

HEALTHY HEALTH CARE SYSTEM WITH SICK PEOPLE OR HEALTHY PEOPLE WITH A SICK HEALTH CARE SYSTEM? - RESIDENT SATISFACTION SURVEY IN NAGYKANIZSA

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Abstract

In Hungary health consciousness relates to people's will and their financial and social circumstances. At present the health care system offers consumers the opportunity for recovery and prevention both in private and public health facilities. Due to financing problems there is a great difference between the two types; health care professionals do their best to overcome difficulties, but in many cases mere expertise is not enough. Long waiting times and services unsubsidised by health funds try the patience of both the taxpayers and the medical personnel. Stress, the accelerated lifestyle and the economic situation can equally be blamed for the development of endemic diseases. However, it is more important to find out what the people behind the numbers want; what they do to maintain their health or to get better regardless of/depending on their financial conditions and what patients and doctors expect from the health care system. We have carried out a residents' survey on health consciousness in Nagykanizsa and analysed the demand and supply relations in order to demonstrate how much satisfied the consumers and health workers are with the health care system. The research included 500 local residents and 21 health service employees. The sample represents the respondents by age and sex. The questions covered the area of health maintenance, health service, eating habits and the efficiency of information.

Keywords: health consciousness, types of health care, prevention, nutrition, physical exercise

1. Introduction, aims of the research

We have a lot of definitions for the concept of health and health consciousness. Most experts believe that health maintenance has two basic types: individual and community-based. Individual health maintenance directly aims to improve the health of the individuals; in order to do that the person has to alter his/her behaviour, lifestyle and other environmental impacts on health. This approach strongly connects to the traditions of clinical intervention, medical advice and direct education. The community-based attitude focuses mainly on the economic, social, cultural, natural and technical elements of health improvement and it promotes the traditions of classical health care and community medicine [Glatz, 2002].

Health includes prevention, which includes primary, secondary and tertiary prevention. The aim of primary prevention is to avoid damage before it even occurs. It means that one tries to prevent health problems by fostering good eating habits and immunisation against contagious diseases and by protecting the environment.

The scope of secondary prevention is to diagnose diseases at an early, asymptomatic stage. By so doing, there is a good chance that the patient can be cured without any

significant damage and at lower cost. Self-examination may as well be ranked into this category. Tertiary prevention is intended to prevent health damage resulting from sickness and to avoid long-term health deficit, chronic pain and poor quality of life.

The aim of the research is to reveal what Nagykanizsa residents do for their health and what kind of prevention they prefer.

The survey includes the analysis of opinions on both the private and the public health service. Health policy is a collection of rules and organised actions, which provide conditions for health (apart from medical treatment), affect the attitude of communities and individuals towards health, and regulate and operate the health care system (health service and funding system) through legislation, ownership regulation, development policy, and financial assistance (investment and distribution) [Bartha, 2010].

2. Relevant publication

The majority of the Hungarian population appreciates health only when it seems to be in danger. In 2010 a survey was carried out on health consciousness based on TGI's research, which represented the 14-69-year old Hungarian population by sex, age, educational level, region and settlement type. The analysis based on TGI's consumer research provides an opportunity to investigate health maintenance and lifestyle closely. Besides health issues, they explored the dominant attitudes in everyday life, and buying and consumer habits.

The results show the lack of preventive approach; our health gains attention in "emergency", which means that most people values health only when it is in danger. Specialists in pharmaceutical industry are familiar with the NHS facts and figures that indicate the ratio of smoking, alcohol consumption and obesity within the Hungarian population. On the contrary, less than half of the adult population feels necessary to take measures towards health maintenance. Fifty percent of the population claims that they stay away from medical examinations (52%) and taking pills (38%), if possible. Less than 20% of the adult population has comprehensive health maintenance techniques, however, these methods are not always considered medically based. This approach is mainly characteristic of females, inhabitants of towns and people in high positions. For young people health is in strong connection with physical appearance. People in their twenties create their lifestyle in compliance with appearance. Their primary aim is to have an attractive, athletic body, but long-term health maintenance is less dominant in their everyday life.

