Global Health Survey, 2011

EXPERIENCE & PERCEPTION IN 28 COUNTRIES

International Research Institutes www.irisnetwork.org

Market Research Worldwide iris

B&A BEHAVIOUR &ATTITUDES

IRIS HEALTH STUDY

33 country members: 28 took part in this Global Health Study.

22,000 interviewed: mix of methodologies.

Update and expansion of a 2005 study.

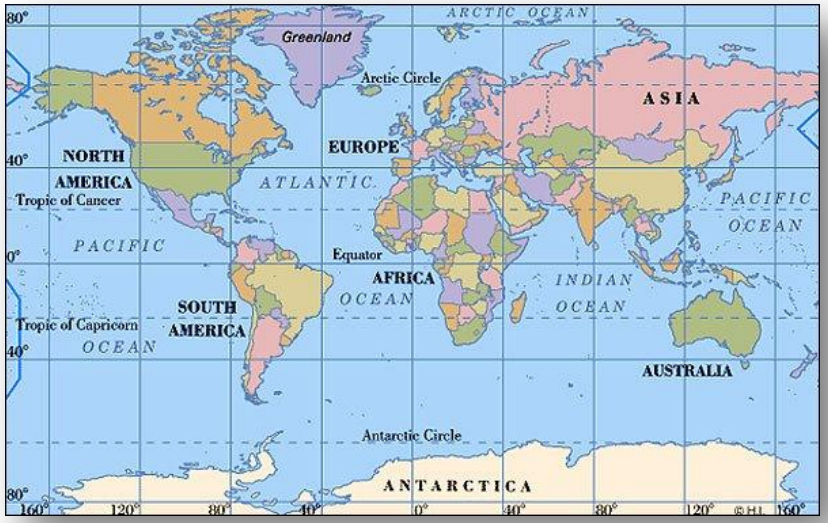
Designed and managed between Ireland, Canada and Romania.

IRELAND

Nationally representative, face-to-face, in-home survey of 1,000.

Behaviour & Attitudes Barometer survey.

Larry Ryan has been a Council Member of IriS since 2001 and co-designed the 2005 survey and developed and co-ordinated this survey.



ABOUT IRIS

International Research Institutes is the largest association of independent market research agencies in the world. Members are respected local companies, owned and run by their management. IRIS currently has 33 members, enabling network clients to access high quality, committed researchers worldwide.

IRIS aims to operate as a conduit of best practice approaches, knowledge, and staff exchange between members, as well as offering clients access to a similarly committed team throughout the world. Agencies meet together six monthly, and participate in inter-agency work teams, so clients can be assured that they are working with colleagues in distant markets that are known and trusted by their local agency. Local members understand the best approaches to use in their own markets: in IRIS there is recognition that local expertise must be balanced with global reach.

All members are committed to a common Quality Code, with highest standards. Members are only invited to apply to join on proof of their ability to meet these high standards, and must then be vetted and endorsed by existing members. All partner agencies also adhere to ESOMAR membership standards.

FOREWORD

Healthcare is one of the key concerns that impacts upon all countries and people worldwide. It is also an important and growing area for market research and a focus for many researchers in the IRIS network and their clients.

In this context, the members of International Research Institutes have conducted this survey to examine global perspectives of and experiences in the context of health and healthcare and to see how this varies by country.

The IRIS Global Health Survey is based upon a comparative survey of perceptions and experiences across 28 countries in Europe, Asia, North and South America, Australia and Africa.

A similar but smaller scale study was undertaken in 2005, in 21 countries, and it is intended that this study will be updated again in the future.

This survey was funded by IRIS members for internal and client use, to demonstrate the networks commitment to the healthcare sector and to illustrate its strength and ability to run multimarket studies with ease.

ABOUT THE STUDY

IRIS is delighted to share the results of 22,493 interviews undertaken across five continents by members of the IRIS network in each country.

The survey reflects the opinions of the adult population in each country. Fieldwork was confined to those aged 18 and over in 22 of the 28 countries with a small proportion of marginally younger respondents (ie: 15+ or 16+) included in Ireland, Lithuania, Slovenia, the Ukraine, Egypt and Pakistan. A substantial sample was used in each country and the data was collected between August and October 2011.

The members of IRIS welcome the use of this data by their clients and by the media, but would ask that references are made to the *International Research Institutes Global Health Survey* and also to the local IRIS member in that research market.

METHODOLOGY

A central methodological approach was not imposed on each country, but rather, local members were asked to use the interviewing method which they felt best meets with the research and cultural norms of their respective countries.

Thus, data was collected using a range of approaches, encompassing face-to-face in-home interviewing, Computer Assisted Telephone Interviewing, and indeed online interviewing. Nonetheless a common questionnaire was used in each market.

An overview of the methodologies and sample sizes used is detailed in the table opposite.

BASE	Method	All respondents	Respondents who received health services from a family physician in the public system
TOTAL		21987	12920
Finland	Online	500	147
France	CATI	959	594
Germany	Online	1087	873
Greece	CATI & Online	1002	352
Hungary	CATI	500	390
Ireland	Face-to-Face	999	646
Italy	Telepanel	2030	1326
Lithuania	Face-to-Face	1005	762
Netherlands	Online	1062	802
Poland	Online	812	610
Romania	Face-to-Face	1100	804
Russia	CATI	520	449
Slovenia	Online	501	424
Turkey	CATI	417	294
UK	Online	1000	683
Ukraine	Face-to-Face	600	284
USA	Online	1014	274
Canada	Online	1006	758
Chile	Online	640	267
Colombia	Online	506	
China	Online & Face-to-Face	1000	-
India	Face-to-Face	1056	692
Indonesia	Face-to-Face	500	129
Malaysia	Online & Face-to-Face	427	159
Thailand	Online	540	304
Pakistan	Face-to-Face	300	219
Egypt	CATI	500	31
Australia	Online	910	648

RESEARCH HIGHLIGHTS

Most people around the world tend to have a positive perspective of the state of their own health but there is evidence that some populations are less well informed about contributors to and detractors from health.

There is a broad spread of attitudes towards the running of local health systems, with many dissatisfied and much blame being placed upon poor management, in most instances ahead of perceived underfunding.

Confidence in local systems can be quite diminished, but this generally contrasts with very positive perspectives of the physicians working in local healthcare systems. Broadly speaking, there is a widespread tendency to criticise the system but to praise the individuals working within it.

Around the world, the majority in most countries favour a more publicly funded system, although there are decisive differences in the context of America particularly.

The study also examined the variation in usage of different types of healthcare professional, with family physicians (or general practitioners) the key point of contact generally, but some healthcare systems relying more centrally upon privately funded specialist physicians.

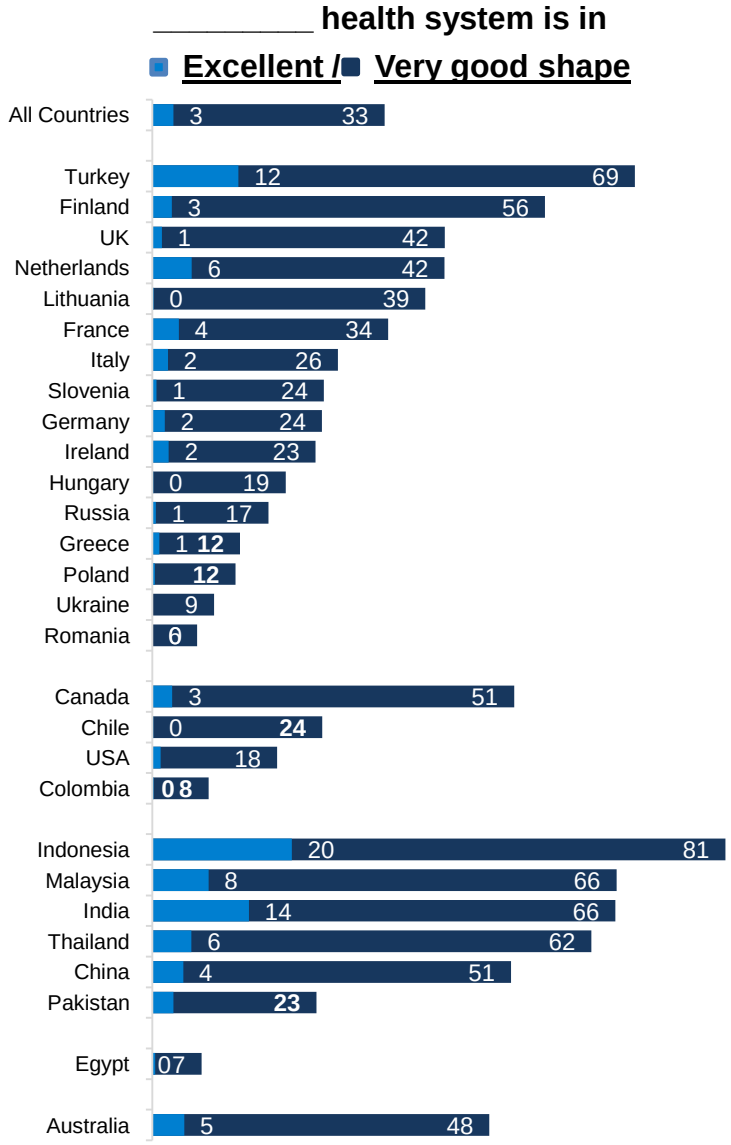
The family physician is a key source of information about health, but interestingly websites are almost as widely used in some countries, although in others this happens to a much more limited extent. The use of social media, smart phone apps and other new media is also focussed upon in this context.

The study also examined the spread of key chronic conditions and focused particularly upon the prevalence of cardiovascular disease. Wide variances in the prevalence of conditions such as high blood pressure and indeed diabetes may relate to differences in diet and health attitude, but are likely to also reflect lower awareness of and screening for these conditions in many countries.

Interesting differences in relation to mental illness are also noted by the study. In most countries it is acknowledged that mental illness experience is quite widespread, but in certain countries very few admit to any direct or personal experience. This may relate to concealment or a lack of knowledge of wider experience, but is highly likely to be reflective of cultural nuances and embarrassment as well.

System Evaluation

NATIONAL HEALTHCARE SYSTEM EVALUATION



The general perception of the quality of local health systems was explored, with higher scores in countries with more broadly acclaimed or universal national health systems, such as Netherlands, Finland, Canada, Australia and the UK.

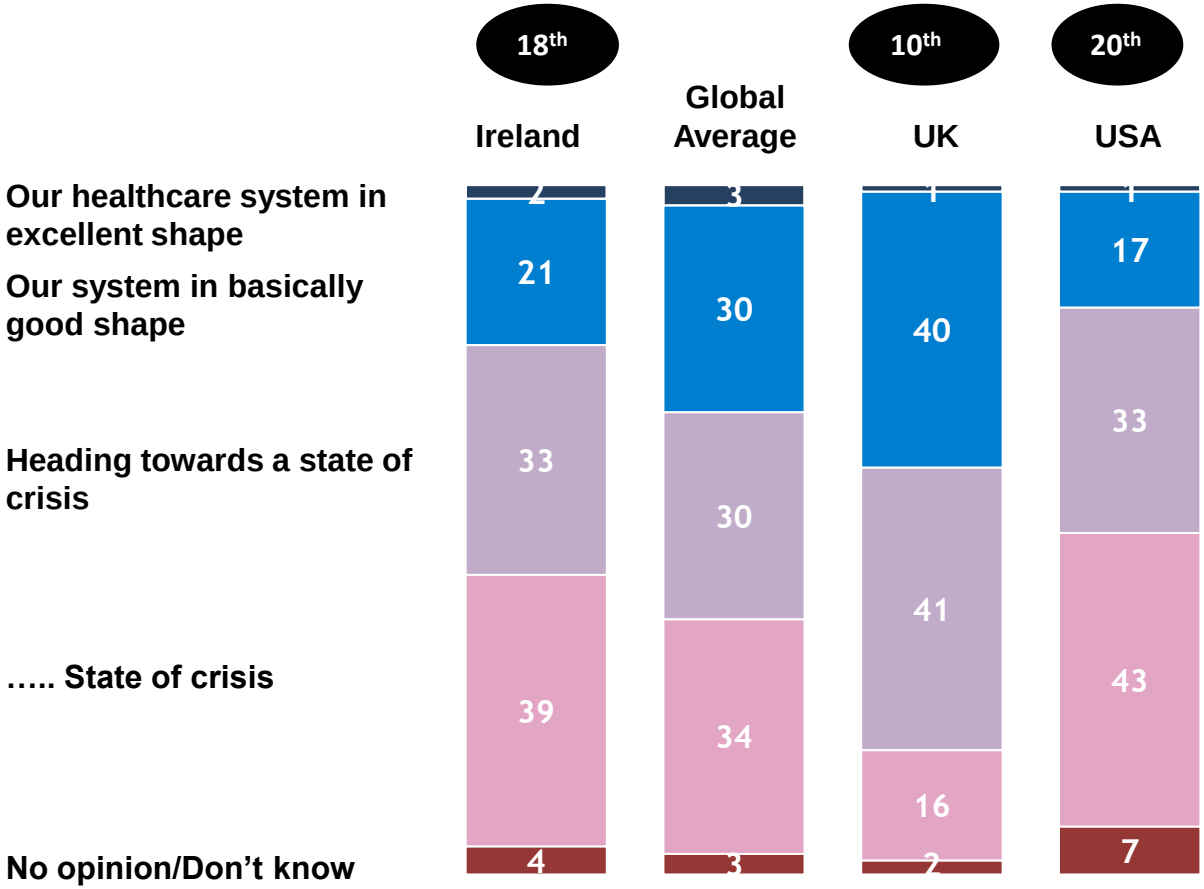
However, in countries including Turkey, Indonesia and Malaysia, (and indeed throughout Asia), the level of acclaim for the local system is equally very high, whereas in much of Western Europe the local populace is considerably less generous in their assessment.

Other countries where **more than half** of the respondents **are pleased** with the healthcare system are **Malaysia**, **India**, **Thailand**, **China** and **Finland**.

Romania, together with **Egypt**, **Colombia**, **Ukraine**, **Poland** and **Greece** register some of **the least positive feedback** on the national medical system.

There is evidently little correlation with personal health perception: Ireland lies 19th and Germany 18th here, but both top the perceived health league.

STATUS OF THE LOCAL HEALTH SYSTEM

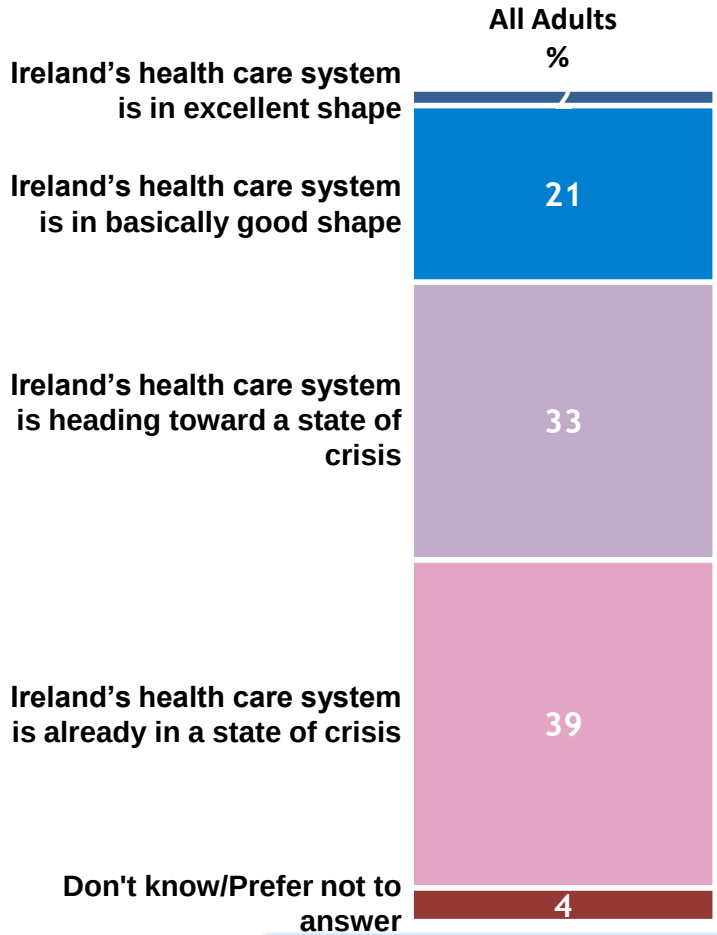


Global stars are Turkey, Indonesia, Malaysia, India, Thailand and China, where people are generally happy with the status quo system.

In Western Europe many feel it is very poor … Ireland just behind Germany, while UK is close to Spain where standards of (free) Universal Access are widely acknowledged.

PERCEPTION OF IRISH HEALTH SYSTEM

Base: All adults aged 16+; 1,000

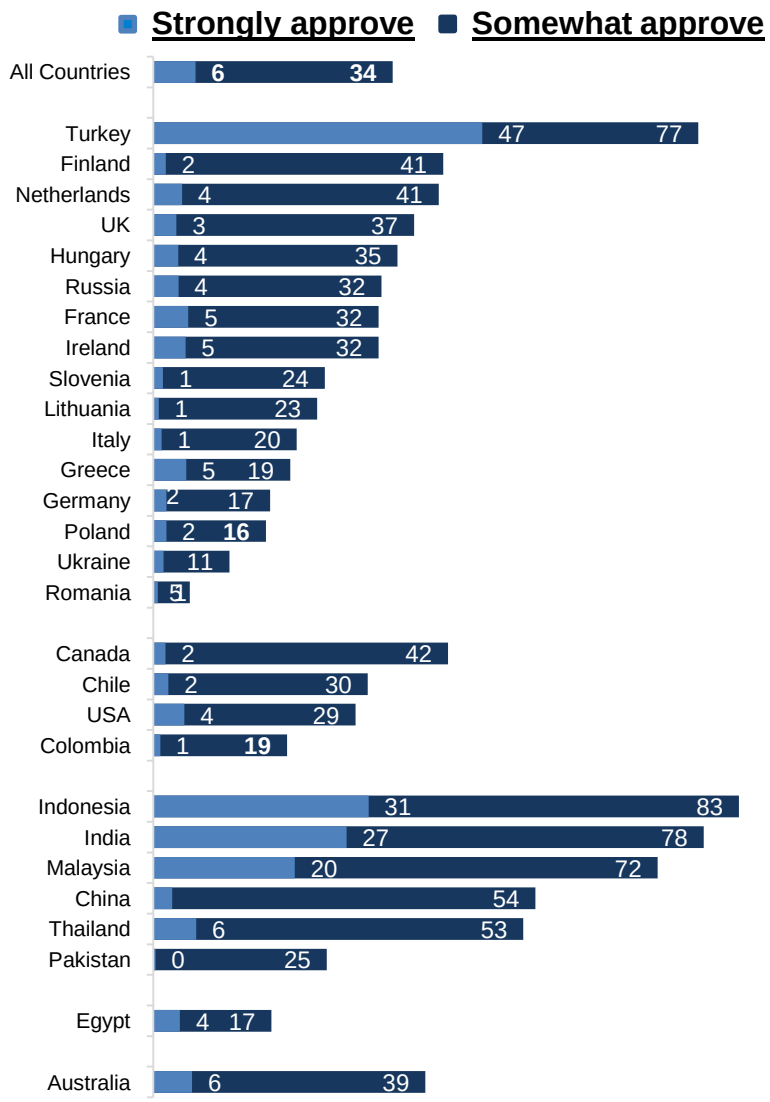


26% said our system was in good shape in 2004, versus 23% now.

System Already in Crisis			
	%		%
Men	37	Excellent health	39
Women	41	Good health	37
U25	29	Fair/poor health	44
25-34	39	Hospital in past year	38
35-49	42	Physician lead	39
50-64	45	Chose own treatment	45
65+	36	Joint decision	39
ABC1	33	Medical Card	40
C2DE	44	Private	34
F	33	Neither	42

Those with private cover are a little more generous about the system.

