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The other health care system in Germany: care for people without health insurance

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Abstract

Background A large number of people in Germany have no health insurance. Their access to the official healthcare system is significantly more difficult or impossible. Charitable institutions try to provide medical care and create parallel healthcare structures. Their possibilities and limits are still unknown.

Methods This study identified 128 institutions for people without health insurance. A data query was used to determine the status of medical care for uninsured patients.

Results Sixty-eight of 128 identified institutions participated in the study. They provided care to 26,300 people, required €7,580,449 for their work, ran doctor's offices (57%), provided mobile care (7.8%), and arranged only medical care (29.6%). Patients of all ages need general, internal and gynecological care. The availability of health care is heterogeneous, and health care is not available throughout the country, especially not for people with limited personal mobility. The most frequent specialties were general medicine, internal medicine, gynecology, psychiatry, and surgery. Even complex care, such as pregnancy, was possible. In a self-assessment using a Likert scale, the median of the subjectively perceived level of care measured against a regular doctor's office for insured patients was 6 of 10. The provision of medicines, medical supplies or specialized medical services depended on private donations and thus on the economic situation in Germany. Participants often used multiple solutions in parallel to conserve available resources. Institutions showed a high level of responsibility to their patients. They were mostly professionally organized, with few full-time staff and many volunteers.

Conclusion Medical care for people without health insurance was heterogeneous and not universally available. Comprehensive legislative changes are needed to provide universal basic health care. The establishment of clearing houses and changes in pharmaceutical and tax law could stabilize care for people without health insurance.

Keywords Health insurance, Uninsured people, Medical care, Healthcare system

Background

The scope, quality and quantity of German social policy ensure that Germany is regarded as a welfare state. However, although health insurance has been compulsory since 2009 [1, 2] and the government only assumes 61,000

people are affected [3], at least 100,000 people in Germany are unable to obtain it [4, 5]. Most affected people have precarious employment or are homeless, students, EU citizens, war refugees, migrants, self-employed, etc. Patients without health insurance can't meet their insurance obligations due to lack of financial resources, living situations that are not described in legislation, illegal employment or delays in granting health insurance or equivalent state benefits.

As a community of solidarity, health insurance has the task of providing preventive, curative and rehabilitative health care measures (SGBV § 11) [2] that are free of

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charge for insured persons or subject only to significantly reduced copayments. Without health insurance, patients must use their own financial resources to pay for medical services [5, 6]. Outside of life-threatening emergencies, physicians can refuse treatment if the patient is unable to pay for it [7]. As a result, various independent charitable institutions have been founded to provide medical care to uninsured people. Until now, there has been no overview of their activities and care provided in Germany.

This study aimed to illuminate the scope and intensity of medical care options for people without health insurance in Germany, which has established themselves as a parallel structure in the healthcare system.

Methods

This study was descriptive, voluntary, anonymous and based on an online questionnaire. A systematic online search identified 128 institutions that provide or arrange medical care for people without health insurance. The search was carried out using the Google search engine (Google LLC, Mountain View). The keywords "free medicine", "free medical care", "uninsured people", "uninsured patients", "people without health insurance" and "patients without health insurance" were searched for all 294 rural districts, 107 independent cities and 3 city states in Germany. The first 50 entries were screened for institutions that offer or arrange medical care for uninsured patients.

A Delphi group of six experts from the fields of sociology and medicine developed 81 questions. The Delphi method involves multistage, written and separate methods. The questions related to care for people in 2022. The online questionnaire was tested on five people who provided care to uninsured people. The test persons indicated that they had no difficulty in comprehending the questions or in providing their responses. The order of the questions was fixed. Questions were displayed sequentially on the same page. There was no completeness check at the end of the questionnaire, questions could be omitted, and no adaptive questions were asked. Answers that had already been given could be changed until the questionnaire was completed. Each IP address could only participate once. There was no time limit. Search engines were unable to index the questionnaire. The server that hosted the questionnaire was part of an SOC-2 accredited data center and bound by the European Union's General Data Protection Regulation.

