., physicians other than the primary care physician—particularly in relation to waiting times for appointments and the frequency with which specialists see patients.

With respect to older adults' access to medical services, the organisation of service accessibility was also examined. Older adults rated the organisational level of the services they use on a scale of 0–10. The resulting ratings are presented in Table 3.

Table 3. *Assessment of the organisation of access to medical services*

Service/Organisational element	Opening days	Opening hours	Waiting time for appointment	Frequency of reception
Pharmacy	9.8	9.4	—	—
Primary care physician	8.2	8.1	8.0	7.0
Specialist physician outside primary care	7.0	7.0	5.0	6.0
Physiotherapist	6.9	6.3	5.4	6.2
Dentist/prosthodontist	7.0	7.2	6.5	6.8
Laboratory tests	8.0	8.5	8.4	8.5

Note: Rating on a scale of 0 to 10, where 0 denotes very poor and 10 denotes very good organisational accessibility)

Source: Own elaboration.

Respondents rated the organisational accessibility of the medical services examined—i.e., the days on which a given facility receives patients, patient-reception hours, the frequency of reception, and waiting time for an appointment (referring to the length of time before the day on which the appointment is scheduled to take place, rather than the time spent queuing immediately before the consultation itself)—surprisingly favourably. The highest ratings concerned access to pharmacies, reflecting the fact that their opening hours and days suit older adults.

The lowest ratings concerned access to specialist physicians outside primary care, particularly with respect to waiting times for appointments and the frequency with which specialists received patients. Even lower ratings were recorded for access to physiotherapists. These low ratings are concerning, since older adults' health deteriorates progressively with age, accompanied by chronic and coexisting

conditions and a progressive decline in physical functioning—hence the need for comprehensive, specialist medical care. The data presented indicate that the large majority of older adults have limited access to this type of medical service.

5. Discussion and Conclusions

The aim of this article was to determine the risk of exclusion from access to medical services faced by older adults residing in rural areas of Eastern Poland. The study findings demonstrate that older adults constitute the group most exposed to the risk of exclusion—in this instance, with respect to medical services.

The findings of this study indicate that the frequency of use of various types of medical services is the product of multiple factors: spatial accessibility of specialist physicians, a limited public transport network (bus, rail), a declining capacity to use a private car with advancing age, low digital competence, and older adults' own personal needs and motivation.

The study revealed that, within the 12 months preceding data collection, approximately 10% of respondents had not visited a primary care physician even once, while 46% had not visited a specialist physician outside primary care. Studies from other countries have reported varying findings depending on the country concerned: the proportion of older individuals who had not visited a physician within the preceding six months was 1% in Japan, 14% in Germany, 31% in Canada, 33% in the United Kingdom, and 40% in the United States (Bibiano *et al.*, 2019; Pilger *et al.*, 2013).

The functional-spatial configuration of municipalities in Eastern Poland, where the older adults surveyed reside, determines the level of accessibility of certain medical services. It is of limited significance in the case of pharmacies or primary care physicians, but it is significant in the case of specialist physicians, physiotherapists, or psychologists. It should also be noted that differences between individual types of medical services in terms of frequency of use stem from difficulties in travelling to certain services.

The basic medical services used by older adults are most often located within their municipality of residence, whereas specialist medical services are located in a different municipality or in the county (powiat) of residence. Research conducted in Sweden has shown that the frequency of medical service use is influenced not only by transport accessibility (travel via public transport), spatial accessibility (travel by private car), or the location of medical facilities, but also by the degree of development of e-health services (Blusi *et al.*, 2016).

Such services may, among other things, contribute to increasing the continuity and accessibility of medical support for patients and their carers, and help reduce health-

related exclusion, particularly for individuals with limited mobility (Manzoor and Vimarlund, 2017).

Among the older adults surveyed in the Polish context, particularly in rural areas, a persistent problem is their low level of digital competence and limited internet access, which excludes older adults from certain e-health services offered by medical institutions—for example, the ability to register for appointments or check test results (Ciechański, 2023; Kujawski, 2018; Czarnecka *et al.*, 2023; Stawnicka, 2025).

The frequency of service use also varies according to the type of medical service. This does not, however, apply to primary-care visits or pharmacy use, but does apply to specialist physicians outside primary care, and to visits to dentists/prosthodontists and physiotherapists, which is consistent with the findings of other studies (Parslow *et al.*, 2004; Pilger, 2013).

Respondents rated the organisational dimension of access to medical services surprisingly positively. The highest ratings concerned pharmacies (which may be linked to their market-based mode of operation) and those types of medical services used relatively infrequently by respondents (e.g., laboratory tests). The lowest ratings concerned access to specialist physicians other than primary care physicians—precisely the medical services of key importance at every stage of human life. The frequency with which different medical services are used varies with age; as the study demonstrated, this frequency increases with respondents' age.

6. Key Recommendations

The ongoing ageing of society means that ensuring older adults have adequate access to medical services is becoming one of the central challenges of health and social policy, pursued at both the national and local-government levels. This is of particular importance in rural areas, where access to health services is limited.

The study demonstrated that the older adults surveyed most frequently use the services of primary care physicians, who play an important role in the diagnostic process, treatment, and referral of patients to specialist care. A consequence of frequent primary care use is regular use of pharmacy services.

The findings point to the need for systemic action aimed at improving the accessibility of medical services for older adults, particularly in rural areas. It appears advisable to develop and finance support programmes for older adults, including improving access to health services, developing transport to medical facilities, health-promotion initiatives, and support in the use of e-health services.

The study indicates the need to increase the availability of rehabilitation services in rural areas. It appears advisable to implement organisational and financial solutions conducive to the development of rehabilitation services, including incentives for

physiotherapists to work in rural areas and the expansion of rehabilitation services delivered at patients' places of residence.

The findings also underscore the importance of psychological support for older adults. The development of psychological services and the organisation of support groups may foster increased motivation among older adults to engage in health-promoting behaviours, to make systematic use of medical care, and to counteract social isolation.

In conclusion, the older adults in the study sample are exposed to a risk of health-related exclusion, which may lead to a deterioration in health status and a reduced ability to access necessary medical services. This phenomenon is of particular significance in the context of the ongoing ageing process, which is frequently accompanied by chronic and coexisting diseases and by increasing demand for healthcare.

The results obtained point to the need to continue research encompassing a larger and more diverse study population. It would also be worthwhile to extend the methodological approach to include qualitative methods, which would allow for an in-depth analysis of older adults' experiences and a better understanding of the factors determining access to medical services.

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