They engage in physical activity sporadically or on an irregular basis, many of them smoke and the ratio of heavy smokers is fairly high (Molnár-Ilk, 2010). Young males, who consider physical training as an integral part of their life, form the most open-minded group in terms of health maintenance and health consciousness. The middle generation, mainly middle-aged females, does little for health, since they have not experienced health-related problems yet. In theory they are interested in healthy lifestyle, but this is not a governing idea in their everyday life, food consumption and buying habits. Low-skilled, older people living in rural areas accept in resignation that their health decline and do virtually nothing to get out of the situation. Their proportion is about 28-30% in the overall population. Sport might as well play an important role in health maintenance, however, only a quarter of the adult Hungarian population engages in sport activities on at least a monthly basis. The most popular sport is cycling, but only 10% of the Hungarians ride a bicycle either occasionally or regularly. Males, young people and people with a higher level of education or holding top positions are most likely to engage in sport activities. The consumption of organic food and other categories of functional foods is not part of the regime; it is typical of a limited proportion (~10%) of the population. The ingestion of organic foods is in vogue but not widespread at all. Mainly women with high educational level and social status are open to this food category. On the other hand, the research shows that despite the low level of health consciousness within the Hungarian adult population, there have been groups formed which can be converted into health conscious consumers with proper, long-term education [Aszmann, 2010].

2.1 Hungarian health statistics

The health of the Hungarian population is declining constantly as it did in previous years. Several factors contribute to this situation such as economic circumstances, unemployment, decreasing wages and increasing poverty. Long-term stress, lack of physical training among adults, malnutrition and environmental hazards make things even worse [<http://egeszsegmegorzes.org>].

Among the member states of the European Union Hungary is near the bottom of the list concerning life expectancy at birth and healthy life years. Life expectancy for females is 77.6 years, for males 69.1 years; number of healthy life years is 55. Mortality rate in Hungary was 926 per 100,000 in 2008, which means the country belongs to the Central/Eastern European block where the rate is far above the EU average.

Leading causes of death in Hungary:

- cardiovascular disease: 50.6%
- malignant neoplasm (cancer) : 24.6%
- digestive system disease: 6.6%
- respiratory disease: 4.8%
- external cause: 5.8%
- other causes of death: 7.4%

[Health Policy Department, 2008]

Hungary's suicide rate was 21.5 per 100,000 inhabitants in 2008. This indicator says the country is last but one in Europe, which means that among the EU members only Lithuania had higher suicide records in 2008.

Statistical information on the smoking habits of the young reveals that the situation in Hungary is worse than the EU average. 21% of girls and 22% of boys smoked at least one cigarette during the one-week investigation in 2005 and 2006. This figure ranks Hungarian youth in the upper third of the countries with the highest smoking rate among young people.

Alcohol consumption in Hungary is far above the EU average as well. 32% of the Hungarian girls under the age of 15 and 40% of the Hungarian boys under 15 have already drunk alcohol at least twice in their lifetime.

Eating habits of Hungarian young people can be analysed and compared by assessing their fruit consumption. In this respect the figures are at the same level as the EU average. As for physical activity, Hungary is in the middle rank, slightly below the EU average. 23.5% of 11-year olds and 15% of 15-year olds do physical exercise on a regular basis. However, we observed that as they grow older regular physical activity (at least five days a week) loses importance.

Obesity and the problems accompanying it are critical factors in Hungary as well. 18.8% of the adults over the age of 15 years were obese (18% of females and 20% of males), which is above the 15.55% EU average.

2.2 Market of medical services in Hungary

The consumption and the utilisation of medical services cannot be self-regulatory due to the unique features of health care system. On one hand, the economic principle saying “demand determines supply” cannot be applied, because health care works the other way around: supply determines demand. There are two reasons for this:

- the demand is not objective enough, because the concept of health is not exact

- health cannot be defined as lack of sickness, since in this case the seller (e.g. a doctor) determines the demand

On the other hand, health market cannot regulate itself because the consumers are not able to control their own needs. It is called information asymmetry [Kincses, 2006].

If we consider health care system as part of the market, we can differentiate four participants: consumers, providers, sponsors and regulatory agencies.

Consumers, patients

They are not in the situation to find solutions to their problems. They expect health care providers not only to cure diseases but also to improve the quality of life. They require appropriate health service to be available all over the country and they want to pay for it as little as possible (including taxes and benefits).