The study was conducted in accordance with the principles of the Declaration of Helsinki. No personal data was collected. No research was conducted on humans, animals or tissue. The participating institutions consented to participate before the questionnaire was started. They were informed about the anonymous data collection and the aims of the study. The institutions reported

anonymously on their institutional structure and their work. Due to the study design, no consultation with the Ethics Committee (IRB) of the State Medical Association of Hesse was required (Berufsordnung für die Ärztinnen und Ärzte in Hessen para. 15, Heilberufsgesetz para. 6a).

In the first step, all the identified institutions received an e-mail with a link to the online questionnaire. In the second step, the institutions received an invitation to participate in the form of a letter sent by postal mail. The invited institutions had access to the questionnaire for three months. The access rate was not recorded; the recruitment rate was 93.1%, and the completion rate was 100%.

The collected data were processed using Microsoft® Excel 2016 software (Microsoft Corporation, Redmond, USA) and statistically analyzed with BiAS version 11.06 software (epsilon-Verlag, Frankfurt, Germany). The mean and standard deviation described absolute scaled values. The median described ordinally scaled values.

Results

An Internet search identified 128 facilities for people without health insurance. Thirty-eight of 128 institutions (29.6%) only arranged medical care and didn't perform any care. A total of 73 (57%) defined themselves as doctors' offices, 3 (2.3%) of which also had a van-based mobile doctors' office, and 10 (7.8%) were purely mobile doctors' offices. The remaining institutions didn't provide any specific information on the form of their work. The providers of the institutions were church-based ($n=49$, 38.3%), private ($n=41$, 32.0%), student-run ($n=33$, 25.8%) and state-run ($n=5$, 3.9%).

Sixty-eight of 128 (53.1%) institutions participated in this study. The institutions were located in 42 large cities (> 100,000 inhabitants), 11 medium-sized cities (> 50,000) and one small town (< 50,000) (Fig. 1). A total of 98.5% (65) of the institutions were networked with other social or charitable organization and authorities, 52.4% [33] had a social counseling or clearinghouse in their area, and 27.7% [18] were the first medical facility for uninsured people in their region. In a self-assessment using a Likert scale, the median of the subjectively perceived level of care measured against a regular doctor's office was 6 (0=level didn't correspond to regular doctor's offices in any respect, 10=level identical to a regular doctor's office).

Medical care

A total of 23.5% [16] of the institutions themselves offered specialist services outside of general practice. A total of 36.8% [25] of the institutions paid external doctors for these specialized services, 35.8% [24] were able to access external doctors free of charge, and 35.3% [24]