APPROVAL OF THE HEALTHCARE SYSTEM MANAGEMENT



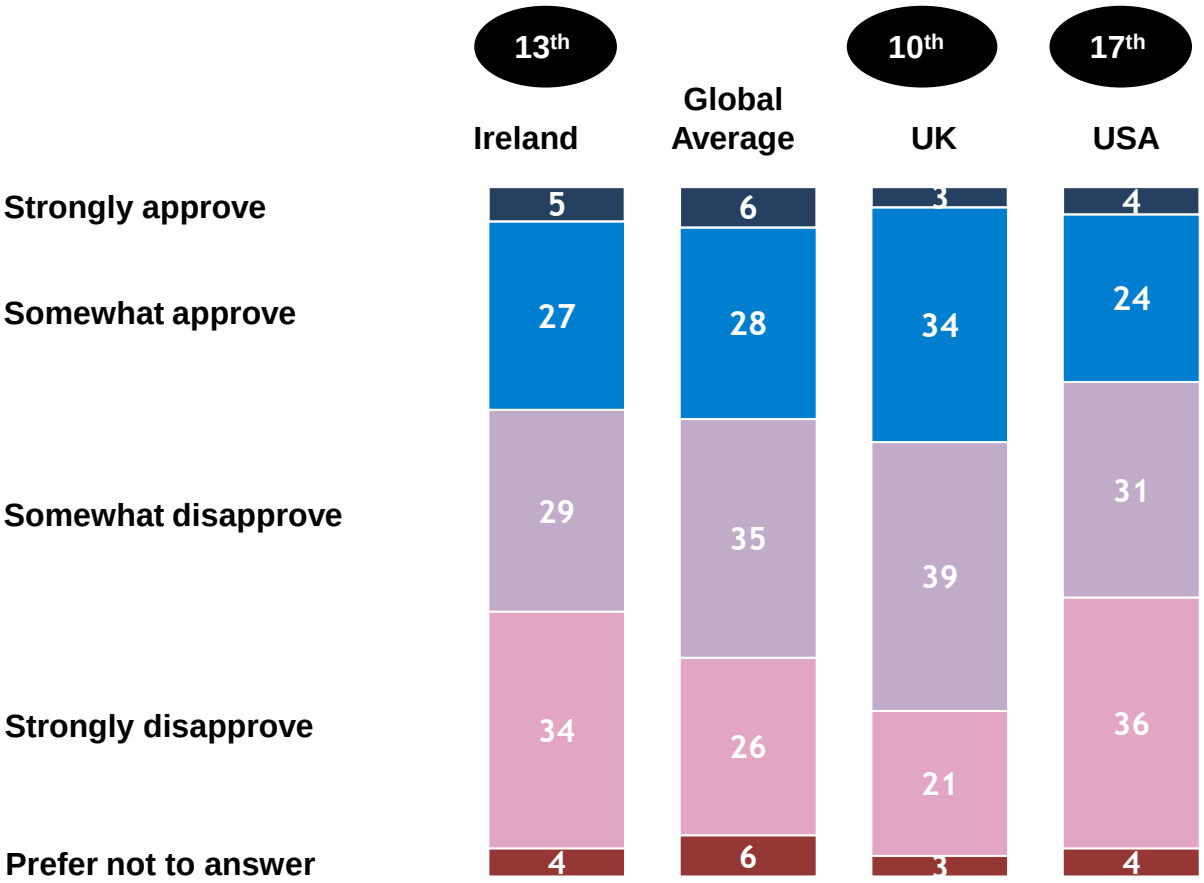
In 22 out of the 28 countries in focus approval of the government's approach to the management of the healthcare system is either low or very low.

Those who run and direct health services must be well used to criticism, but one wonders whether such predominant negativity may be inherently undermining of those working within the system, and indeed whether this may become a self-fulfilling system 'norm'.

The populations of Indonesia, Turkey, India and Malaysia are quite supportive of their Government's handling of the healthcare system in their countries while close to half of the populations of China, Thailand, Finland, Netherlands and the UK give positive ratings to their national systems.

Throughout Eastern Europe and in Germany, Italy, Colombia and Egypt, there is little praise for the management of the local healthcare system.

Approval of our Governments management of National Health System

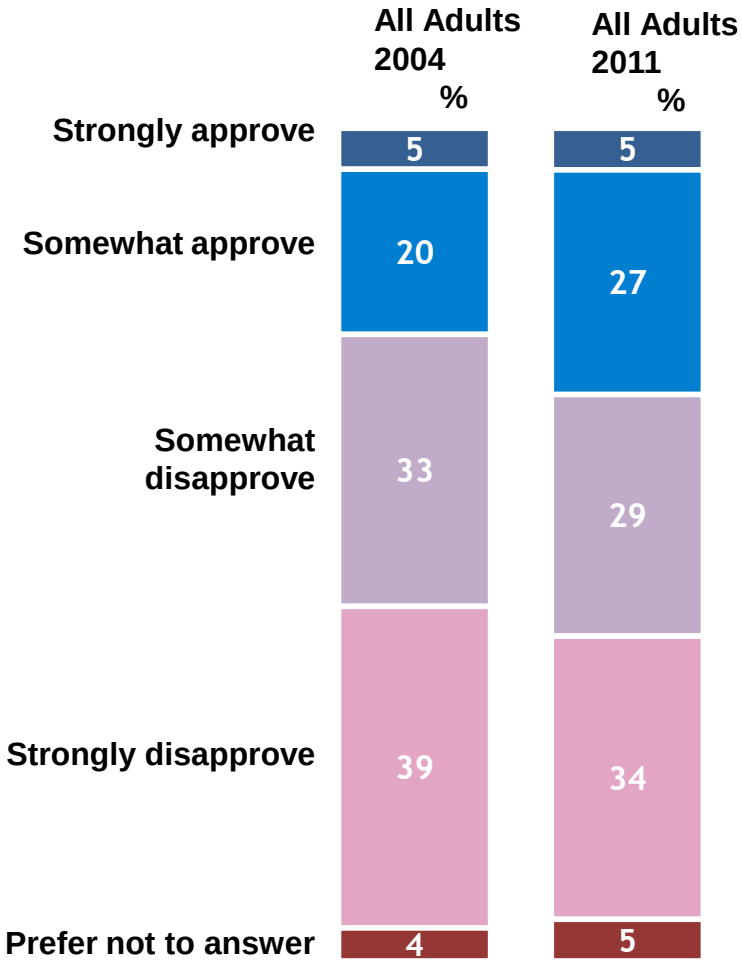


The Dutch and the Canadians particularly approve of how their Governments manage healthcare, while in Asia there is much broader support for how the system is managed by the State.

The Irish score was equally very low in 2005, then close to the bottom of 24.

APPROVAL OF GOVERNMENT'S HANDLING OF HEALTHCARE

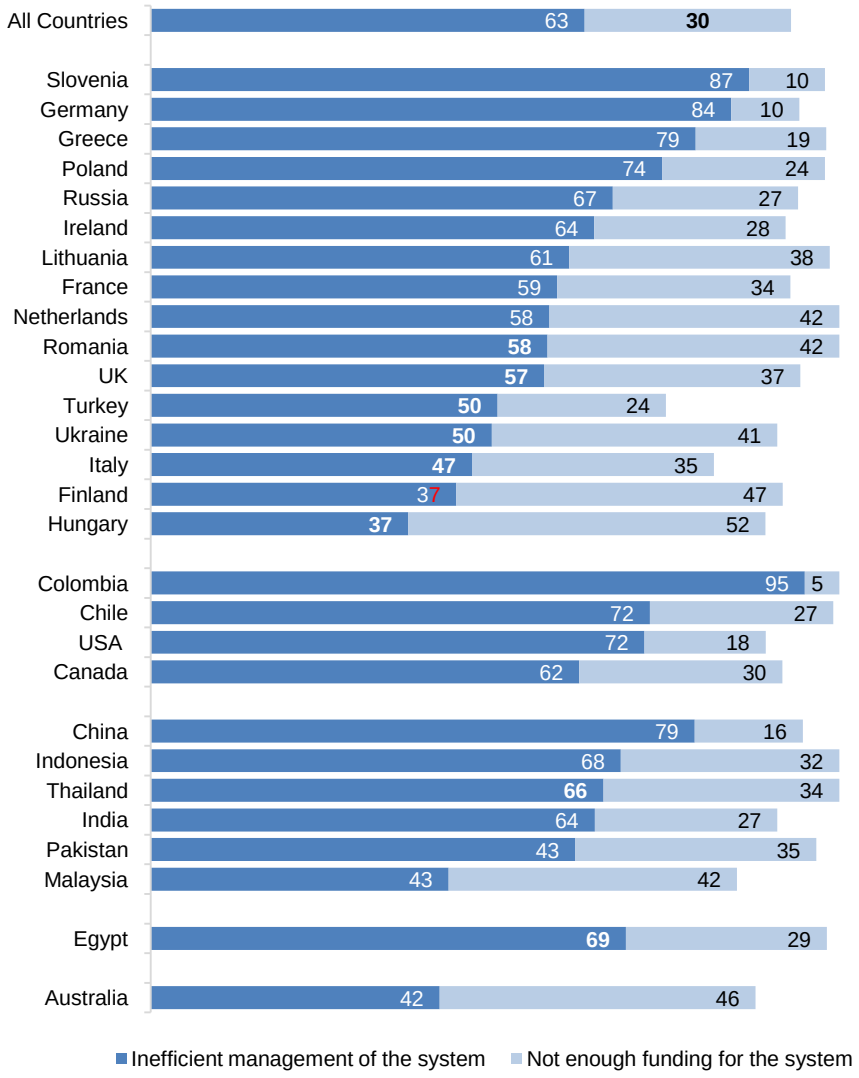
Base: All adults aged 16+: 1000



Strongly disapproved			
	%		%
Men	30	Physician-lead	30
Women	38	Chose own treatment	37
U25	26	Joint decision	36
25-34	33	Chronic Condition	38
35-49	40	No conditions	33
50-64	39	Personal hospital visit	41
65+	36	Family hospital visit	37
ABC1	33	No experience	32
C2DE	37	Medical Card	36
F	17	Private	33
Excellent health	34	Neither	33
Good health	32		
Fair/poor health	42		

Marginal improvement but with a majority quite unhappy, and particularly women, middle aged, system-exposed and more involved patients.

SOURCE OF PROBLEMS IN THE HEALTHCARE SYSTEM

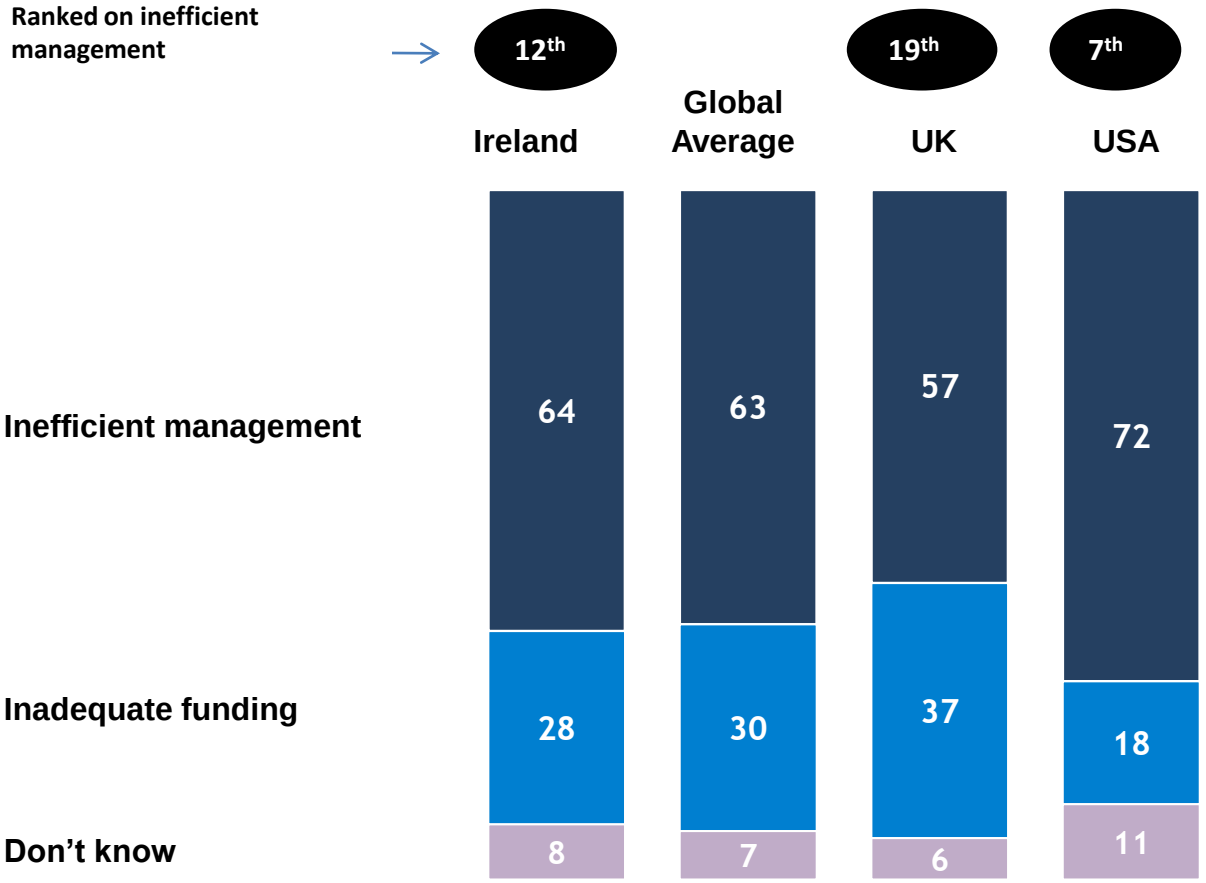


At a global level, most tend to perceive the basis of problems in the medical system as being a function of **mismanagement.** When asked to nominate the main undermining factor of the local health system, poor management was chosen ahead of **inadequate funding** in the majority of all countries, with particular criticism on this basis throughout Eastern Europe, Greece, Germany, Poland and Ireland and equally, to a very substantial extent, in Colombia and China. The Colombians are the most vehement in singling out poor management of their national medical system.

Hungary is the only country where people consider that insufficient funding is a more acute element than poor management.

It is intriguing that we seem to largely adhere to a view that health services could be better run and, by extension, that there is presumably wastage of resources rather than inadequate funding of the health system. The controllers of national health systems seem to be quite unsuccessful at articulating a coherent understanding of their plans and activities.

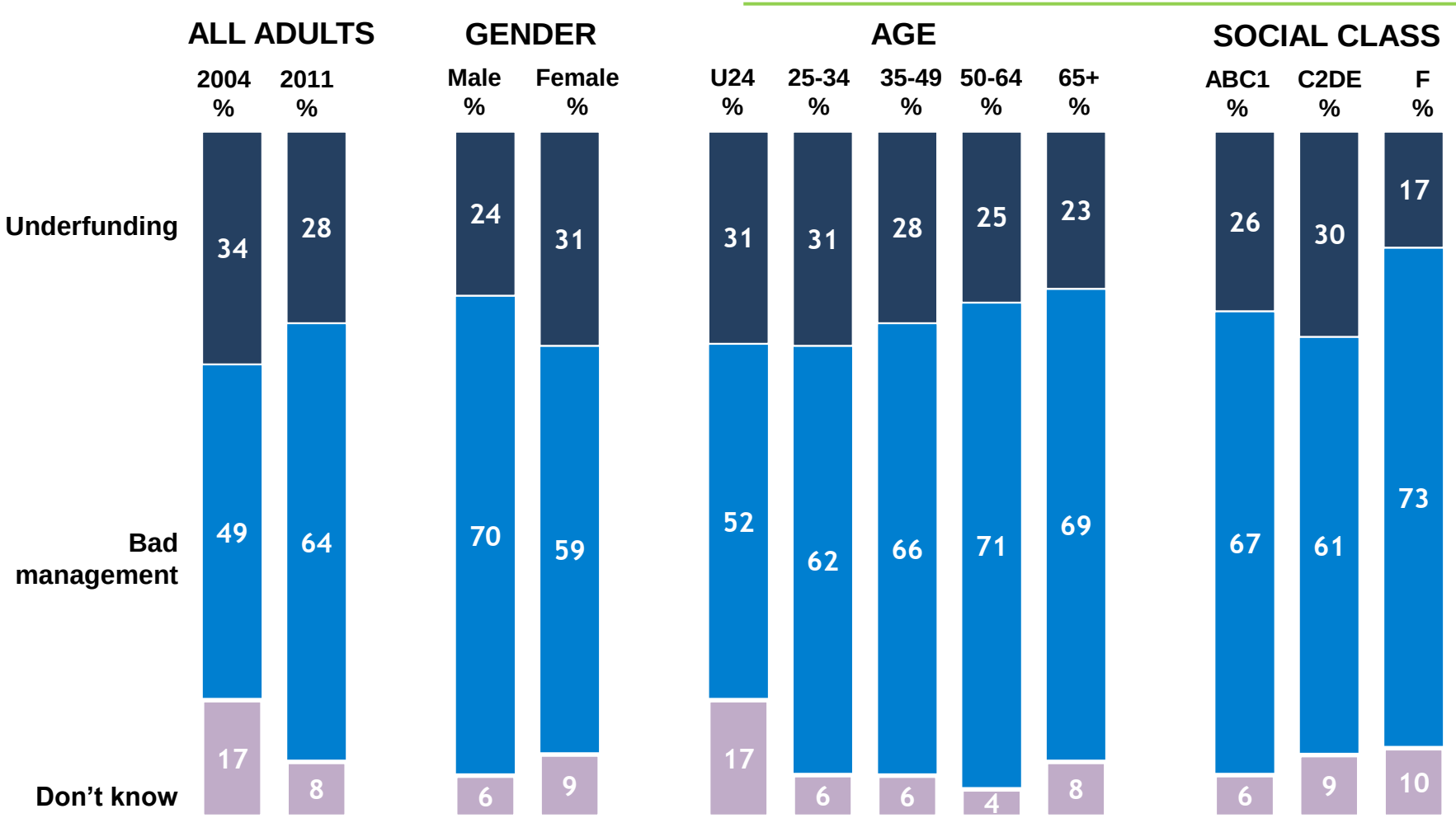
Why are there problems in our health system?



We tend to share the broad global view that systemic problems derive more from poor management than from underfunding. Indeed the levels suspecting poor management in Germany are as high as 87%, indicative of a broad view in industrialised countries that inefficiency is manifest within the system.

PRIMARY CONTRIBUTOR TO SYSTEMIC PROBLEMS

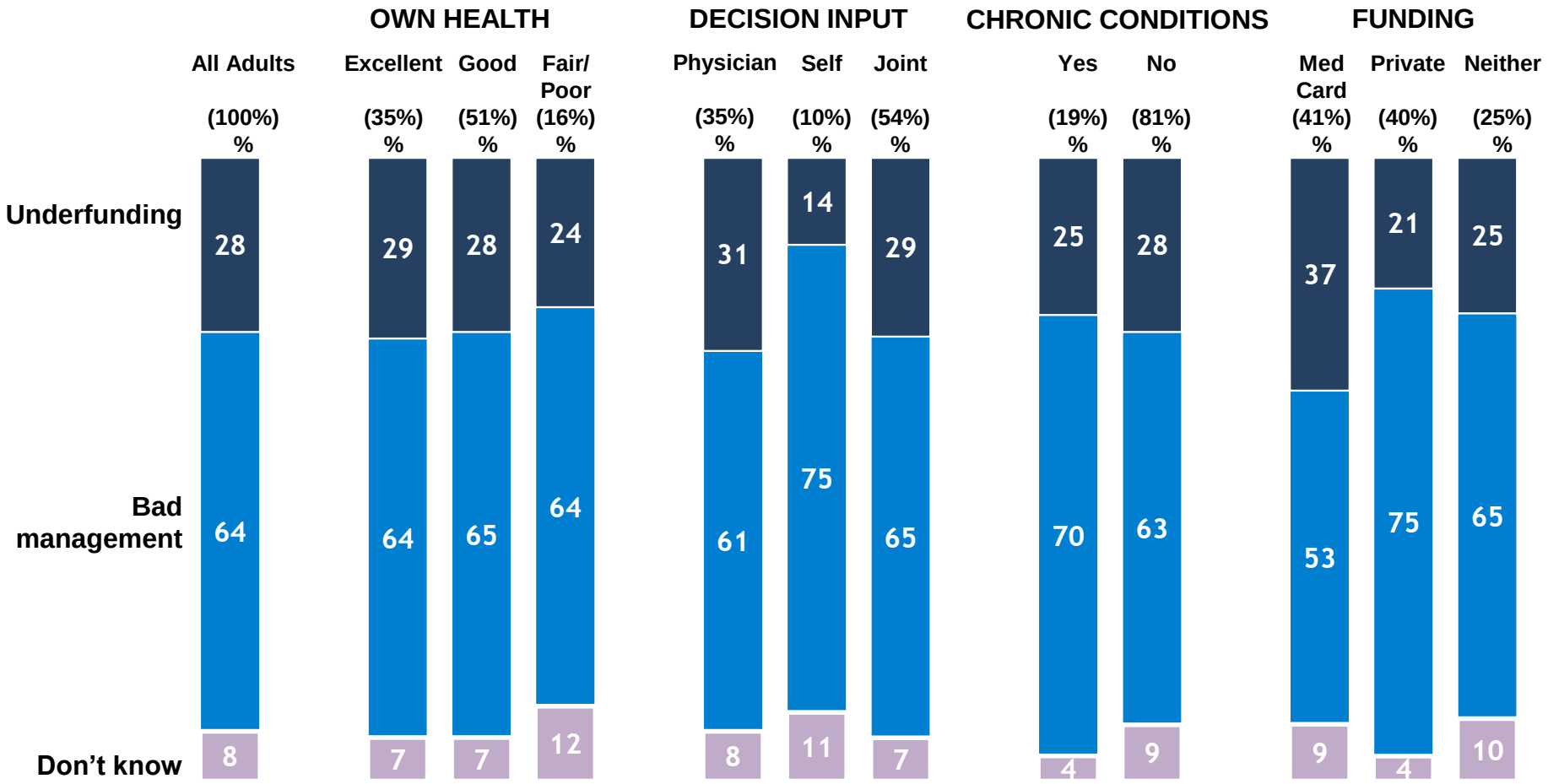
Base: All adults aged 16+: 1000



49% suspected bad management in 2004 and 34% underfunding: a growing conviction of bad management now.