Health care providers

Providers include hospitals, clinics, doctor's offices, pharmacies, health resorts etc., and their suppliers as well (pharmaceutical companies, manufacturers of medical devices, construction and food industry). Providers have expectations for sponsors in the first place demanding predictability and reasonable, cost-sensitive prices.

Sponsors

Public and private health insurance companies, state budget, civil organisations, churches etc. belong to this group. Their intention is to buy optimal quality services at a reasonable price. They aim to control expenditure and minimise moral hazard. Gyula Kincses states that the conflict between „technically possible” and „economically affordable” raises fundamental problem in sustaining health systems [Kincses, 2006]

Regulatory agencies

The most important participant in this group is the state apparatus that is responsible for creating objectives and strategies for health policy. The State defines the objectives and assigns financing methods to the goals, and finally incorporates them into a law. The State has the duty to provide high-quality services and equal opportunities for all.

There may be other participants such as local governments, social organisations, foundations, non-profit companies, churches etc. [Karner, 2005].

Activity of health care system can be measured by assessing certain data, e.g. patient-doctor encounters that consists of three parts: GP service, ambulance service and in-patient care. Table 1 shows how the figures changed between 2005 and 2009. The number of GP

visits and outpatients increased after 2007, while the number of hospitalised patients stagnated or slightly fluctuated.

Table 1: Number of patient-doctor encounters

<i>per thousand cases</i>	2005	2006	2007	2008	2009
GP visits	71,911	72,436	61,466	64,176	68,996
Specialised ambulance service	69,876	68,139	56,395	59,568	62,000
Specialised in-patient care	2,800	2,716	2,423	2,508	2,528

Source: <http://medinfo.hu>, retrieved 24 November 2011

The funding of health care system is built on performance-based financing through normative legislation. This policy means that the central budget refunds the expected average costs of services performed.

In terms of *primary care* it is manifested in per capita subsidies; general practitioners are basically paid by the number and age structure of their patients.

As for *ambulance service*, the providers are given points for the services performed (diagnosis, therapy) as established in the ICPM (International Classification of Procedures in Medicine) coding system. Health insurance system pays the current value of HUF for these points.

Providers in *in-patient care* are financed through a flat-rate contribution, which is determined by DRGs (disease related group). Cases are arranged in homogenous groups in terms of medical similarity and similar cost claims. Each DRG has its own cost structure and weighting factor, which indicate the expenditure requirements of cases.

The sum of health care expenditures in Hungary was 1,567 billion HUF in 2003 and 1,932 billion HUF in 2008. In per capita terms, it was 155 thousand HUF in 2003 and 192 thousand HUF in 2008.

Hungary is the only OECD country in which recession made health care expenditures decrease each year between 2007 and 2009 in real terms.

Public expenditures per capita accounted for 113 thousand HUF in 2003 and 137 thousand HUF in 2008.

Households spent more money per capita as direct (i.e. not through tax) health care expenditure between 2003 and 2008. The sum increased from 37 thousand HUF (2003) to 46 thousand HUF (2008), thus they paid 33% of the entire public expenditure; in other words, households added 1 HUF to every 3 HUF the government spent on health care.

If we consider health expenditures as a share of GDP, we realise that the ratio was above 8% between 2003 and 2006, and it dropped back to 7.2% in 2008. GDP declined significantly in 2009, yet health spending ratio remained the same.

In Hungary, public expenditure accounted for 71%, while private expenditure had a share of 29% in 2008. Public share is below the OECD average of 73%.

The bulk of public expenditure is spent on curative health care, more specifically on in-patient care and drug price support. Private household expenditures were distributed equally between curative health care and pharmaceutical products.

As for funding, in Hungary public health expenditures are financed by the central and municipal budget, and by the National Health Insurance Fund (OEP) that has a share of 80%, the largest part of the total health care expenditure.

In-patient care has the largest ratio (34%) of public expenditure. In Hungary in-patient care is financed by public expenditure mainly, the proportion of private fund is low.

The costs spent on medical products, including pharmaceutical products and therapeutic appliances, has a share of 28% of public health expenditure and 36% of total health expenditure. Per capita expenditure on medicine is not excessive in Hungary, meaning that not the expenses spent on pharmaceutical products are high, but the amounts invested into other services are low.