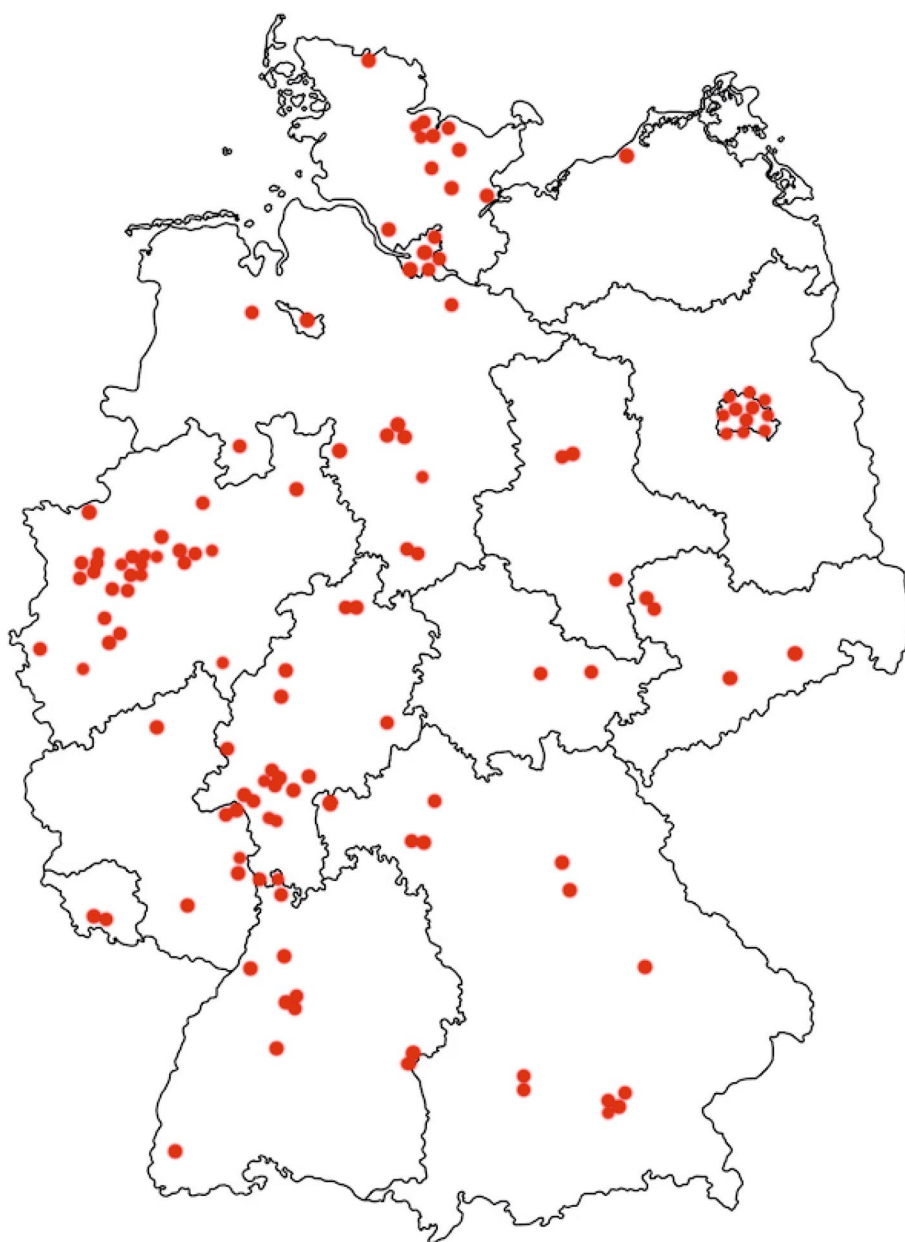


Fig. 1 Locations of institutions for people without health insurance in Germany

were unable to provide medical care outside of general practice. Numerous institutions had different forms of care at the same time.

Pregnant women were generally able to receive support at 94.1% (64) of the institutions, and deliveries were possible at 58.2% [40]. The costs of this care were very heterogeneous and ranged from free to reduced-cost delivery, in which women and institutions shared costs. Depending on the institution, outpatient or inpatient deliveries were possible.

A total of 20.6% [14] of the institutions provided dental care with their own physicians, 50.0% [34] cooperated with external dentists working free of charge, and 32.4% [22] paid external dentists (Table 1). Dental care was rarely provided in the institutions' own facilities but rather took place mostly in the practices of external dentists.

A total of 52.9% [36] of the institutions could perform minor surgical wound care (lacerations, minor wound debridement, removal of stitches), 22.1% [15] had

Table 1 Spectrum of dental care options

	% (n)
Preventive medical check-up	32.4 (22)
Denture	32.4 (22)
Tooth extraction	61.8 (42)
Root canal treatment	51.5 (35)
Tooth crown	16.2 (11)
Dental implant	5.9 (4)

physicians who could provide this care free of charge, 14.7% [10] paid external physicians to provide this care, and 13.2% [9] could't offer such care. A total of 50.0% [34] could, in principle, arrange an operation. The financial limits of surgery costs were't addressed.

A total of 17.6% [12] of the institutions prescribed medication that patients had to buy themselves at a pharmacy. A total of 14.7% [10] provided a permanent supply of medication, 51.5% [35] only provided subjectively favorable medication, 19.1% [13] only provided acute medication, and 20.6% [14] only provided medication for individual patients. A total of 57.4% [39] of the institutions supplied their patients with free medication. Numerous institutions had different forms of care at the same time. Laboratory tests were possible in 51.5% [35] of the facilities, and point-of-care testing (blood sugar, pregnancy, urine, etc.) was possible in 13.2% [9]. A total of 44.1% [30] received laboratory tests via cooperating regular doctors' offices or hospitals. Patients were able to receive vaccinations at 54.8% [34] of the facilities. The equipment used for medical aid and the provision of aids were heterogeneous (Table 2).