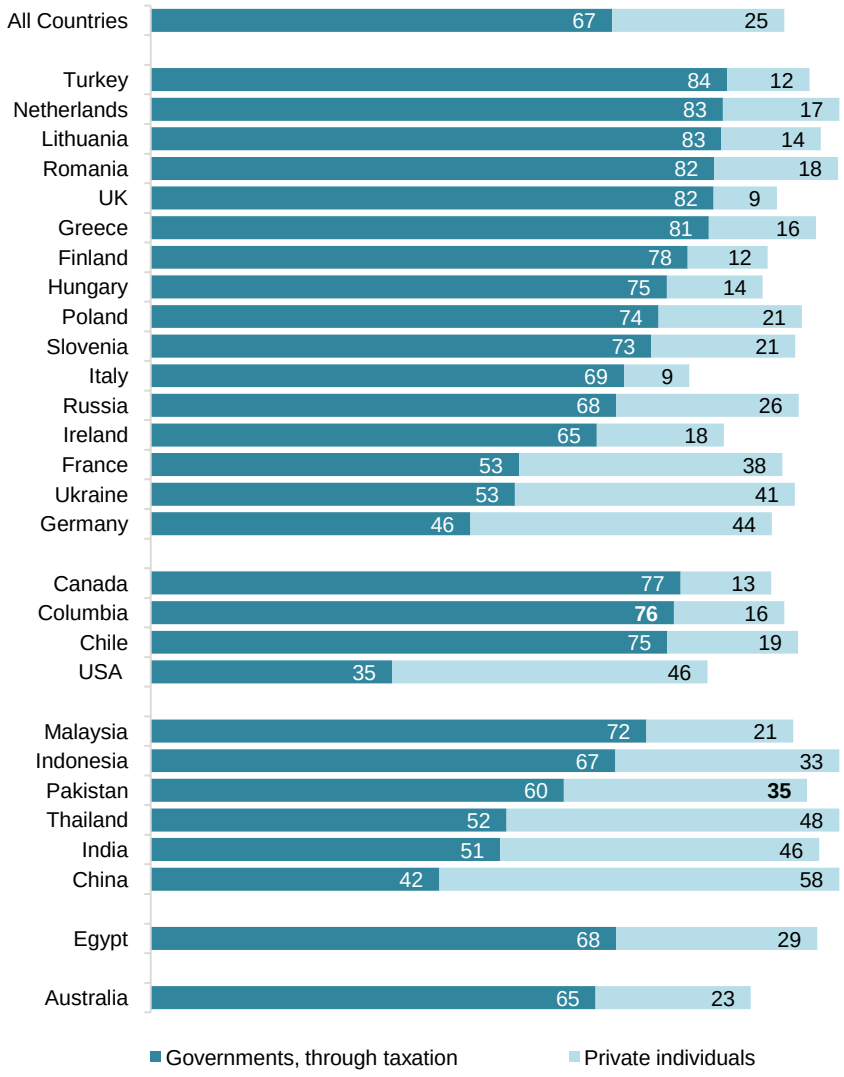
CAUSE OF SYSTEMIC PROBLEMS X HEALTH STATUS

Base: All adults aged 16+: 1000



Those with private cover (and the "self-managed") are more critical of management.

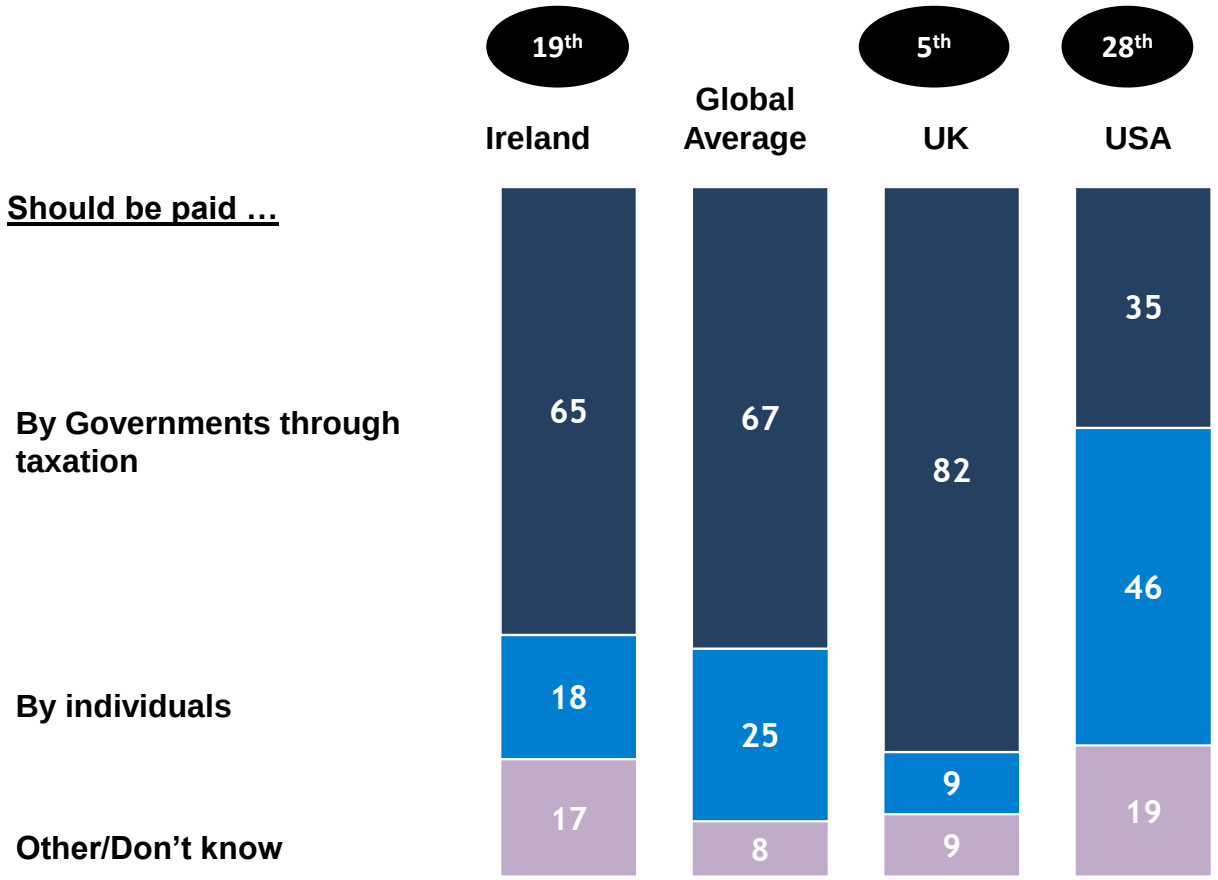
FUNDING PREFERENCE



In 21 of the 28 countries under study, there is preference for public over private funding of the health services. In America and China, a majority favour private funding, reflecting the norms of the local system, while a quite even preference is apparent in India, Germany and Thailand.

Distinct differences are apparent between America and Europe with many of those preferring the notion of public funding based upon the European continent and again reflective more of the norms of the systems in those countries.

Funding preference for the healthcare expenses of individuals

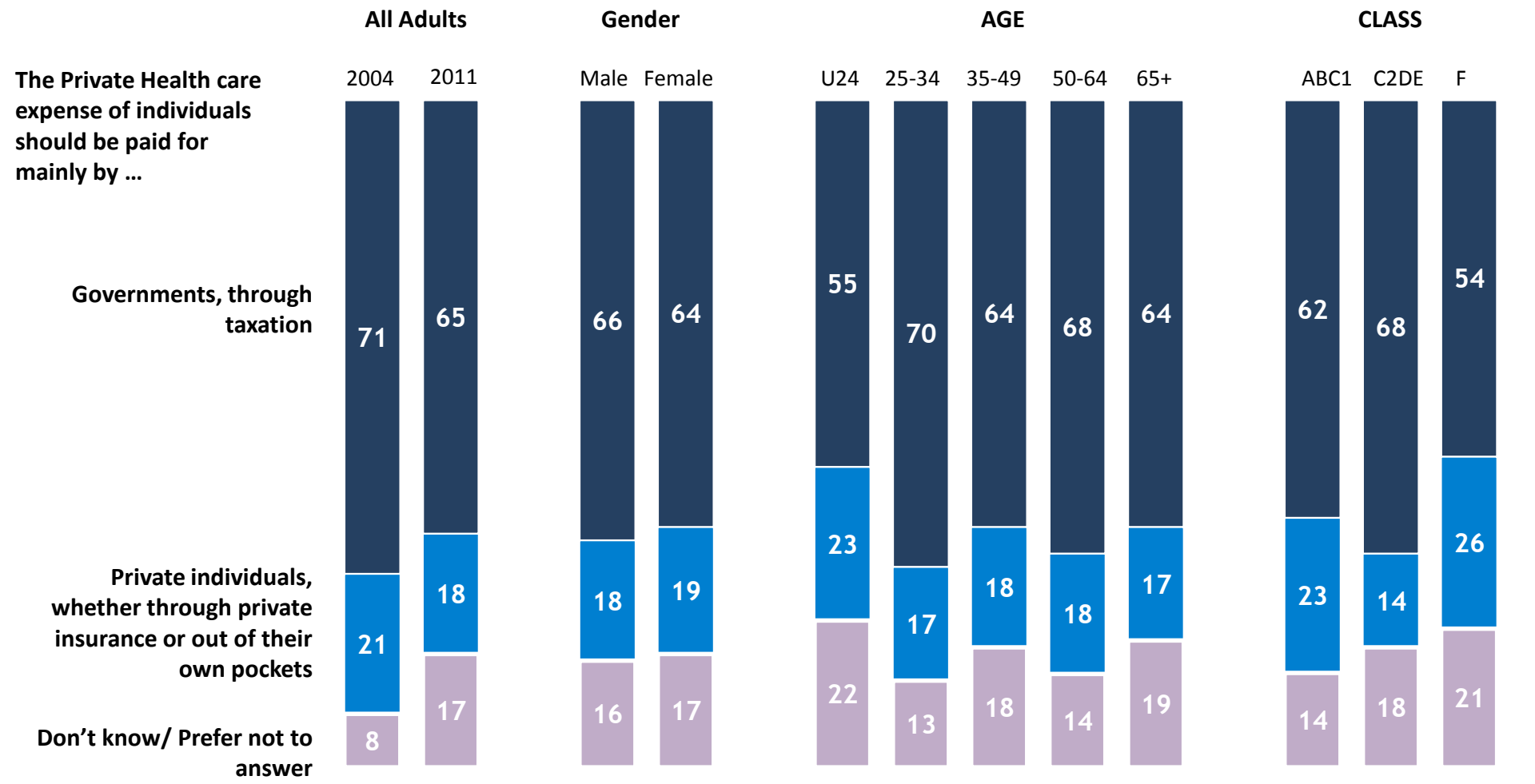


Most European countries have a predominant preference for state funding, with Ireland showing a more limited commitment to it. The lowest preference for state funding is in America, followed by China (42%) and Germany (46%) with France (53%) not far behind.

Our preference for state funding has grown since 2005.

FUNDING PREFERENCE

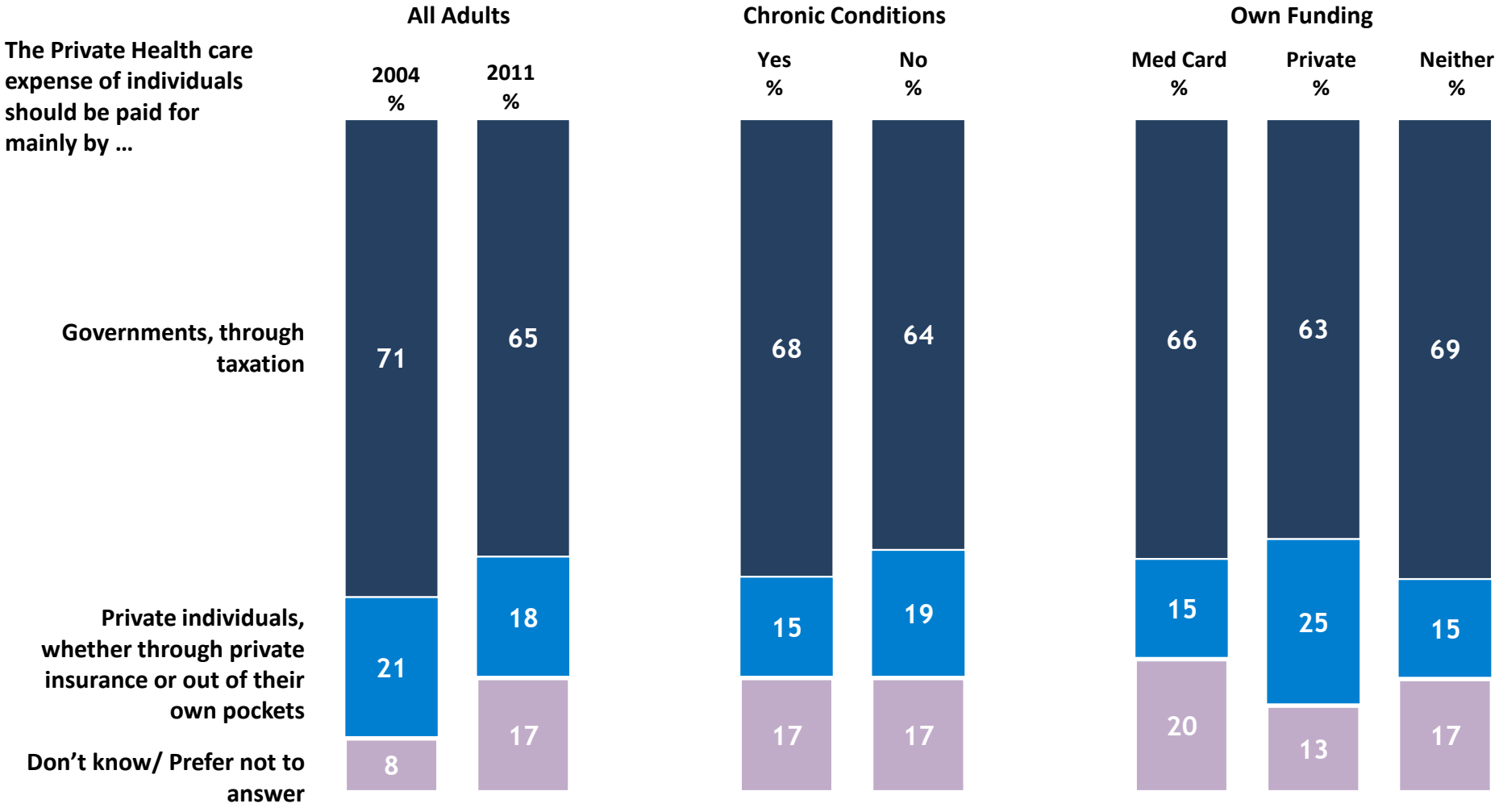
Base: All adults aged 16+: 1000



There is a majority preference for state funding, although this has slightly reduced since 2004.

FUNDING PREFERENCE X CONDITIONS EXPERIENCE AND MEDICAL FUNDING

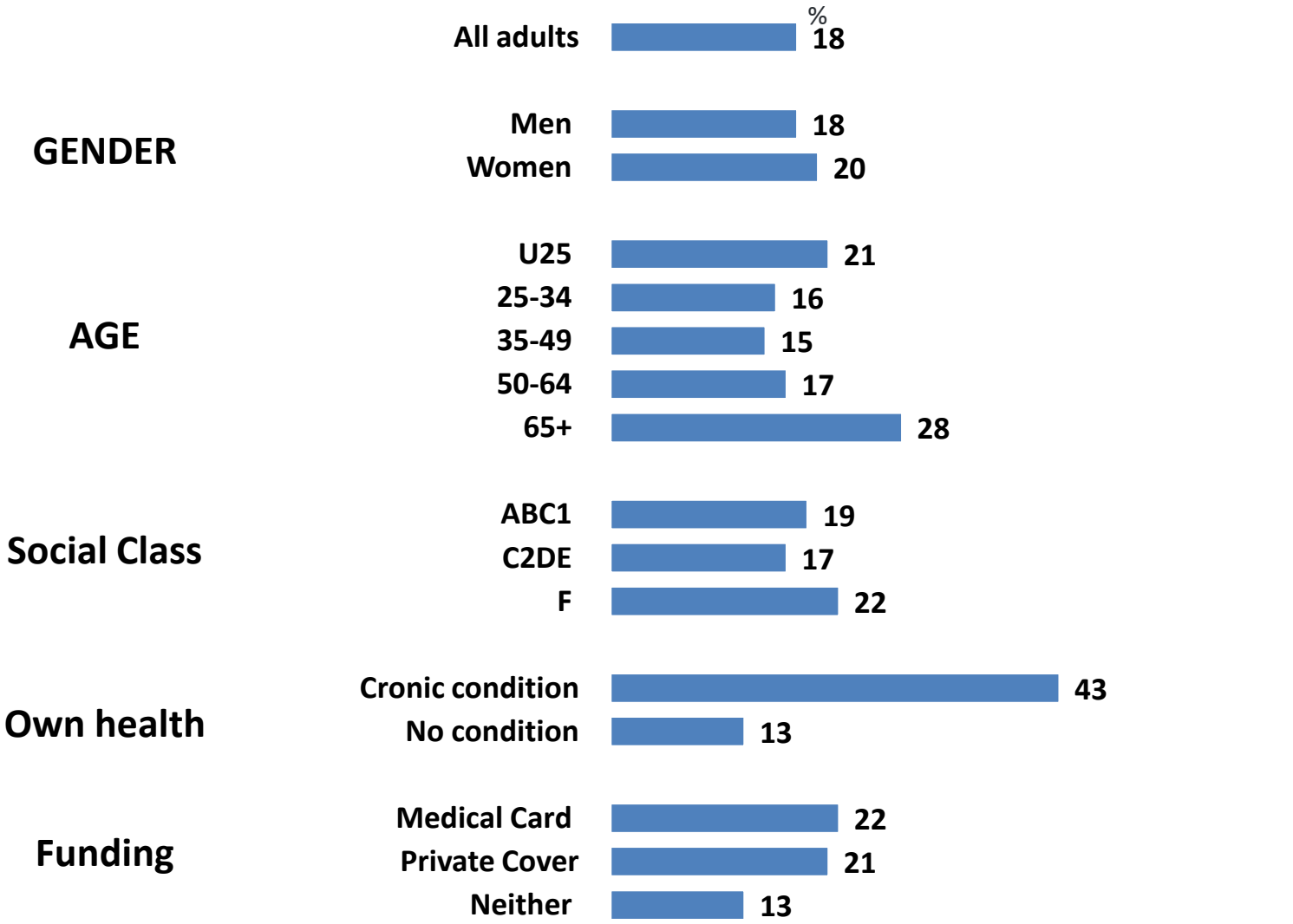
Base: All adults aged 16+: 1000



Those with private cover are marginally more likely to see some benefit in this system but still the majority would prefer central funding.