The ratio of public expenditure reserved for prevention is 4%. Expenditures on disease prevention and protection of mothers and children represent the largest share of prevention [Hungarian Central Statistical Office, 2010].

2.3 Nagykanizsa health facts

Having summed up the results of former health surveys in Nagykanizsa, the ratio of active smokers has been found relatively high, half of whom has never even tried to break the habit. Alcohol consumption is a significant problem: out of 1000 respondents, more than 600 drink alcohol at least monthly. Few people engage in sport activities on a regular basis, the inhabitants consider their activity level average. Although residents do not recognise, the majority has a weight problem (56% of a sample of 1000). One-third of the inhabitants have hypertension, the average cholesterol level is high. About 10% of the population in Nagykanizsa has hyperglycaemia. A significant number of people claim that they are often under stress, mainly at work. The most frequent diseases are obesity and hypertension, and cardiovascular diseases pose serious risks as well [Kercsmaricsné Kövendi – Kalmár, 2008].

In order to explore health situation, there has been an investigation to detect the proportion of 50,000 inhabitants being registered with the general practitioner system. The figure was 43,382 in 2009, i.e. about 85% of the residents can be found in the system and are represented in this statistics. The following table contains adults (19+) only.

The decreasing number in people having access to health care is due to the population fall experienced in Nagykanizsa in recent years.

With this in mind, let us have a look at the patient volume in the past few years. Table 2 shows that the majority of doctor-patient encounters were visits at the doctor's office, namely 291,816 cases in 2009. The number of patients sent to in-patient care (hospitalised patients) is significantly high as well, 48,180 cases in 2009.

Table 2: Patient volume in Nagykanizsa

<i>Nagykanizsa</i>	<i>Patient volume by type of medical service (general practitioners)</i>						
<i>Year</i>	<i>office visit</i>	<i>home visit</i>	<i>sent to outpatient centre</i>	<i>sent to inpatient care</i>	<i>preventive examination</i>	<i>follow-up visit</i>	<i>other</i>
2006	309,446	19,694	37,329	1,350	0	43	33
2007	236,608	10,682	29,054	1,085	n/a	21	2
2008	256,408	11,862	30,952	1,040	n/a	25	n/a
2009	291,816	11,865	48,180	763	n/a	25	4

Source: Hungarian Central Statistical Office (KSH), retrieved 28 November 2011

Notice the constantly increasing number in hospital care, however, the other categories usually show decline. Sadly, the preventive examinations do not show up in the statistics, since prevention is not a general activity for GPs.

3. Methods

The empirical study took place in Nagykanizsa. Besides quantitative research we carried out a questionnaire-based survey. The polling was run between March and June in 2011. The samples for the quantitative survey were based on the population figures provided by the Mayor's Office on 17 January 2011. The sample consisted of 500 people, 47% male and 53% female. The survey represented the population by sex and age group. We applied random selection when choosing samples [Babbie, 2001]. We conducted in-depth

interviews with 21 health care professionals, including doctors, physiotherapists and non-medical practitioners.

We carried out correlation analysis by doing cross tabulation in the process of hypothesis testing. The relation between the nominal scaled variables is called association, which was measured by contingency table. If the independent variable differs from the dependent variables, there is a correlation between the two variables; the greater the difference, the stronger the correlation. Null hypothesis formed the basis for the testing, which claims that there is no correlation between the two variables in the sampling frame. Based on the separate distribution of variables, joint probability distribution of variables can be calculated assuming there is no correlation between the two variables. If the independent variable differs from the dependent variables, there is a correlation between the two variables; the greater the difference, the stronger the correlation [Molnár-Barna, 2004; Kardos Z-né-Dugonics, 2000]. The research was supported by János Bolyai research scholarship.

4. Research results

We want to present the consumer assessment of the quantitative study, including the analysis of health maintenance, health service (public and private health care), outpatient care, eating habits and marketing strategy. 92.3% of the people involved in the research claim that they have positive attitude towards health maintenance. 60.7% consider their health condition average, 28.2% feel completely healthy, and 11.1% admit having some kind of disease.