Radiological examinations were possible in 76.8% [45] of the institutions (27.9%, *n*=19 free of charge; 35.3%, *n*=24 against payment by the institution). Patients could be examined with conventional X-ray (45.6%, *n*=31), computed tomography (29.4%, *n*=20), magnetic resonance imaging (30.9%, *n*=21) and scintigraphy (17.6%, *n*=12).

Framework of care

Medical care was available anonymously at 92.4% (61) of the facilities, 59.1% [40] provided medical care themselves, and 40.9% [29] only arranged for care from external physicians. A total of 35.9% [23] of the institutions cooperated with at least one home care for changing dressings, personal hygiene and administering medication. Contact between uninsured patients and institutions was established through various fixed communication channels (Table 3).

A total of 5.8% [4] of the institutions could offer regular home visits, 20.6% [14] did so only for particularly

Table 2 Technical equipment and provision of aids

	% (n)
12-lead ECG	55.9% (38)
Cardiotocograph	5.9% (4)
Dental chair	11.8% (8)
Ergometer	1.5% (1)
Examination couch	63.2% (43)
Eye test charts (Landolt ring, Ishihara color charts, etc.)	22.1% (15)
Gynecological examination chair	16.2% (11)
Long-term blood pressure measurement	8.8% (6)
Long-term ECG	7.4% (5)
Manual/automatic blood pressure monitor	22.1% (15)
Otoscope	57.4% (39)
Pulse oximeter	45.6% (31)
Tuning fork	29.4% (20)
Ultrasound	24.4% (37)
Crutches	52.9% (29)
Hearing aids	25.8% (16)
Noninvasive ventilation devices	11.3% (7)
Orthoses	20.6% (14)
Oxygen concentrators	16.1% (10)
Eyeglasses	46.8% (29)
Rollators	42.6% (29)
Wheelchairs	33.8% (23)

immobile patients, and in some cases, contact took place in the form of outreach social work. A total of 16.1% [11] of the doctors' offices were licensed to bill statutory health insurance for patients with health insurance who were homeless or desocialized. A total of 32.8% [21] of the institutions had a quality management system in place to ensure consistent structural quality and 50.8% [33] had detailed hygiene plans; assuming 40 participating doctors' offices, the rate increased to 82.5%.

The documentation of patient data (personal data, medical history, examinations, therapy recommendations)

Table 3 Communication channels for patients to the institutions

	n (%)
Consultation hours on fixed days	44 (64.7)
Consultation hours without fixed appointments	24 (35.3)
Consultation hours with appointments	10 (14.7)
Consultation hours on demand	19 (27.9)
Fixed phone consultation hours	4 (5.9)
Phone hotline for general questions	17 (25.0)
E-mail	32 (47.1)
Messenger services	11 (16.2)
Video telephony	0 (-)

was carried out by 23.5% [16] using standard software for doctors' offices, by 30.9% [21] using standard office applications (MS Office, OpenOffice, Libre, etc.), and by 39.7% [27] using index cards, while 10.3% [7] didn't engage in any documentation. Personal data (67.6%, $n=46$), contact data (77.9%, $n=53$) and health-related data (79.4%, $n=54$) were documented. The medium and content of the documentation were very inconsistent.

The institutions had been caring for uninsured people for $11.5 \text{ years} \pm 7.9$, and the oldest had been founded in 1994. On average, 13.6 ± 10.0 (0–45) volunteers and 1.6 ± 3.5 (0–20) full-time employees calculated in full-time equivalent worked in participating institutions. The volunteers included 7.3 ± 7.7 (0–41) physicians and 3.6 ± 3.3 (0–12) nonphysician medical staff per facility. Each volunteer invested 10.3 ± 9.0 (0–45) hours per month. The institutions were financed mainly by private donations and rarely donations from companies, foundations, or government grants. On average, institutions needed € $158,732 \pm € 514,883$ (15–3,371,030) for medical care and administrative work in 2022. The sum for all German institutions was € $7,580,449$ in 2022. The extrapolated cost per patient averaged across all patients was € 288.23 (Table 4). A total of 61.3% [38] of the institutions took care of all financial matters themselves (fundraising, account management, donation receipts, etc.), while others outsourced these tasks completely or partially. Only 4.8% [3] of the institutions would be able to continue their work if there were no more donations.