HOSPITAL VISIT IN PAST YEAR

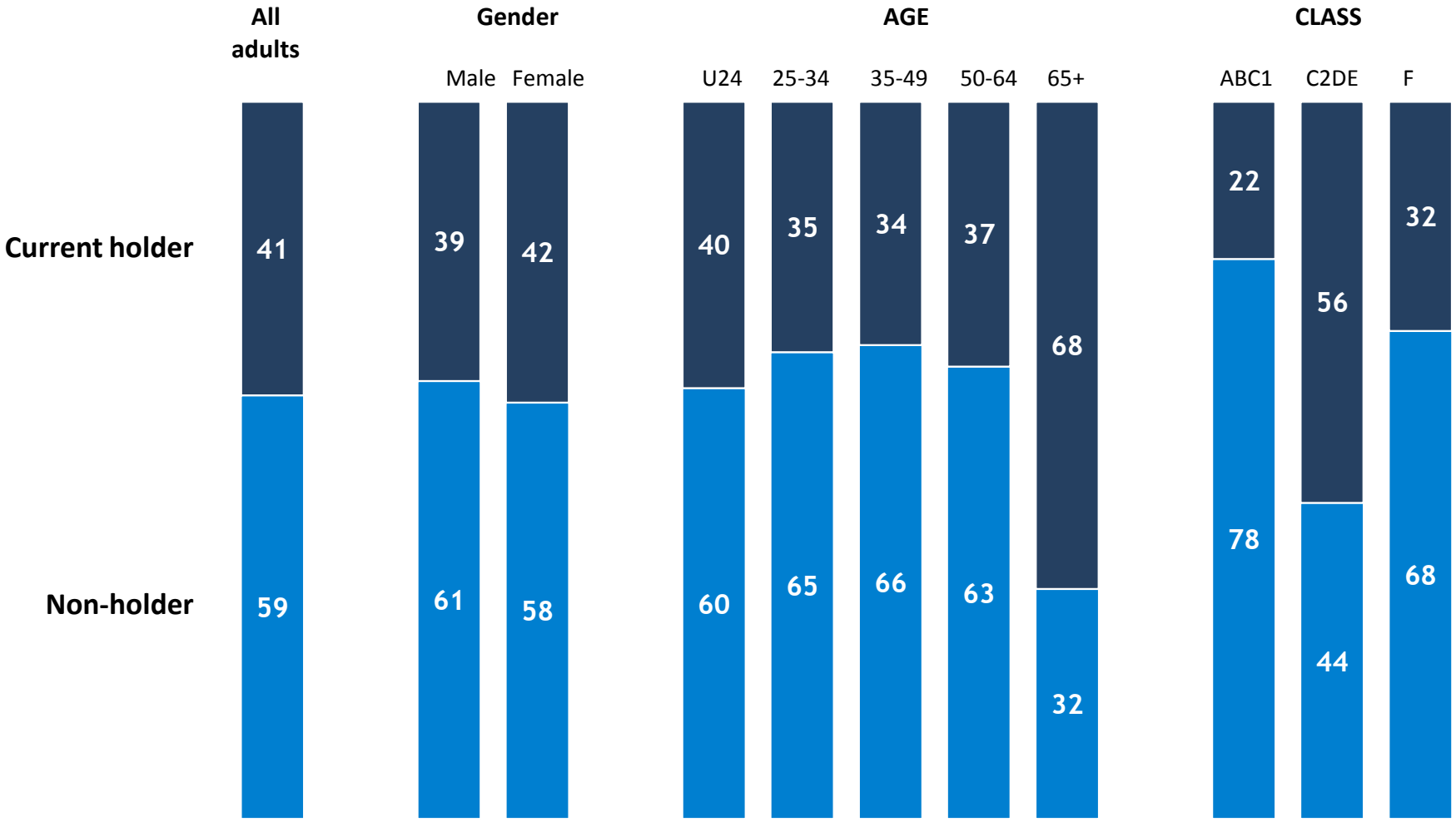
Base: All adults aged 16+; 1,000



Experience relates predominately to conditions experience and age .

MEDICAL CARD HOLDING

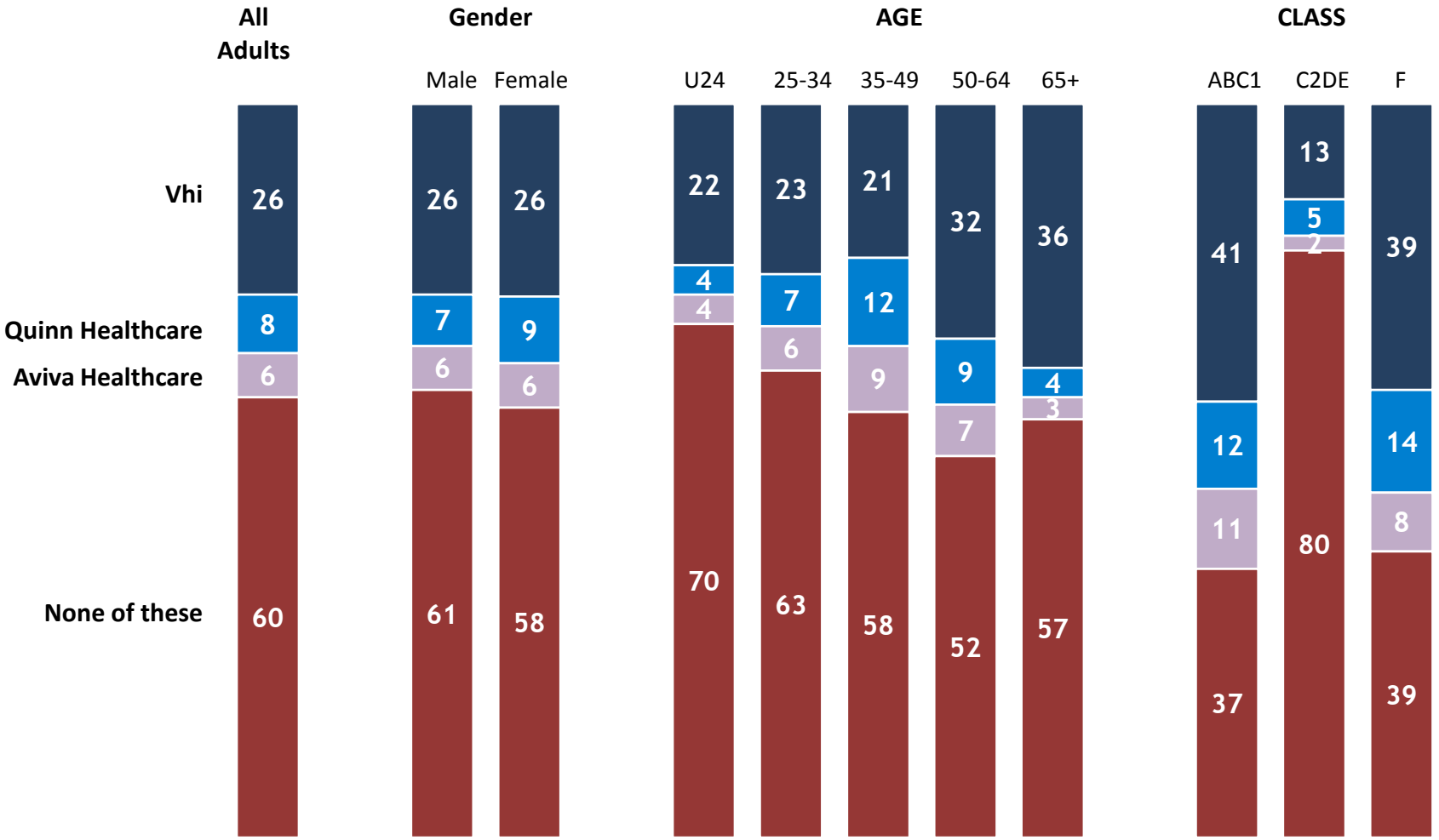
Base: All adults aged 16+; 1,000



More than a third in every age group now benefit from a medical card.

HOLDING OF PRIVATE MEDICAL INSURANCE X DEMOGRAPHICS

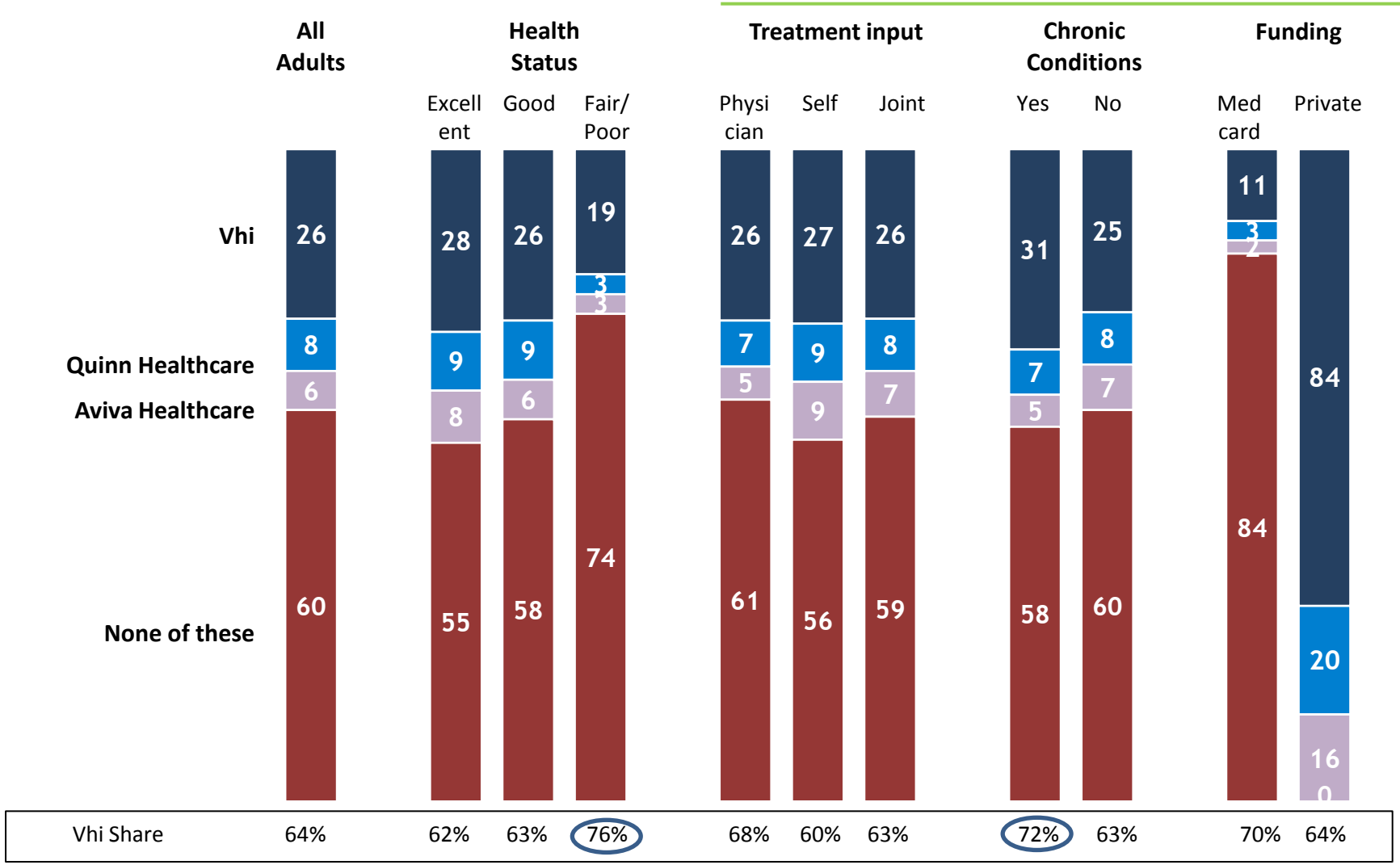
Base: All adults aged 16+; 1,000



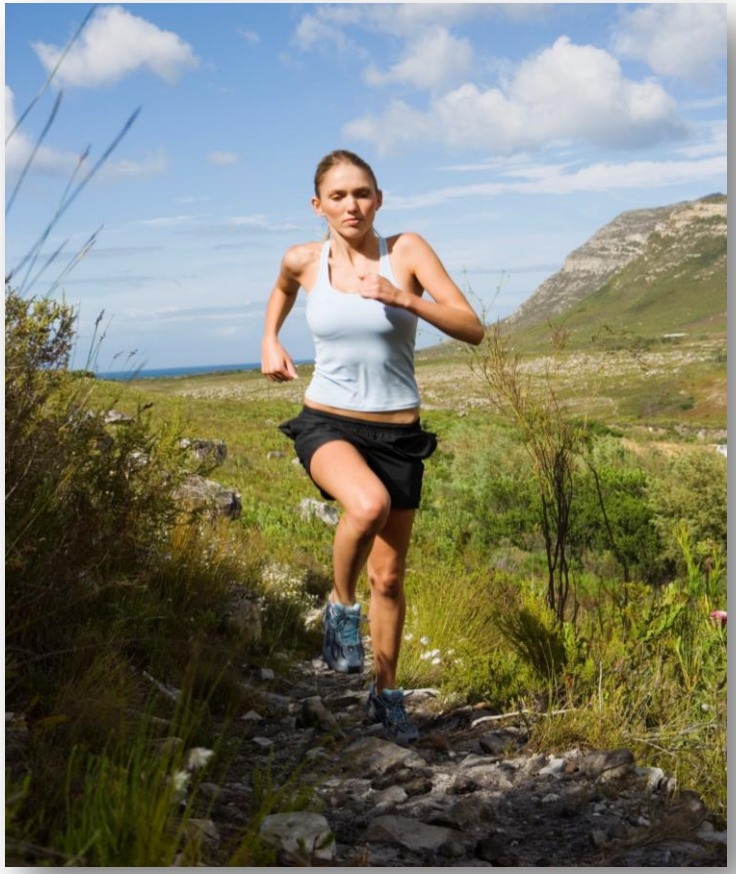
Greatest competition in middle age, where Vhi's share just equals that of the combined competitors.

HOLDING OF PRIVATE MEDICAL INSURANCE

Base: All adults aged 16+; 1,000

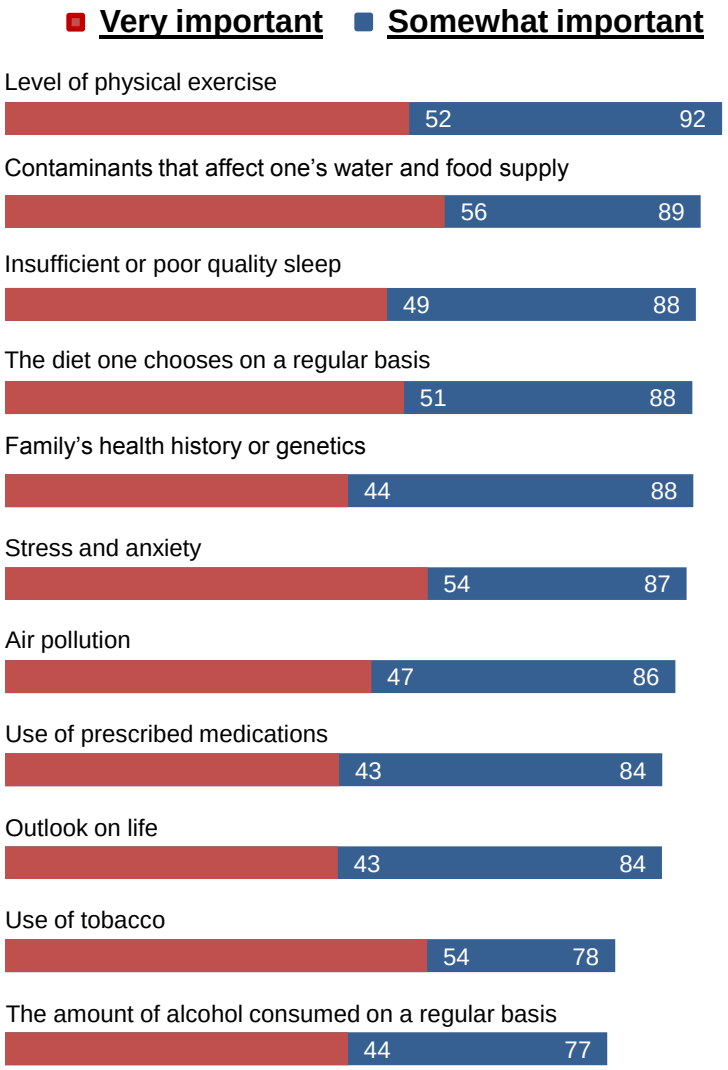


Vhi has a strong share of those in poorer health and indeed of those who have now qualified for a medical card. It has fewer customers who want to direct their own treatment decisions.



Health Influences & Contributor

SNAPSHOT OF FACTORS PERCEIVED TO CONTRIBUTE TO HEALTH



The factors which are perceived as contributory to health are reasonably uniform across countries and regions. In most cases, almost all of the factors assessed tend to be regarded as important potential contributors, but there are distinct regional differences, with the data from Asia suggestive of knowledge gaps and perhaps cultural differences.

Almost all place a high premium on the importance of **physical exercise**, and equally, on having an **uncontaminated water and food supply** and sufficient **sleep**.

The two factors that are seen as generally less influential over health are the **use of tobacco** and the **amount of alcohol** regularly consumed.

Weaker scores for these factors are primarily reflective on their lower prioritisation in countries such as India, Indonesia and Pakistan, where the link between smoking, drinking and health is evidently less clearly established. India specifically has an absence of control upon tobacco advertising and overt tobacco linkages to popular and youth culture remain commonplace there.

VERY IMPORTANT CONTRIBUTORS TO HEALTH BY COUNTRY

	All Countries	Australia	Canada	Chile	China	Colombia	Egypt	Finland	France	Germany	Greece	Hungary	India	Indonesia	Ireland	Italy	Lithuania	Malaysia	Netherlands	Pakistan	Poland	Romania	Russia	Slovenia	Thailand	Turkey	UK	Ukraine	USA
TOTAL	*21226*	*910*	*1006*	*640*	*1000*	*506*	*500*	*500*	*961*	*1087*	*1002*	*500*	*1056*	*500*	*999*	*2030*	*1005*	*427*	*1062*	*300*	*812*	*1100*	*520*	*501*	*540*	*417*	*1000*	*600*	*1014*
Contaminants affect water / food supply	56%	41%	57%	53%	54%	68%	95%	56%	55%	32%	55%	70%	40%	53%	73%	59%	55%	57%	58%	49%	46%	64%	79%	56%	54%	79%	43%	62%	56%
Use of tobacco	54%	60%	73%	69%	40%	54%	82%	67%	60%	52%	69%	42%	66%	7%	72%	52%	61%	37%	59%	6%	65%	46%	59%	57%	15%	57%	67%	35%	78%
Stress and anxiety	54%	52%	66%	68%	46%	75%	83%	54%	53%	53%	73%	46%	16%	10%	74%	45%	56%	40%	51%	21%	60%	60%	58%	69%	27%	74%	58%	47%	68%
Level of physical exercise	52%	46%	58%	54%	39%	70%	78%	56%	42%	31%	50%	53%	54%	59%	76%	35%	49%	51%	52%	68%	43%	65%	52%	54%	56%	65%	52%	33%	64%
The diet one chooses on a regular basis	51%	56%	57%	50%	53%	67%	70%	44%	26%	46%	52%	50%	67%	28%	72%	48%	16%	50%	26%	93%	28%	76%	61%	60%	51%	63%	55%	38%	65%
Insufficient or poor quality sleep	49%	47%	56%	57%	52%	51%	73%	56%	54%	41%	37%	60%	36%	38%	68%	31%	45%	47%	49%	38%	43%	59%	55%	46%	52%	81%	43%	44%	56%
Air pollution	47%	27%	41%	48%	40%	80%	92%	23%	46%	22%	47%	61%	40%	57%	62%	51%	45%	52%	49%	34%	37%	59%	73%	43%	47%	78%	26%	53%	38%
Family's health history or genetics	44%	38%	49%	29%	44%	70%	56%	32%	41%	29%	40%	47%	38%	37%	70%	35%	43%	42%	41%	44%	33%	53%	50%	34%	33%	82%	45%	42%	59%
The amount of alcohol consumed on a regular basis	44%	47%	48%	52%	28%	71%	67%	45%	55%	42%	49%	36%	62%	5%	64%	46%	56%	32%	48%	6%	36%	44%	65%	50%	15%	52%	51%	30%	49%
Use of prescribed medications	43%	34%	47%	34%	22%	65%	74%	47%	34%	36%	27%	43%	60%	37%	62%	33%	43%	44%	51%	73%	29%	57%	26%	31%	47%	83%	37%	26%	48%
Outlook on life	43%	42%	46%	61%	30%	80%	66%	16%	42%	19%	47%	54%	43%	39%	66%	33%	36%	42%	35%	40%	27%	46%	60%	42%	31%	76%	39%	28%	54%
None of the above	7%	14%	7%	1%	5%	1%	0%	5%	4%	11%	4%	2%	7%	12%	2%	15%	4%	10%	10%	1%	7%	2%	0%	5%	8%	-	8%	12%	5%

Key contributors vary substantially by country and it is probably more interesting to focus on those aspects which don't score as highly such as the lower focus on smoking and alcohol consumption as health contributors in many countries.