Close to one-fourth of the inhabitants (21%) aim for health maintenance and live a health conscious life, 27.45% eat vegetables regularly and 44.1% spend time in the open air on a regular basis. The bulk of respondents make efforts to live healthy, however, more than 44.7% drink coffee habitually (more than 3 cups a day). It is a positive fact that many of them (88.3%) neither visit solariums nor drink alcohol (70.4%) regularly.

On a daily basis 32.4% take vitamins and food supplements, 21.1% on the grounds of illness and 21.1% never.

We were also interested in their sporting activities. 20.2% take a walk regularly, 14.1% ride a bicycle, and 10.3% are fond of ball games (handball, basketball and football), on the other hand 15.2% are not engaged in any sport activity.

We had a wide range of answers for the question concerning addiction: 40% have no addiction at all in their opinion, which might as well be good news; however, addicts are often unaware of their condition.

17.8% admit being a heavy smoker, 12.5% drink too much coffee and 9% overuse sugar. There number of people, who spend a great amount of time sitting in front of the computer, has increased (9.6%). Other harmful habits are - though the figures are insignificant - the consumption of fast foods and the excessive intake of medical products as a preventive measure. The use of psychotropic substances accounts for 0.2%.

We asked people about their participation in screening tests. 20.7% of the sample frame took part in pulmonary screening, 16.7% in dental screening and 16.2% in ophthalmologic screening. 10.1% were screened for gynaecological cancer, which is a significantly low number since 53% of the respondents belong to the female sex. Nearly 6% attended either mammography or cardiovascular and general medical examinations. 2.7% of the respondents, most of whom are children, did not participate in any screening.

35.1% voluntarily go to screening because they feel it necessary, 31.1% attend on the advice of a doctor, while 21.7% need screening because of their job or driving licence. Other category included school physical exam and genetic disorders.

Health of the skin is very important, because it can be either a protective shield or a “root” of a disease. 25.4% used suntan lotion while sunbathing, 14% hydrate their skin on a daily basis. 4% visit solarium, the excessive use of which may have serious consequences. 3% turns to dermatologists for advice, 3.6% attach importance to the care of the aging skin while 13.8% are not concerned with this matter.

Tooth-brushing seems to be more important, 8.1% clean their teeth after every meal, 57.6% two or three times a day and 29.9% once a day. Sadly, 3.4% of the respondents happen to brush their teeth a few times per week only and 1% is not preoccupied with this activity at all; consequently sooner or later they will have nothing to worry about.

4.1 Comparison between public and private health service

69.1% of the respondents in Nagykanizsa are dissatisfied with public health care. The main reason can be that sick people are more sensitive and require intense attention, which cannot be provided by the inadequately financed public service, with shortage of staff. The majority complain about the long waiting times, however, they are contented with the skills of the medical personnel. Several of them express displeasure about gratuities in public health care and prefer private service, because they are paid more attention in the latter one.

Many people think that public health care can be financed solely by social security contribution (45.3%) or private payments (27.5%). Another question concerned the funding of public service by taxes and social security contribution; 54.4% of the inhabitants believe that these two forms of financial assistance manage to cover the expenditures of public health care. 61% would be willing to sign to additional voluntary health insurance, subject to improvement of the system.

43.3% utilise both private and public services, 38.8% attend only public services and 17.8% go to private doctors exclusively. 12.3% of the respondents allot a maximum of 2,000 HUF to private services, 26.4% pay 2,000-4,000 HUF and 27.2% 4,000-6,000 HUF. The remaining proportion would devote any amount, if they are given more attention by private doctors. 54.7% visit a specialist when they are sick, 31.7% treat themselves at home or ask a family member for help, 6% prefer complementary medicine (non-medical practitioner, chiropractor), and 4.5% consult a pharmacist. In most cases (more than 88%) people know what kind of specialist they should turn to. Regarding private services, we focussed on the frequency they are visited by patients. Private dental, ophthalmologic, dermatological, gynaecological and otorhinolaryngological services are attended most frequently because of the delicate procedures and the confidence they require. In spite of the health propaganda, 90.2% of the population does not take part in oncological screenings and more than 80% do not participate in cardiovascular, orthopaedic, urological, pulmonary, rheumatological, neurological and psychiatric screenings. Dietitians are contacted virtually only by people who are sick already.