Patients

Patient information wasn't subject to a universal minimum standard. In mean, each institution treated 487 ± 782.9 patients in 2022, for a total of 26,300 uninsured patients. The largest institution treated 3,900 patients, and the smallest institution treated 10 patients. Some institutions focused on a specific clientele. On average, $6.6\% \pm 5.9\%$ of patients per institution were under 18 years of age; in total, this accounted for 3.6% (971) of all patients. A total of $14.5\% \pm 15.7\%$ of the patients were older than 65 years per office, representing a total of 8.9% (2353) of all patients. The patients included $47.3\% \pm 21.3$ females, $49.0\% \pm 21.2$ males and 0.3 ± 1.5 other gender identities per office. The most frequently required

specialties were, in descending order, general medicine, internal medicine, psychiatry, gynecology, dentistry and orthopedics. These specialties sometimes differed substantially depending on the focus of the facility. For example, institutions for homeless people treated more psychiatric illnesses but no children. A total of 16.4% [10] of the patients treated required long-term oxygen therapy and 8.2% [5] of patients received noninvasive ventilation therapy.

Discussion

The aim of this study was to explore medical capabilities and material, personnel and financial expenditures within care for people without health insurance in charitable institutions. A structure that developed parallel to the regular healthcare system over the last two decades. The collected data can be considered representative due to the number of participating institutions and the level of responses.

Availability of medical care for uninsured people is very dependent on where they live, with some large geographical gaps. The probability of finding medical support within a metropolitan region or a large city is higher than in rural areas, which are the predominant living setting in Germany [8]. Uninsured people either had to live close to the facility or have sufficient mobility to receive basic medical care. In view of their often-limited financial resources [9], they were unlikely to meet either of these conditions. The other healthcare system relies on physicians to comply with their codified professional ethics [7, 10]. On average, the level of care provided by charitable institutions was significantly lower than that provided to insured patients in a regular doctor's office. However, while a wide range of abilities was observed, basic medical care was usually available and treatment of chronic conditions was limited. Funding is closely linked to the general economic situation of private donors. Community-based, subsidiary care for the uninsured is therefore vulnerable in the long term. However, the professionalisation of aid is leading to a significant increase in costs. The more professional an institution tries to be, the more patients it will serve. This in turn increases the need for funding and the risk of instability in the organisation.

Table 4 Cost of institutions per patient, $n = 54$

Size of institution in patient cases	Institutions	Cost per patient in EUR	Institutions paying for radiological examinations n (%)	Full-time staff
1–99	17	$175,87 \pm 184,35$	4 (23,5)	$0,4 \pm 1,3$
100–999	30	$224,28 \pm 374,52$	14 (46,7)	$0,9 \pm 1,4$
1000	7	$1025,49 \pm 1389,94$	4 (57,1)	8 ± 7

There should be minimum standards for the documentation that is kept. People in vulnerable situations, especially those in an illegal situation, also have a right to transparent treatment to ensure patient safety [Q]. Where appropriate, pseudonyms should be used.

Despite international commitments, access to basic medical care is difficult in Germany [11–13], without sufficient awareness of this in the public debate. Those affected are ashamed of the topic [14] and don't communicate openly with their social environment. Conversely, the official German statistics, which indicate that 61,000 individuals have been affected [3], suggest that the issue may be relatively minor. However, non-governmental organizations have estimated that at least 100,000 people have been impacted, with an even greater number of unreported cases [6, 15]. Extrapolated to all 128 facilities for uninsured people, these 49,500 patients would have been treated in 2022. The reason for this delta is probably a selection bias in the official census [5]. The IMIRA project of the Robert Koch Institute (German federal government agency for disease control and prevention) shows that the recruitment of the census can be improved and that new determinants should be used [16]. Focus surveys and priority studies could be appropriate tool. The socio-political discourse urgently needs reliable and transparent figures.

The lack of access to preventive, curative and rehabilitative care for uninsured individuals in a society has significant economic consequences [17]. It can be deduced that the German government should have a vested interest in facilitating enhanced access to the healthcare system. Furthermore, the German state is constitutionally obliged to safeguard the well-being of all citizens [18], thereby upholding the principle of welfare.