VERY IMPORTANT INFLUENCES ON A PERSONS OVERALL HEALTH

	All Adults	GENDER		A G E					SOCIAL CLASS		
		Male	Female	-24	25-34	35-49	50-64	65+	ABC1	C2DE	F
Base:	1000	482	517	148	216	268	218	149	447	483	69
	%	%	%	%	%	%	%	%	%	%	%
Level of physical exercise	76	74	77	70	72	79	79	75	77	74	78
Stress and anxiety	74	70	77	55	78	78	76	77	76	72	76
Contaminants that affect one's water and food supply	73	71	74	64	72	75	77	74	73	71	82
The diet one chooses on a regular basis	72	68	76	60	73	74	76	73	75	70	69
Use of tobacco	72	71	74	55	72	76	77	78	76	70	71
Family's health history or genetics	70	68	71	63	66	71	75	72	68	70	74
Insufficient or poor quality sleep	68	65	71	50	67	73	71	72	67	68	70
Outlook on life	66	64	69	55	62	69	75	69	65	67	72
The amount of alcohol consumed on a regular basis	64	62	65	51	62	68	66	69	64	63	69
Air pollution	62	60	64	50	60	61	71	66	60	62	70
Use of prescribed medications	62	59	64	50	60	61	66	73	58	64	68

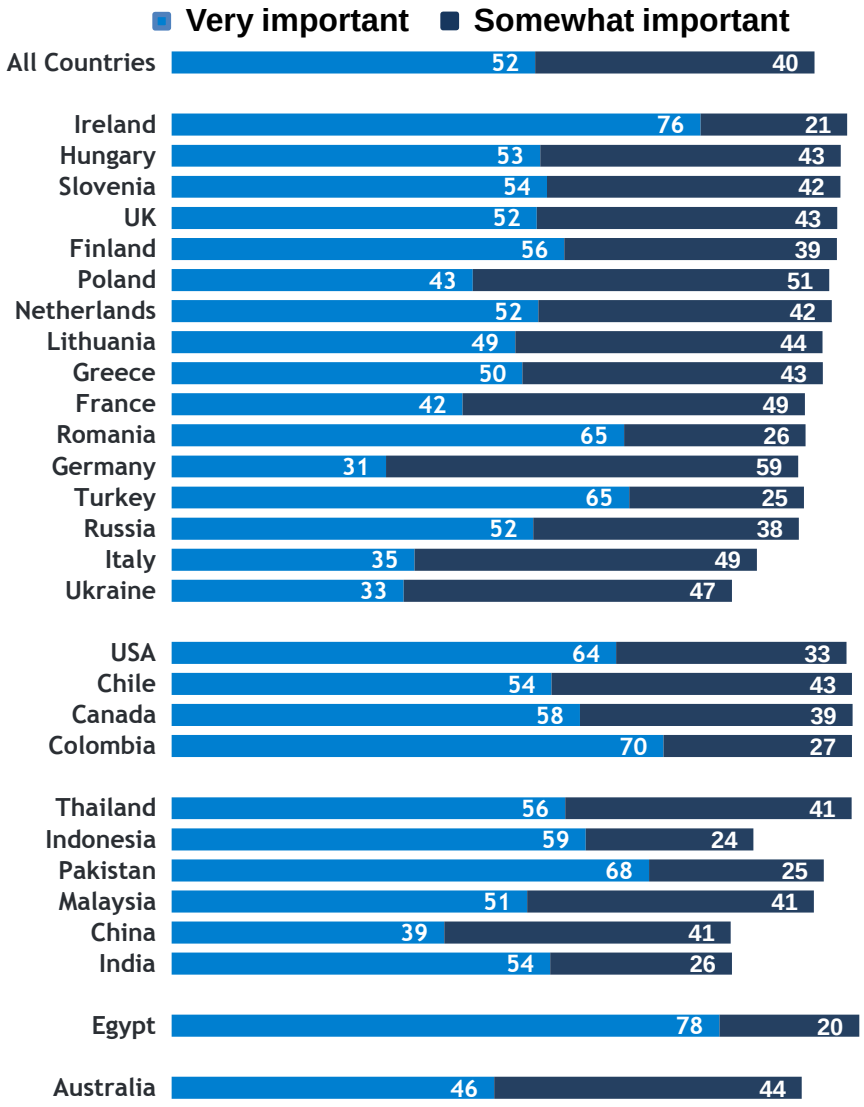
Older adults connect many more facets with health than do younger adults; male attitudes mirror those of younger adults generally.

VERY IMPORTANT INFLUENCES ON HEALTH X HEALTH MEASURES

	All Adults	Own Health			Input To Decision			Chronic Conditions		Funding		
		Excel-lent	Good	Fair/ Poor	Phys-ician	Self	Joint	Yes	No	Med Card	Private	Neither
Base:	1000	331	514	154	347	101	538	191	808	393	426	248
Level of physical exercise	76	77	76	73	71	75	79	80	75	71	79	78
Stress and anxiety	74	74	75	71	69	77	76	79	73	70	77	75
Contaminants that affect one's water and food supply	73	79	69	74	69	71	76	75	72	71	73	76
The diet one chooses on a regular basis	72	76	70	70	69	70	75	72	72	69	74	73
Use of tobacco	72	75	70	73	69	67	76	78	71	67	77	73
Family's health history or genetics	70	71	68	72	68	68	71	78	68	71	66	71
Insufficient or poor quality sleep	68	68	67	72	65	66	71	77	66	69	69	65
Outlook on life	66	69	66	63	62	66	70	72	65	67	66	67
The amount of alcohol consumed on a regular basis	64	62	65	65	59	61	68	71	62	64	67	58
Air pollution	62	65	57	70	56	57	67	70	60	66	58	65
Use of prescribed medications	62	65	59	64	60	67	63	69	60	64	59	64

Those with private cover more exercised about smoking. Those in better health are more diet conscious. 'Passives' and medical card holders are similar: join fewer 'dots'.

FOCUS ON PHYSICAL EXERCISE AS A HEALTH CONTRIBUTOR

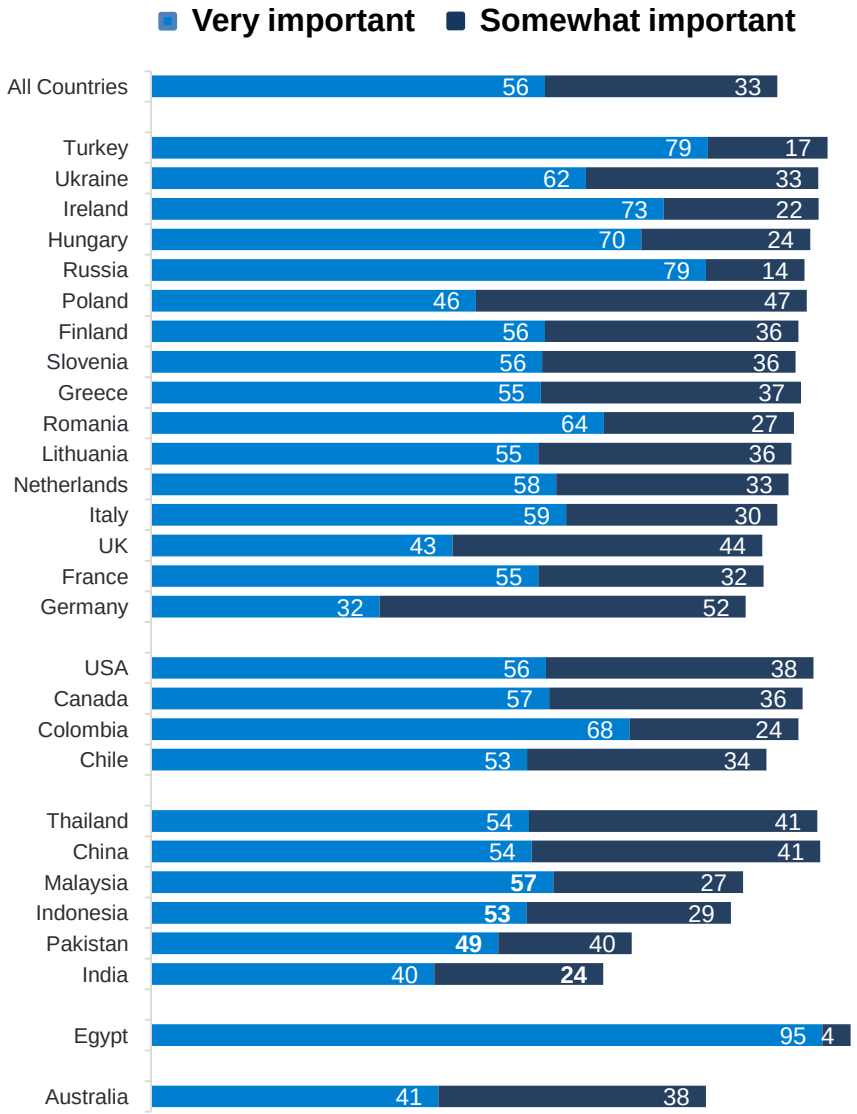


The majority in all countries attribute high importance to taking physical exercise as a means of ensuring health. In effect this reflects the cultural acceptance of the importance of exercise in most developed societies.

Results from India, Ukraine and Italy are marginally weaker but still register at a very high pitch.

In effect there is essentially almost universal recognition of the importance of exercise, but with a few slight dips from country to country, perhaps reflective of more traditional mindsets in some of those countries.

FOCUS ON FOOD CONTAMINANTS AS A CONTRIBUTOR TO HEALTH

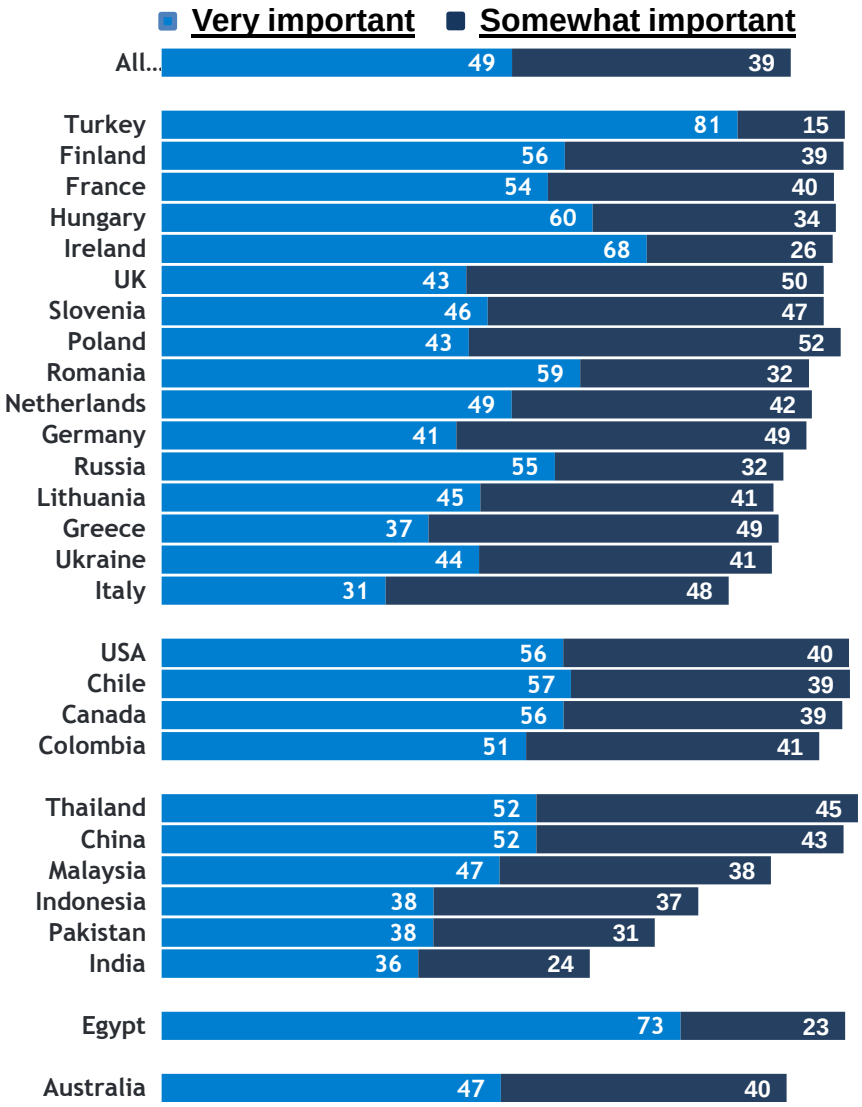


The presence or absence of contaminants in food is seen as a central potential contributor to health in Europe and America, but is much less readily conceptualised in this regard in Asia, and particularly in India and Pakistan.

Again, as in the case of smoking, it is quite stark that in those environments where the sanctity of an uncontaminated food chain is likely to be most at issue, awareness of the potential adverse effects upon health seem more tenuously developed.

The necessity to boost understanding of the importance of hygiene, and the need to maintain provenance of supply and a safe storage regime is clearly more at issue in Asia.

FOCUS UPON ADEQUACY OF SLEEP AS A HEALTH CONTRIBUTOR

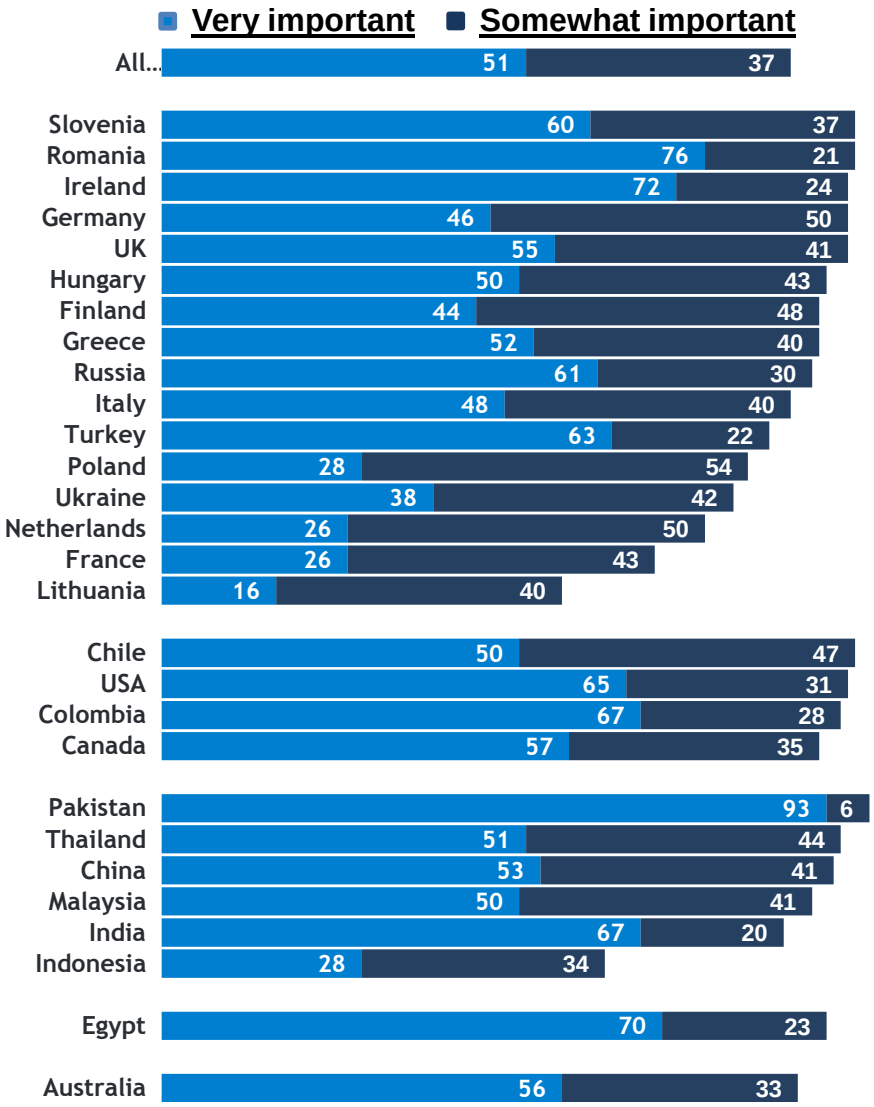


In European and American states there is common agreement that getting sufficient sleep is strongly contributory to health.

However the valuation of the adequacy or quality of sleep as a potential health contributor is again much lower in Asia.

The more limited perspective of the factors which fuel good health in Asia must reflect a simpler and less complex view, and perhaps less stress and anxiety in relation to health than seems common in more developed economies.

FOCUS ON DIET AS A HEALTH CONTRIBUTOR



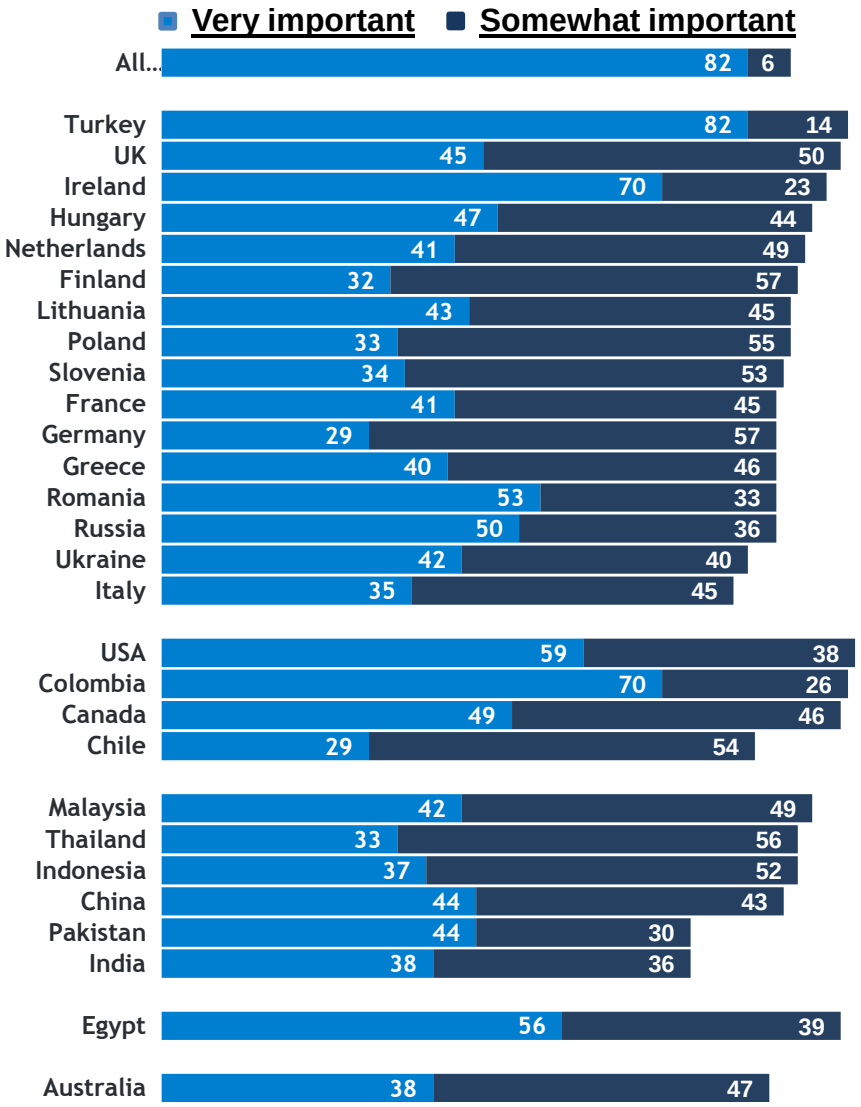
Diet is generally seen to be a key factor but with a more notable separation of views between Eastern and Western Europe principally.