38.4% of the respondents take medicine or medicinal products on a daily basis, 19.9% keep analgesics and antipyretics at home. 12.6% have anti-cold products and 12.7% have vitamins in their house. Eating habits of the residents, including preferred foods, were studied also. 25.5% have a light meal in most cases; on the other hand, 20.9% enjoy Hungarian cuisine. Foods rich in carbohydrates (18.1%) and high fat meals (11.4) are popular enough with the consumers. 20.8% like mineral water the best, 14.5% prefer tap water, 16.7% drink coffee and 15.5% favour tea. Fruit juice (8.5%) and carbonated soft drinks (6.2%) are popular with young people and children mainly. 26.7% eat titbits during social events and 22.9% while watching TV; 11.3% of the respondents do not consume snacks. We have found out the way they gather information about health services. 27.3% choose a doctor on the basis of recommendations from relatives or acquaintances. They also collect data from free health-related publications (7.4%), the Internet (7.3%), advertising papers (4.2%) and the local media (television and radio).

4.2 Verification of correlation analyses

We summarise the results of hypothesis testing, in which we searched for correlations between health service and the willingness to sign additional voluntary health insurance. We also analysed the sporting activities of people who consider prevention important and the effect of sport on their general state of health.

Hypothesis 1: There is correlation between the satisfaction with public health care and the willingness to sign additional voluntary health insurance.

Table 3 shows that most respondents think that neither additional health insurances would help “cure” public health care, nor they would get better service as a patient. The majority of people are dissatisfied with long waiting times and poor work conditions in health care that make medical personnel show less empathy. 14% are strongly against additional health insurance and 32.8% doubt its successfulness.

Even people satisfied with the system prefer private service to capital injection into public health care. Both groups acknowledge the professional competence of medical staff; since they demand help from the very professionals in private service, too. However, people feel that they are paid more attention in private care and the services offer high standard, quality value for money. Level of significance accounted for 0,0000 in the study.

Table 3: Correlation between the willingness to sign additional health insurance and the satisfaction with public health care

		<i>Willingness to sign additional voluntary health insurance</i>			
		<i>strongly opposes it</i>	<i>doubts its successfulness</i>	<i>supports it subject to services</i>	<i>supports it in any case</i>
<i>Satisfaction with health care system</i>	<i>not satisfied</i>	14%	32.8%	16.6%	8.2%
	<i>satisfied</i>	7.8%	8.2%	6.8%	5.6%

Source: own research

Hypothesis 2: Inhabitants of Nagykanizsa who attach importance to prevention do more physical exercises

Sporting activities within the population of Nagykanizsa vary widely. The results show that on one hand young people receive compulsory physical education within the frame of the education system. On the other hand, people at the age of 30-40 who consider prevention important engage in sporting activities on a regular basis to stay healthy and 69.2% do physical exercises individually.

Table 4: Correlation between sporting activities and the importance of staying healthy

<i>Importance of staying healthy</i>		<i>Sporting activities</i>	
		<i>Not engaged in sports</i>	<i>Engaged in sports</i>
	<i>Not important</i>	4%	4.4%
	<i>Important</i>	22.9%	69.2%

Source: own research

5. Conclusions

Nagykanizsa residents think that 87.1% of the population supports public health care in the proportion of their income. They dislike public health care system because of the long waiting times and the lack of empathy. They feel their problems are given more attention in the private system.

The public system is inadequately financed and often even essential medical treatments are delayed for financial reasons. The respondents are satisfied with the competence of doctors and medical personnel.

Real preventive approach and practice do not exist or are imperfect; preventive attitude in everyday life is restricted to a minority of people. Primary prevention is less widespread than secondary and tertiary prevention. On the basis of the results we can say, that the value of health is recognised by most people only when it is in danger.

The consumption of organic foods and other categories of functional foods is not part of the regime; it is typical of a limited fraction of the population. Most people still prefer fast foods and spicy dishes that are hard to digest, however, sport activities are gaining popularity. Preventive screenings should be promoted to increase attendance rate.

There exists correlation between the attitude towards sporting activities and the ambition for living healthy that can be strengthened through adequate education and modelling at a young age.

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