For a significant proportion of the population, the acquisition of health insurance is hindered by the numerous bureaucratic obstacles that exist between statutory health insurance (solidarity principle) and private health insurance (capital-covered provision for government officials, self-employed and high incomes). Despite the enactment of legal reforms in 2009, which were met with considerable opposition from health insurance funds [19, 20], instances of delays and denials of insurance coverage persist. The most common cause is financial hardship experienced by policyholders, who are often in a state of ill health. A health system financed entirely by taxes (National Health Service, NHS) as in England, with universal access for all residents after simple registration [21], would be hardly conceivable given the self-image of the German welfare state according to the Esping-Andersen typology.

An alternative would be the abolition of private health insurance as a replacement for statutory health insurance.

As in France or Austria, all residents subject to compulsory insurance would be covered by statutory insurance. Co-payments would have to be made for certain services (dentistry, medication, etc.) [22], and could be covered by private insurance [23, 24]. Nevertheless, supplementary services, such as those pertaining to medication or specialized therapies, ought not to be prohibitively expensive, thereby ensuring that individuals with constrained financial resources are also able to access them [25].

The simplification of the often intricate regulations governing state aid would undoubtedly be beneficial, even beyond the fundamental restructuring of the healthcare system. A comparable challenge can be observed in Austria, where intricate and protracted procedures result in lacunae in insurance coverage [14]. Moreover, there is a lack of coherence between certain elements of German social legislation. These laws are no longer aligned with the evolving life plans of the population, including those related to education, marriage, professional careers, and other aspects of life. Additionally, they fail to address the needs of vulnerable groups, such as children, asylum seekers, and individuals engaged in precarious work. Other German legal areas have already undergone preliminary efforts to streamline their regulations [26]. The provision of more accessible and easier-to-obtain support services could potentially address some of the existing gaps in care. With regard to vulnerable groups, it is notable that in England, compared to other countries, there is the option of obtaining an exemption from co-payments (for medication, dental care, etc.), which those affected are required to take care of themselves [27]. In France, on the other hand, the tax-funded *Aide médicale de l'État* (general medical assistance, AME) can provide comprehensive medical care if the person has lived in France for at least three months [28]. However, the use of AME is rather limited [29]. If German social legislation is not adapted and simplified, the establishment of one clearing office per district would be very helpful. Houses of care help people obtain health insurance by providing advice and assistance with bureaucratic procedures. They had a high success rate of helping bring people into an insurance relationship [30]. In addition, 6.2 million people in Germany cannot read or understand complex texts [31]. Understandably, people with poor literacy skills face obstacles in obtaining health insurance, even if they are fully eligible for insurance. Improved literacy and the implementation of low-threshold support services would certainly be useful.

Another weakness is Germany's emergency care system, where uninsured patients are repeatedly turned away in non-life-threatening conditions [32]. In situations where the patient's life is at risk, English hospitals provide care to all patients, regardless of their legal status

[33]. In France, a special AME is applicable to emergency care, with the objective of averting serious chronic or life-threatening illnesses.

The rationale behind this phenomenon in Germany is frequently rooted in economic considerations, given that hospitals are profit-oriented commercial entities. At this juncture, it is not possible to ascertain whether the forthcoming reform of the German hospital financing system will engender a shift in the conduct of emergency rooms. One potential avenue for consideration is the establishment of a state fund for emergency situations, accompanied by a reinforcement of physicians' decision-making prerogatives vis-à-vis hospital management. One solution, also in line with international conventions [11, 13] and the German constitution, would be a state fund for emergency situations and a strengthening of physicians' decision-making powers vis-à-vis hospital management. In Hesse, for instance, the attending physician is legally obliged to determine which patients require hospitalization. The sole criterion for this decision is the presence of a medical indication [34].