The countries which place a distinctly lower priority on the importance of diet as a health contributor are Lithuania, Indonesia and France.

In effect, those who don't recognise the importance of diet appear not to be countries that lack a native or distinctive cuisine, and the presence of France in particular in this group might be regarded as unusual.

However, this may suggest that dietary expectations and achievement are higher in certain countries. Less concern may reflect a generally better standard of diet perhaps, and thus a diminished need to prioritise a facet of which a country may be generally proud, or indeed perhaps complacent.

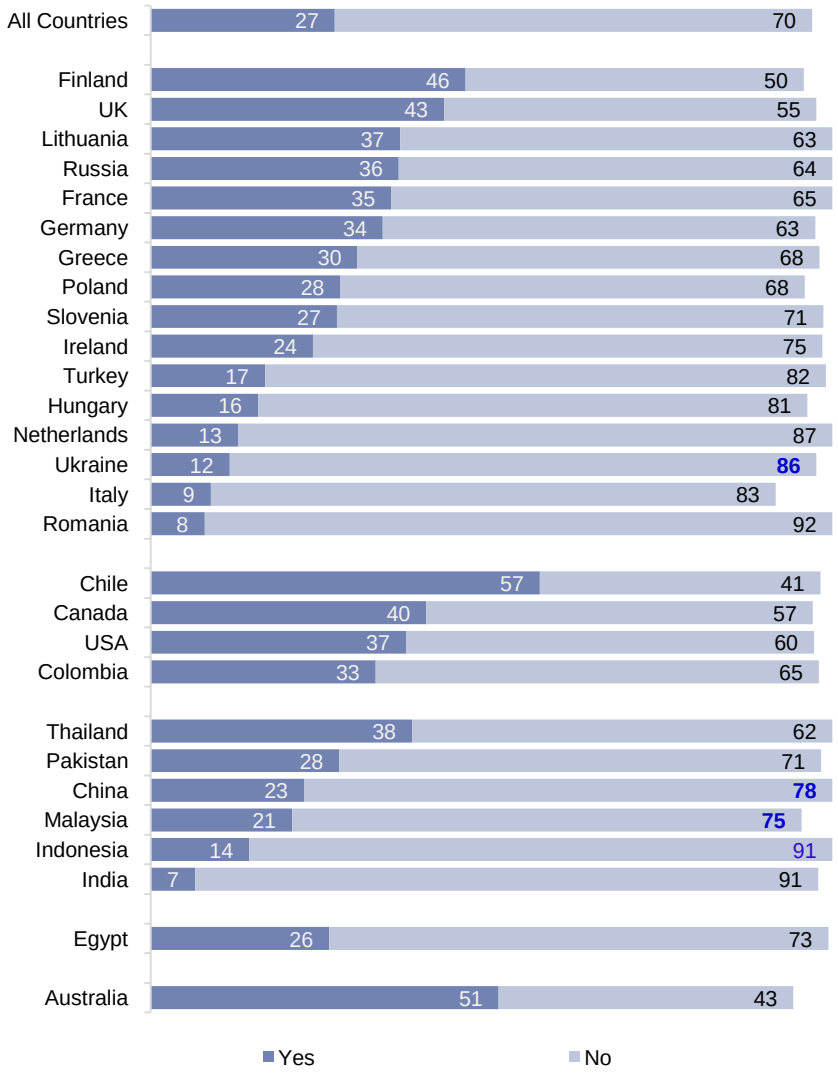
FOCUS ON FAMILY HEALTH HISTORY OR GENETICS AS A HEALTH CONTRIBUTOR



One's family history or genetics emerges in the Top 5 perceived contributors to health worldwide. In every country more than 7 in 10 believe genetic factors to be contributory to health.

Interestingly in Pakistan and India, but also in Chile this linkage to health status appears much more weakly established than in other countries, although the extent of variation seems slight.

PERSONAL EXPERIENCE OF MENTAL ILLNESS OR SUICIDE IN ONES PEER GROUP



In 20 of the 28 countries under investigation, more than a fifth of the adult population has some experience of mental illness, either by virtue of direct, personal experience or through the experience of someone close.

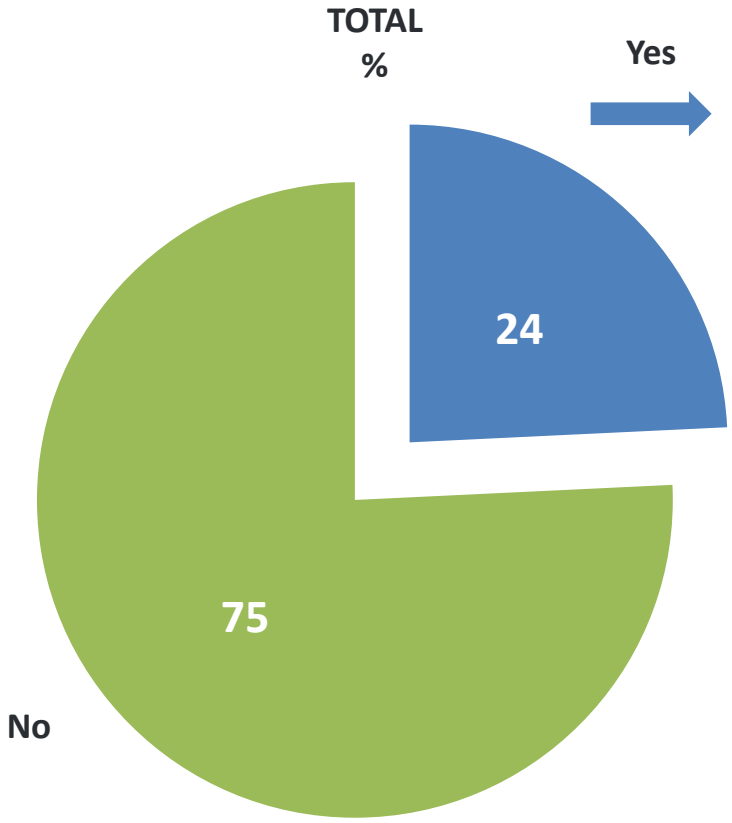
Direct experience is more substantially claimed in Chile, Finland and the UK with comparatively high levels in Canada, America and particularly Australia.

Some countries are evidently much slower to admit to such experience with evident cultural difficulty in this regard in Italy, Romania and India.

PERSONAL AFFECT OF DEPRESSION, MENTAL ILLNESS, OR SUICIDE

Base: All adults aged 16+; 1,000

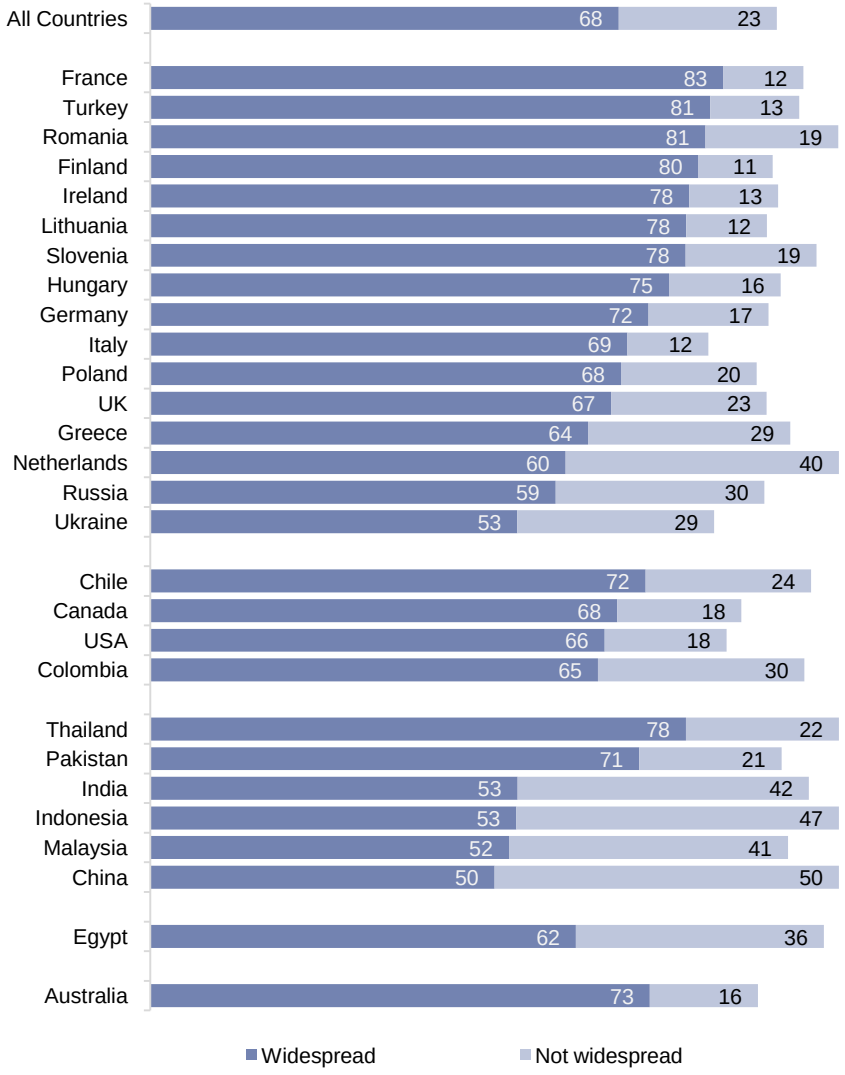
Q. Has your life been directly affected in any way (either because of personal experience or that of someone else) by depression, mental illness or suicide (or attempted suicide)?



Personal Experience			
	%		%
Men	20	Excellent health	22
Women	27	Good health	23
U25	14	Fair/poor health	30
25-34	31	Physician lead	22
35-49	29	Chose own treatment	17
50-64	20	Joint decision	26
65+	19	Chronic Condition	27
ABC1	25	No condition	23
C2DE	24	Medical Card	26
F	20	Private	24
		Neither	22

A quarter of the population have experienced these conditions with women and mid 20's plus the more commonly affected.

PERCEIVED PREVALENCE OF MENTAL ILLNESSES

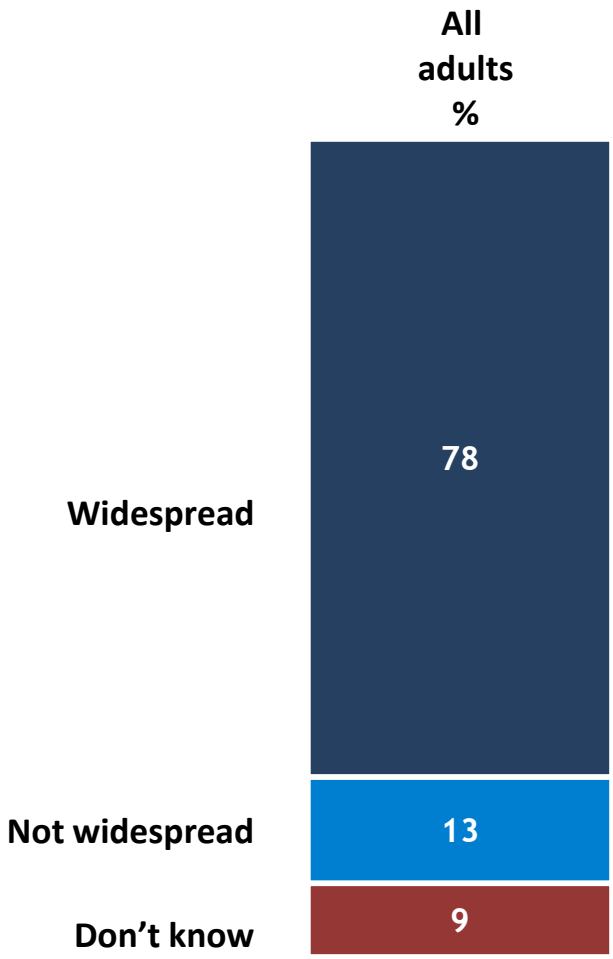


Although incidence and experience of mental illness and suicide may be quite varied and indeed very low in some countries, there is nonetheless a broad perception that mental illness is widespread in almost all countries under review. 6 in10 or more respondents in all but five countries regard mental illness as widespread these days.

The difference between the perceived prevalence and the direct experience of mental illness may be explicable by stigma in relation to mental illness, or may be a factor of reluctance to recognise manifestations of it in certain cultures.

PERVASIVENESS OF ILLNESSES RELATED TO DEPRESSION, MENTAL ILLNESS OR SUICIDAL TENDENCIES

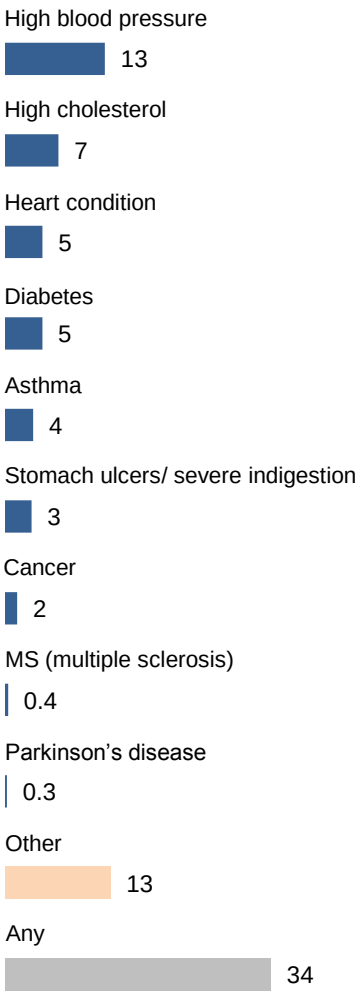
Base: All adults aged 16+; 1000



Widespread			
	%		%
Men	75	Excellent health	75
Women	81	Good health	79
U25	66	Fair/poor health	82
25-34	80	Physician-lead	77
35-49	81	Chose own treatment	81
50-64	79	Joint decision	79
65+	84	Medical Card	78
ABC1	78	Private cover	79
C2DE	79	Neither	77
F	75		

The vast majority feel these condition are common: three times as many as claim a personal affect.

KEY MEDICAL CONDITIONS



Three of the most pervasive chronic medical conditions globally relate to the cardiovascular system: high blood pressure, high cholesterol and indeed heart condition.

Fully a third of the global population surveyed suffers from one of a range of chronic conditions, with diabetes indicated as the next most prevalent after the various cardiovascular conditions mentioned above.

The study also explored experience of some more immediately fatal or degenerative conditions such as cancer, multiple sclerosis and Parkinsons disease, but as expected, incidences are comparatively low. 2% globally have experienced cancer.

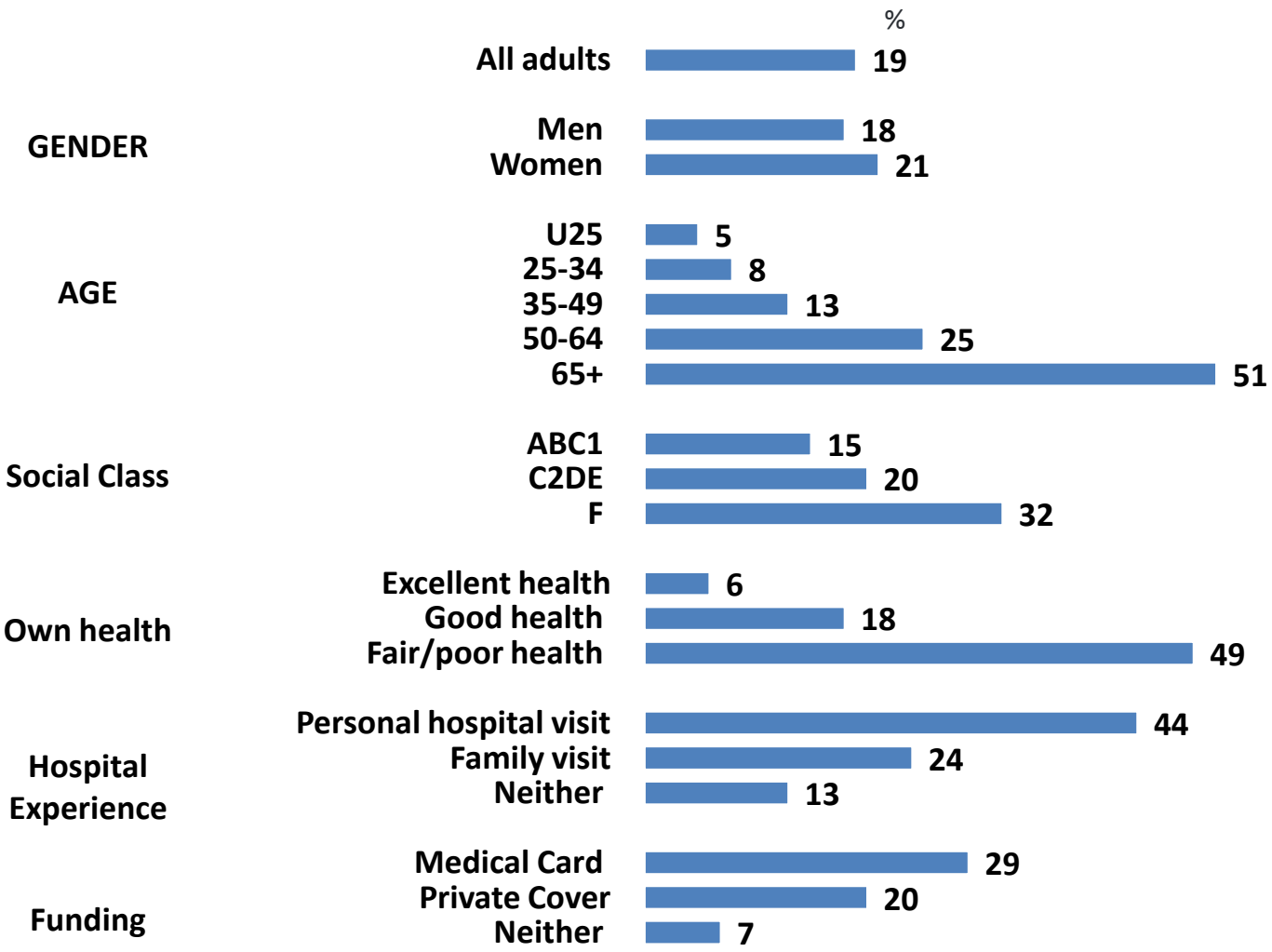
INCIDENCE OF INDIVIDUAL CHRONIC CONDITIONS NECESSITATING ONGOING TREATMENT

Base: All adults aged 16+; 1,000

	All Adults	Gender		Funding		
		Male	Female	Med Card	Private	Neither
Base:	1000	482	517	393	426	248
	%	%	%	%	%	%
High blood pressure	5	5	5	8	6	1
Heart condition	4	4	4	7	3	1
High cholesterol	3	2	3	5	2	-
Cancer	2	1	2	2	2	1
Asthma	2	2	1	2	2	2
Diabetes	2	2	2	4	2	0
Stomach ulcers/severe indigestion	1	1	1	2	0	-
MS (multiple sclerosis)	0	-	0	0	-	-
Parkinson's disease	0	0	0	0	0	-
Other severe conditions	7	5	10	12	8	2
Prefer not to answer	9	3	10	8	7	12

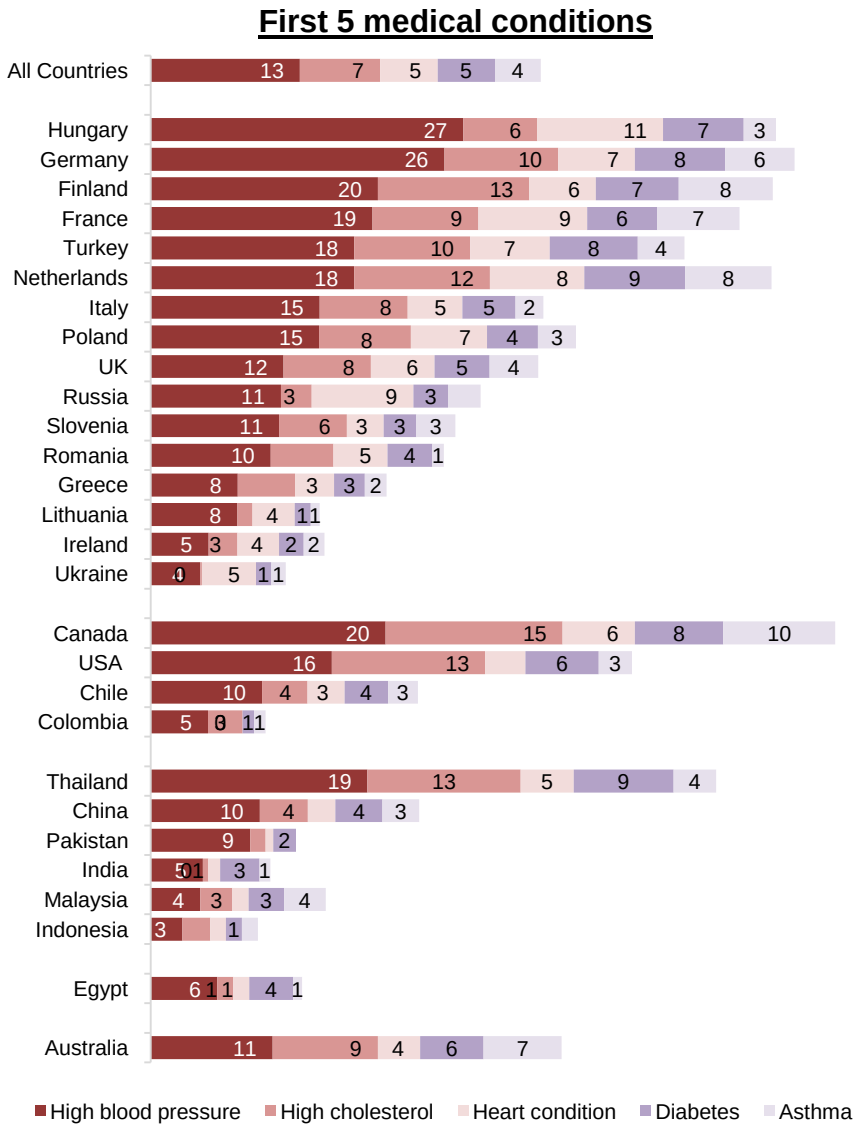
INCIDENCE OF ANY CHRONIC MEDICAL DIAGNOSIS FOR WHICH RECEIVING MEDICATION

Base: All adults aged 16+; 1,000



Chronic conditions experience grows with age, and 3 in 10 on medical cards are undergoing treatment.

CHRONIC CONDITIONS BY COUNTRIES



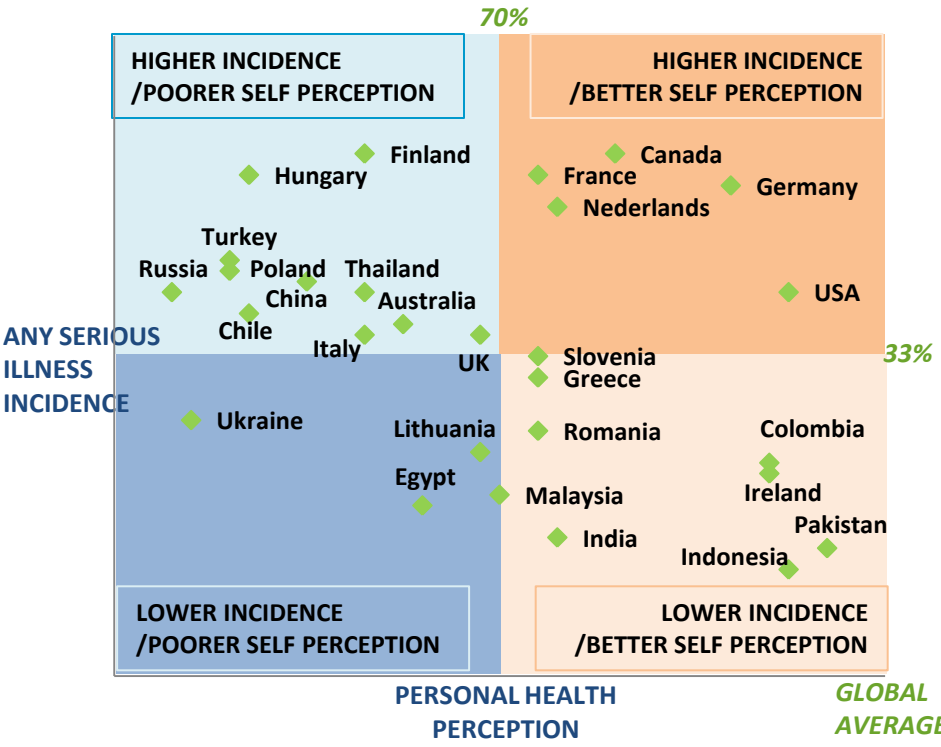
In the context of high blood pressure, there is a remarkable diversity of incidence with particularly high levels recorded in Hungary, Germany, Finland and France and remarkably low claimed incidence in some of the Asian sub continent but also in the Ukraine, Ireland, Lithuania and Greece. It seems highly probable that this may be related more to a lack of knowledge or screening, than to such substantial differences in actual incidence.

High cholesterol emerges as particularly prevalent in Canada, the USA, Thailand, Finland and the Netherlands.

Diabetes is again more readily acknowledged in Netherlands, Thailand, Germany, Turkey and Canada. As in the context of high blood pressure, one suspects that there are many cases of undiagnosed diabetes in other countries.

Asthma has a somewhat higher incidence in Canada, Finland and the Netherlands.

ACTUAL & PERCEIVED HEALTH CONTRAST



Contrasting the incidence of any of the serious health conditions examined by country (top to bottom scale) with each countries' perceived health score (left to right scale) enables us to determine whether there is an obvious global relationship between actual and perceived health.

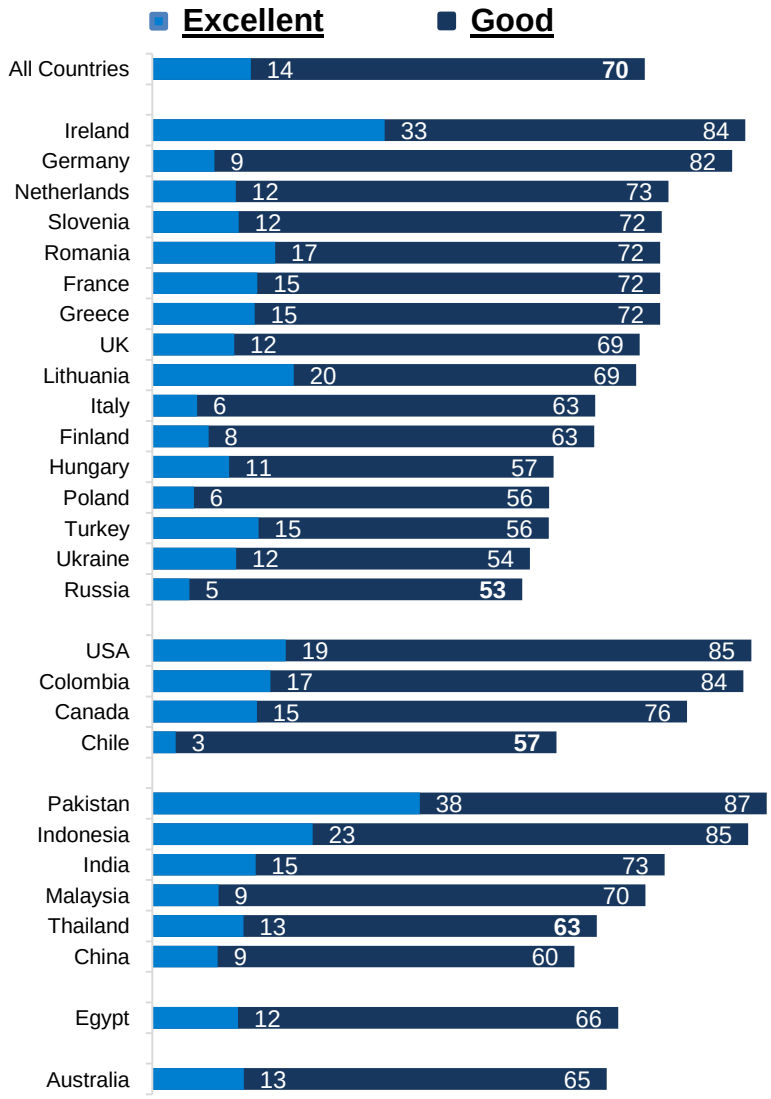
The principal developed countries in the top right quadrant have a generally higher disease incidence but their populations feel better on average. In the quadrant below that there are countries with lower illness incidences as well as a better overall health perception. Ireland, Colombia, Pakistan and Indonesia are typical in this regard.

Generally more unwell and also feeling worse on average are countries such as Hungary, Finland, China and Poland, while countries such as Ukraine, Lithuania and Egypt feel less well than average but with an apparently lower incidence of serious illness.

There is evidently no very direct relationship between the two facets, suggesting that levels of diagnosis and testing may differ widely by country. Furthermore, those countries where illness may be more prevalent don't seem to feel that much worse overall. Differences in healthcare provision may boost feeling of wellbeing in the upper right quadrant and depress them in the bottom left perhaps.

Personal Attitudes & Involvement

PERCEIVED PERSONAL HEALTH ASSESSMENT

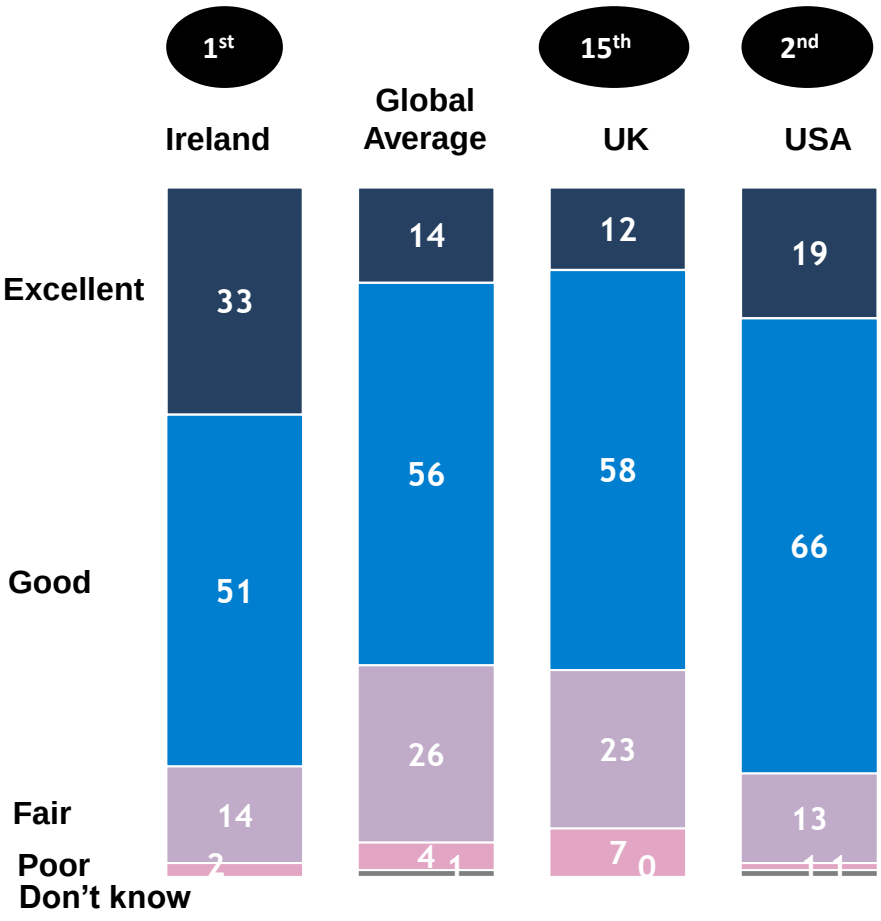


Perceived health is now accepted as an important predictor of actual health. 7 in 10 worldwide describe themselves as being in **excellent** or **good health** with notably higher scores emerging in Ireland, Germany, America, Columbia, Pakistan and Indonesia.

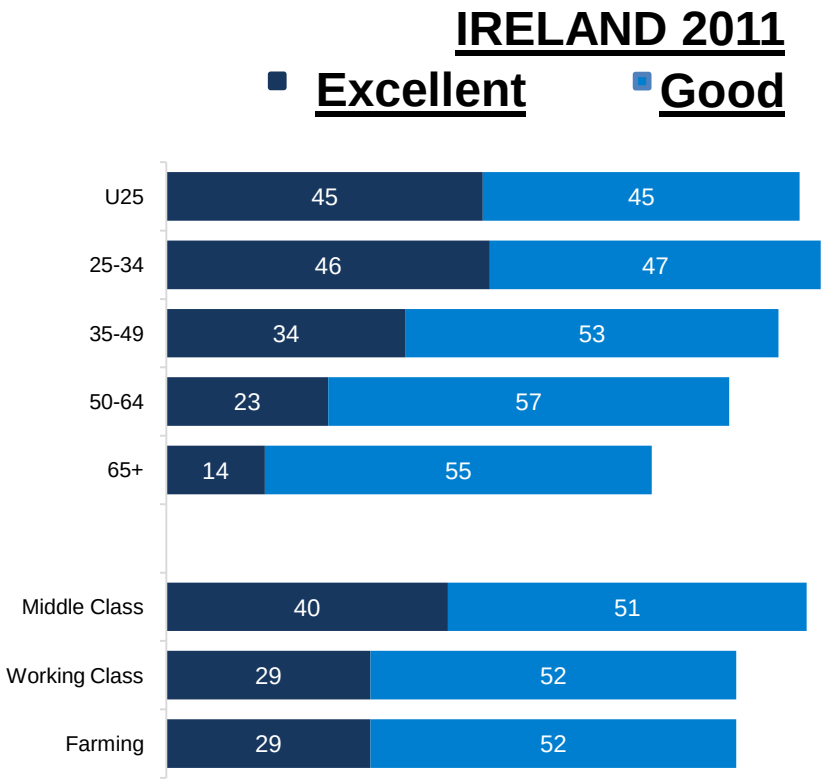
Pakistan and Indonesia earlier emerged as countries where there was a lower connection made between health status and a variety of issues which are considered significantly contributory in many other countries. Less concern about health may contribute to higher perceived personal health but may also mask a lack of informed health knowledge too.

The Irish have traditionally rated themselves more highly in this regard and it is felt that this may correlate with generally greater positivity of outlook perhaps. There is evidence too that better self perception of health may reflect a more youthful population structure and relatedly, lower disease incidence levels. A contrary view is that such elevated self perception of health reflects a somewhat selective perspective of the area.

Perceived Personal Health



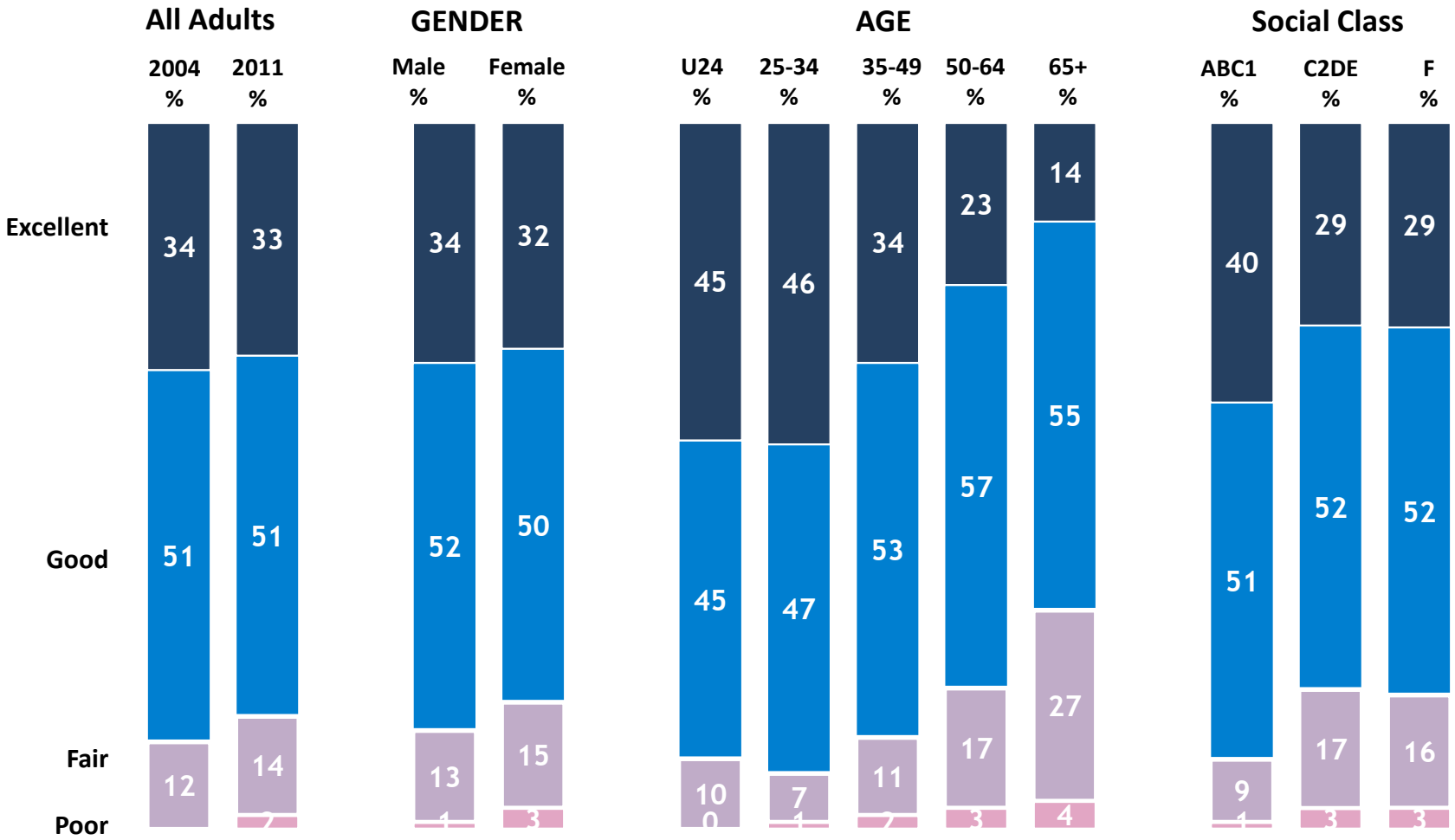
When we ran a similar study across 24 countries in 2005, Ireland also topped the list.



The quality of Irish self perception of health still defies logical assessment, with the proportion "excellent" far out pacing almost all other countries. This mirrors our general positivity in many studies and also our better performance on "quality of life" assessments.