In France, undocumented immigrants are eligible to receive care through the special AME, which, after a nine-month waiting period or upon a doctor's request, also covers non-emergency illnesses [35]. However, few immigrants are aware of the opportunities offered by the AME [29]. This differs from the situation in England and Germany, where such assistance is associated with harsh sanctions. In England, patients have to leave the country once the emergency is over [33]. In Germany, welfare offices would generally cover the costs of emergency care for patients residing illegally, but under the Residence Act, they would have to report the case to the immigration authorities [36]. This would lead to the expulsion of the person concerned. Only an administrative regulation of the Ministry of the Interior is supposed to prevent the transfer of patient data to the immigration authorities [37], as the information in the report comes from medical treatment and is subject to an extended duty of confidentiality. However, the validity of the administrative regulation is highly questionable in light of another law. Austria rejects direct state provision for people without legal residence status and instead refers to assistance provided by charitable organizations [14]. These institutions receive government co-funding in addition to private donations [38]. It is not difficult to see that the health of migrants is being used as a means of exerting pressure on them. Human dignity and the right to avoid illness are weighed against the aims of migration policy. In ethical terms, the conflict between preventing harm and providing medical care comes to the fore. There is no data to show that restricting medical care would affect the flow of illegal immigrants. The risk of further impoverishment of sick

undocumented immigrants is increasing [39]. Furthermore, German asylum law ignores the fact that refugees are not only young and healthy, but can also be chronically ill. For the latter group, there is no provision for their chronic illness during the ongoing asylum process [40]. An amendment of the law to include the treatment of chronic diseases would be urgently needed in view of the prevention of bodily harm enshrined in Article 2 of the German Basic Law [2].

One way to improve the situation for all uninsured patients would be to set up a state treatment fund that is unconditional on residency and guarantees the anonymity of patients vis-à-vis the state. The city of Cologne and the state of Thuringia have already successfully implemented such a fund [41]. Alternatively, the local health authorities could be given the task of providing or organizing low-threshold primary health care. Of course, this will not be possible without additional financial and human resources for the health authorities.

If the existing conditions in asylum and social law aren't changed, at least the charitable institutions that care for people without health insurance could be strengthened with a structured package of measures. An important point would be government co-financing, as in Austria. In addition, the donation of drugs should be facilitated. The problem is that, for legal reasons, discounts are not allowed, and donations from pharmacies would be expensive for the donor [42, 43]. This is because the donating pharmacies have to pay VAT on each donated medication [44]. The financial situation of charitable institutions could be less fragile if tax and drug laws made it easier for them to access discounted or donated drugs. The same applies to other medical institutions and practices that would provide free care to uninsured patients if they could claim a tax benefit for doing so. The above measures would be complemented by clearinghouses mentioned above and the establishment of low-threshold social work to overcome fear, shame and lack of perspective.

As a final step, each physician should ask himself how he can act in the best interest of his patients within the framework of his duty of care to people in need of assistance in the area of conflict between economic constraints [45], normative guidelines and professional ethics [46].

Limitations

Institutions without an internet presence couldn't be included in the study. More precise collection and analysis of the diagnostic data weren't possible due to inconsistent documentation. Similarly, no objective statements can be made about the quality of medical

care. The study didn't include data or feedback from registered doctors who provide free care in their practices.

Conclusion

Health care for people without health insurance is only provided locally and is based on structures that are very dependent on private donations and volunteer work. The narrative of seamless health care coverage is not accurate. The European neighbors have implemented a variety of strategies to ensure the provision of healthcare to the greatest number of individuals.

One potential solution would be to eliminate the dual insurance structures by significantly limiting the scope of private health insurance. Social law needs to be optimized for coherence and adapted to the realities of life in society. The right to asylum should be extended to include people with chronic illnesses, so that their underlying conditions can be treated to prevent a long-term deterioration in their health. Furthermore, the right to physical inviolability should take precedence over the enforcement of migration policy objectives based on existential hardship. As an alternative, local health authorities could be provided with enhanced financial and personnel resources to facilitate the implementation of low-threshold healthcare services.

If the current complexity of the health care system persists, the nationwide establishment of state-financed clearinghouses would be an effective means of providing affected people with advice and legal assistance, thereby facilitating their access to health insurance. Concurrently, state co-financing would be necessary for the charitable institutions that provide care for uninsured patients.

The other health care system should either be enhanced or rendered obsolete.

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Authors' contributions

M.Z. planned and conducted the study, analyzed the data, wrote the main manuscript text, and created Fig. 1.

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Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

The study did not include human participants, human data, or human tissues.

Consent for publication

Not applicable.

Competing interests

MZ is the medical supervisor of a voluntary institution for people without health insurance.

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