PERSONAL HEALTH PERCEPTION

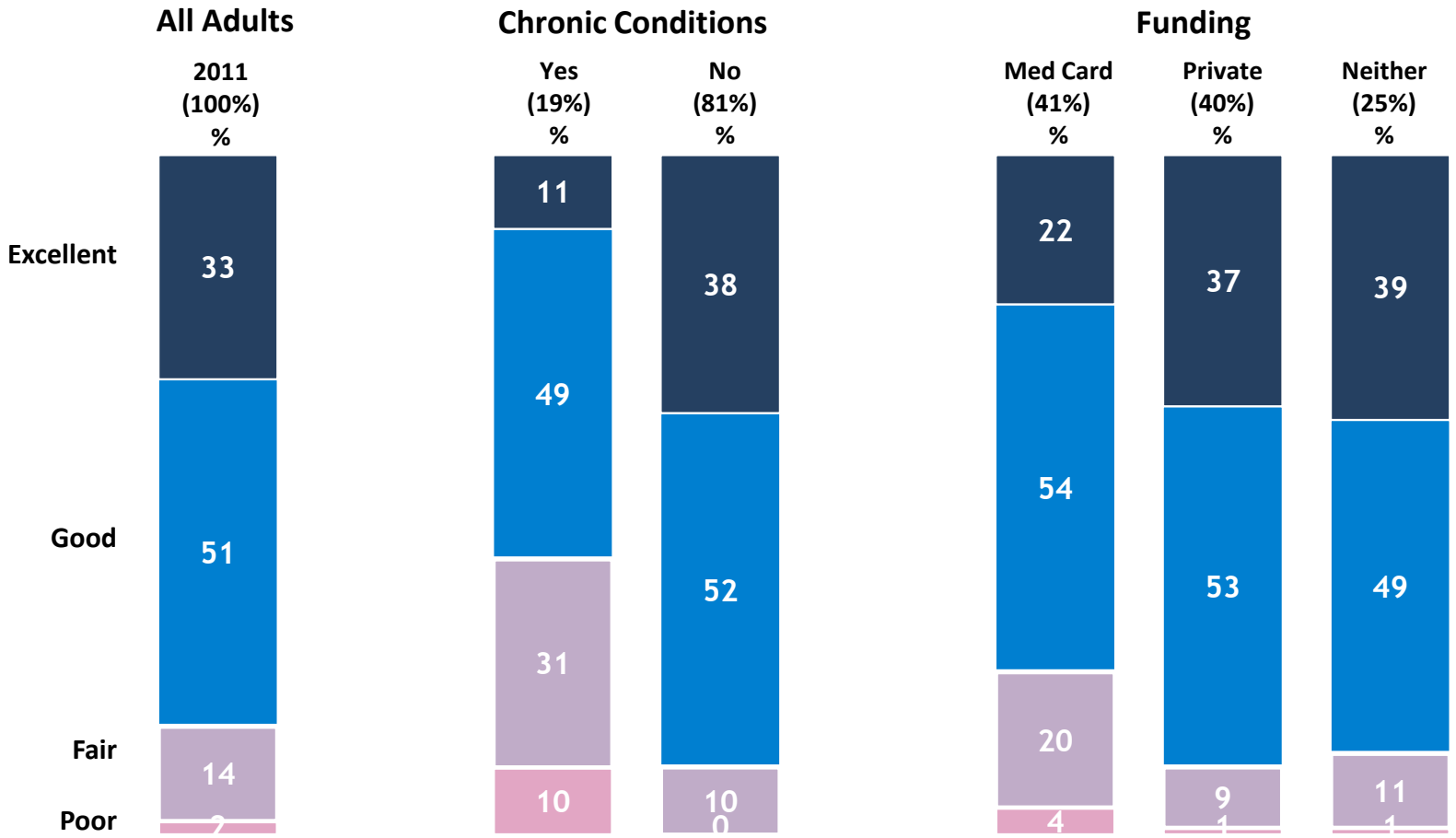
Base: All adults aged 16+: 1000



Perceptions of good health mainly coloured by age but also by affluence.

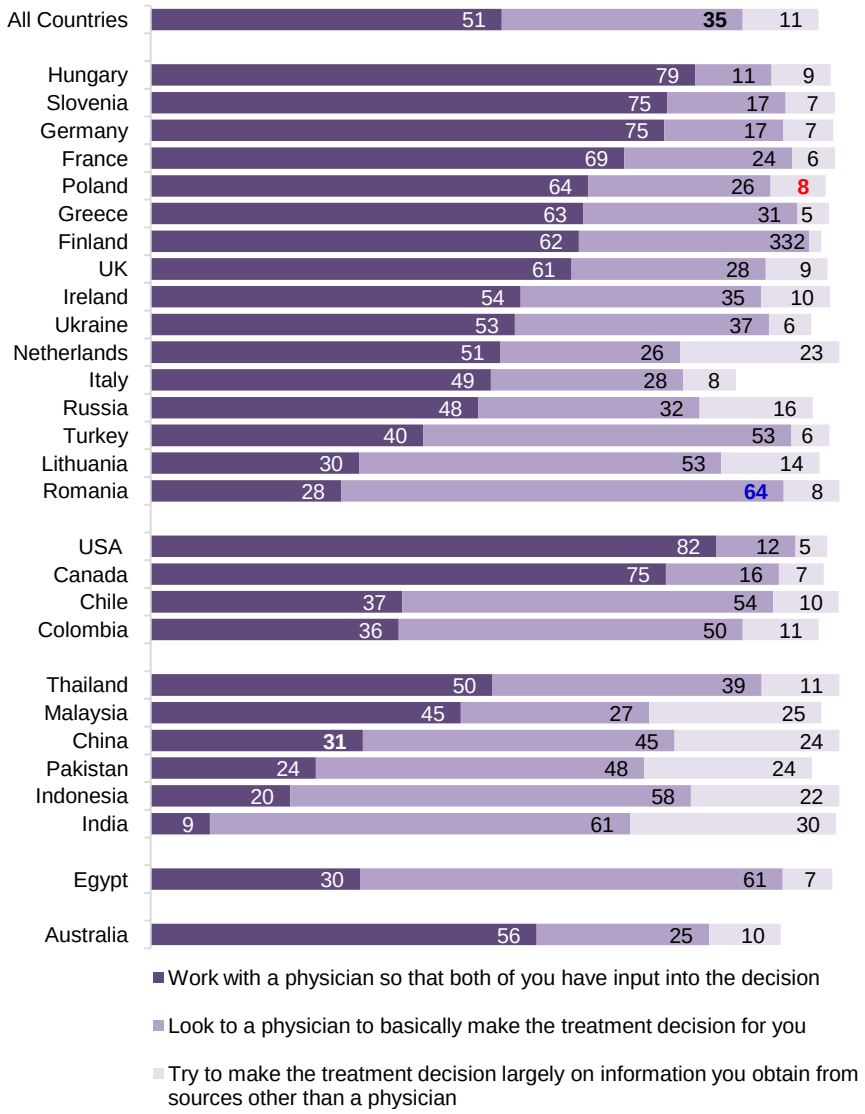
HEALTH PERCEPTION X HEALTH STATUS & COVER

Base: All adults aged 16+: 1000



Holders of private cover are marginally more healthy than the average person.

PATIENT INPUT INTO TREATMENT DECISIONS



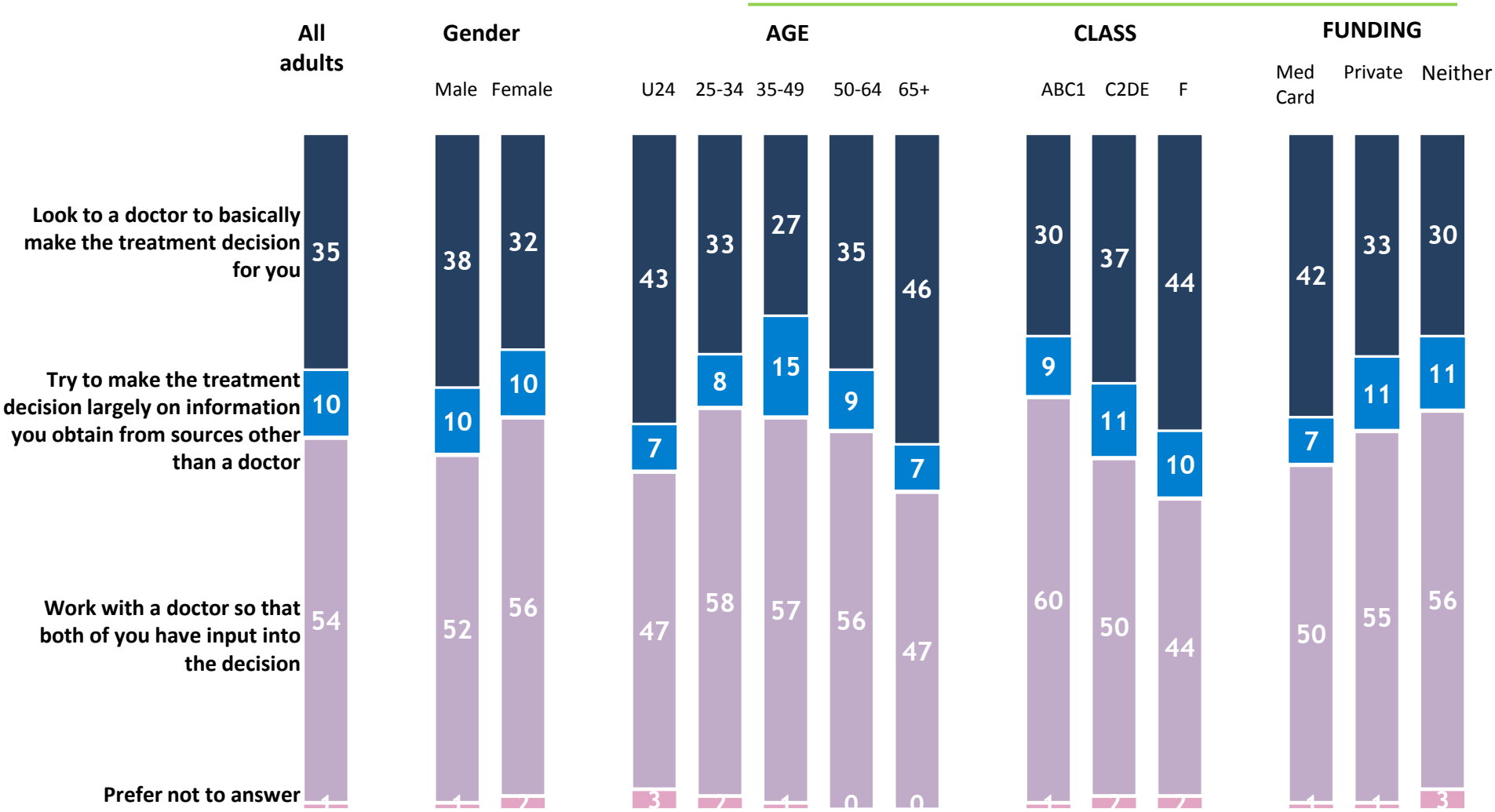
When asked how one prefers treatment decisions to be arrived at, there is evidence of a preference for collaboration between patient and physician in as many as 18 of the 28 countries studied.

Such collaboration is most expected in USA, Hungary, Slovenia, Germany, Canada, France, Poland, Greece, Finland and the UK. Conversely, greater reliance upon the physician to take the decision for the patient is apparent in Romania, India, Egypt, Indonesia, Chile, Turkey, Lithuania and Turkey.

In a small number of countries, there is evidence of a small but substantial group of patients preferring to direct their own treatment based upon information available to them. In this context, India, Malaysia, China, Pakistan, The Netherlands and Indonesia stand out to a slightly greater extent.

INPUT DESIRED ON OWN TREATMENT DECISIONS

Base: All adults aged 16+; 1,000



Female, middle aged and middle class patients the most hands-on, as are those who fund or pay for their own cover.

CONFIDENCE IN FACETS OF THE NATIONAL HEALTHCARE SYSTEM

TOP 2 BOXES	Quality health care services will always be available	Medical science and pharmaceutical products will be able to solve most, if not all, of the health issues	Healthcare services are among the best in the world	Does a good job of caring for the health of the more vulnerable in society
Total	48	39	40	47
Netherlands	77	70	79	60
France	76	54	80	68
Turkey	72	73	41	71
Finland	64	34	73	41
UK	63	57	70	59
Germany	55	61	68	55
Ireland	46	43	28	40
Russia	44	31	15	14
Italy	43	49	38	37
Hungary	41	55	18	33
Lithuania	40	29	14	19
Ukraine	30	21	9	10
Slovenia	22	22	23	22
Greece	16	28	7	12
Romania	13	17	4	9
Poland	12	27	15	14
Canada	66	51	76	60
USA	52	49	66	35
Chile	36	37	11	30
Colombia	25	42	14	11
India	78	76	60	71
Malaysia	73	66	53	65
Indonesia	68	67	25	53
Thailand	46	57	39	43
Pakistan	42	50	25	24
China	37	59	24	30
Egypt	38	48	13	27
Australia	58	42	58	47

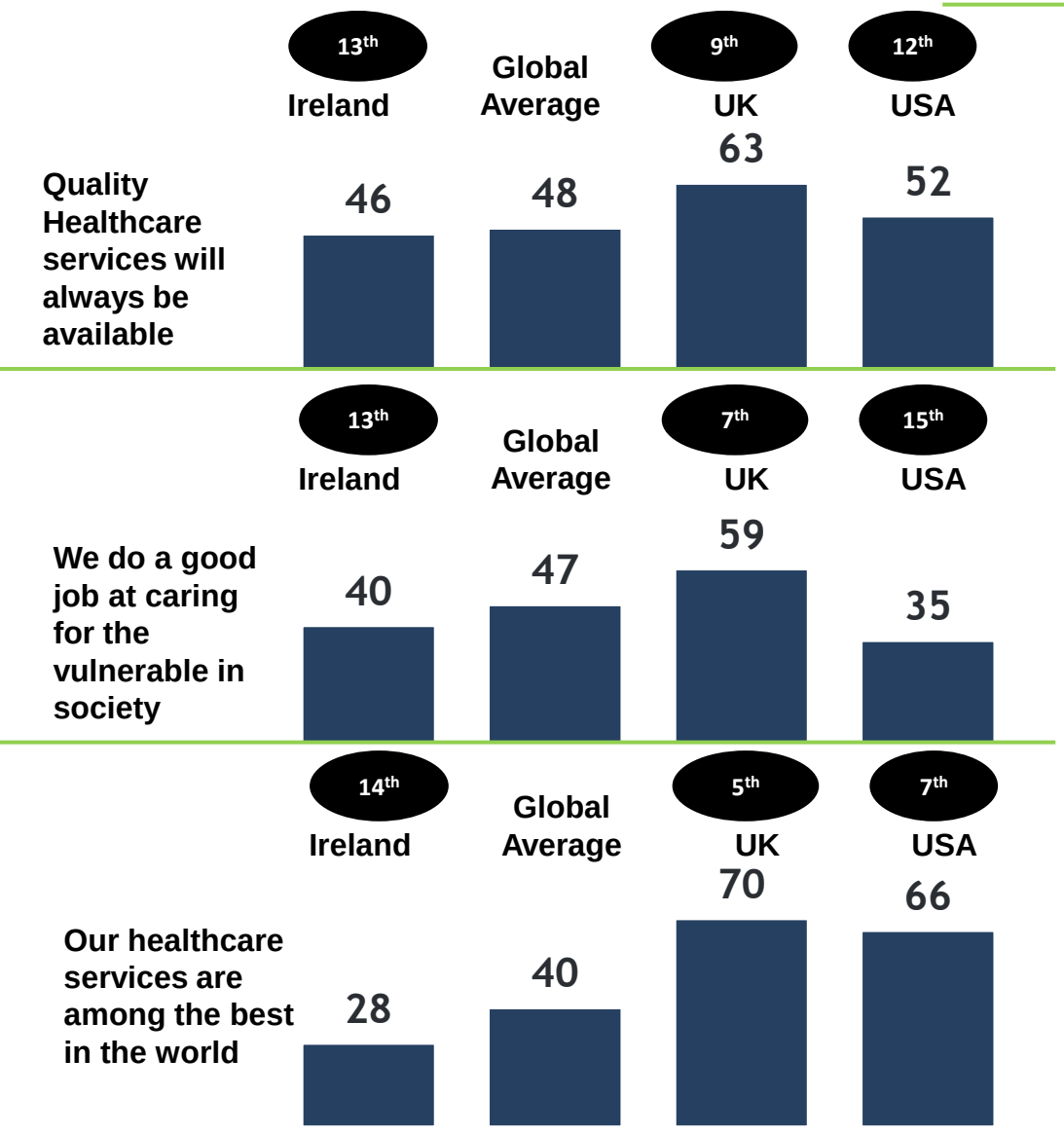
Perspectives of local healthcare systems differ substantially around the world. For example, there is a very broad view in the Netherlands and France that quality healthcare services will always be available in their countries and that their systems are among the best in the world. There is less commitment however that those countries do as good a job at caring for the vulnerable in their societies.

The populations of France, the Netherlands, Canada, Finland and the UK are the most likely to praise the healthcare services available in their countries.

Conversely, in Poland, Romania and Greece, the local perspective is much more muted about the perceived underpinnings of their systems. Those living in the Ukraine and Slovenia are also quite lacking in confidence about the ability of their local systems. The areas with the least confidence about the systems ability to address the needs of the more vulnerable in society tend to be voiced in Central and Eastern Europe and indeed in Colombia.

In 13 of the 28 countries, there is a slight majority view that medical science is capable of solving most if not all of today's healthcare issues. Interestingly such views are much more prevalent in either countries with better regarded medical systems or alternatively in Asia and North America.

CONFIDENCE ABOUT FACETS OF LOCAL HEALTH SYSTEMS



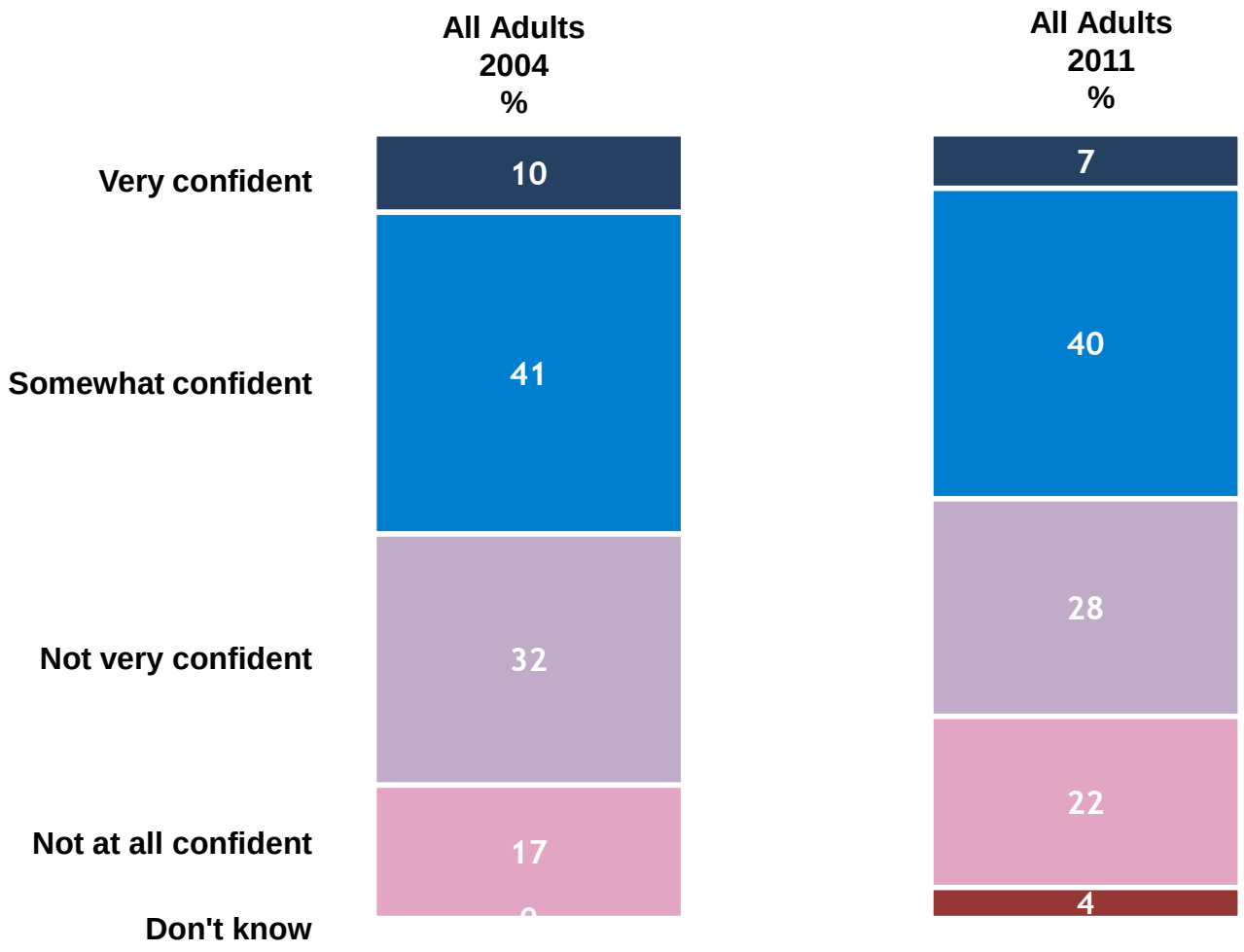
As a nation we lack confidence in the underpinnings of our system, only approaching the global average in our view that quality services will always be available.

Ireland lags far behind the UK in all regards, but creeps ahead of the Americans in our confidence that we care the vulnerable in society.

We fall well behind the Netherlands, Germany, France, Australia and Canada in all respects.

QUALITY HEALTH CARE SERVICES WILL ALWAYS BE AVAILABLE IN IRELAND FOR YOU AND YOUR FAMILY WHEN YOU NEED THEM

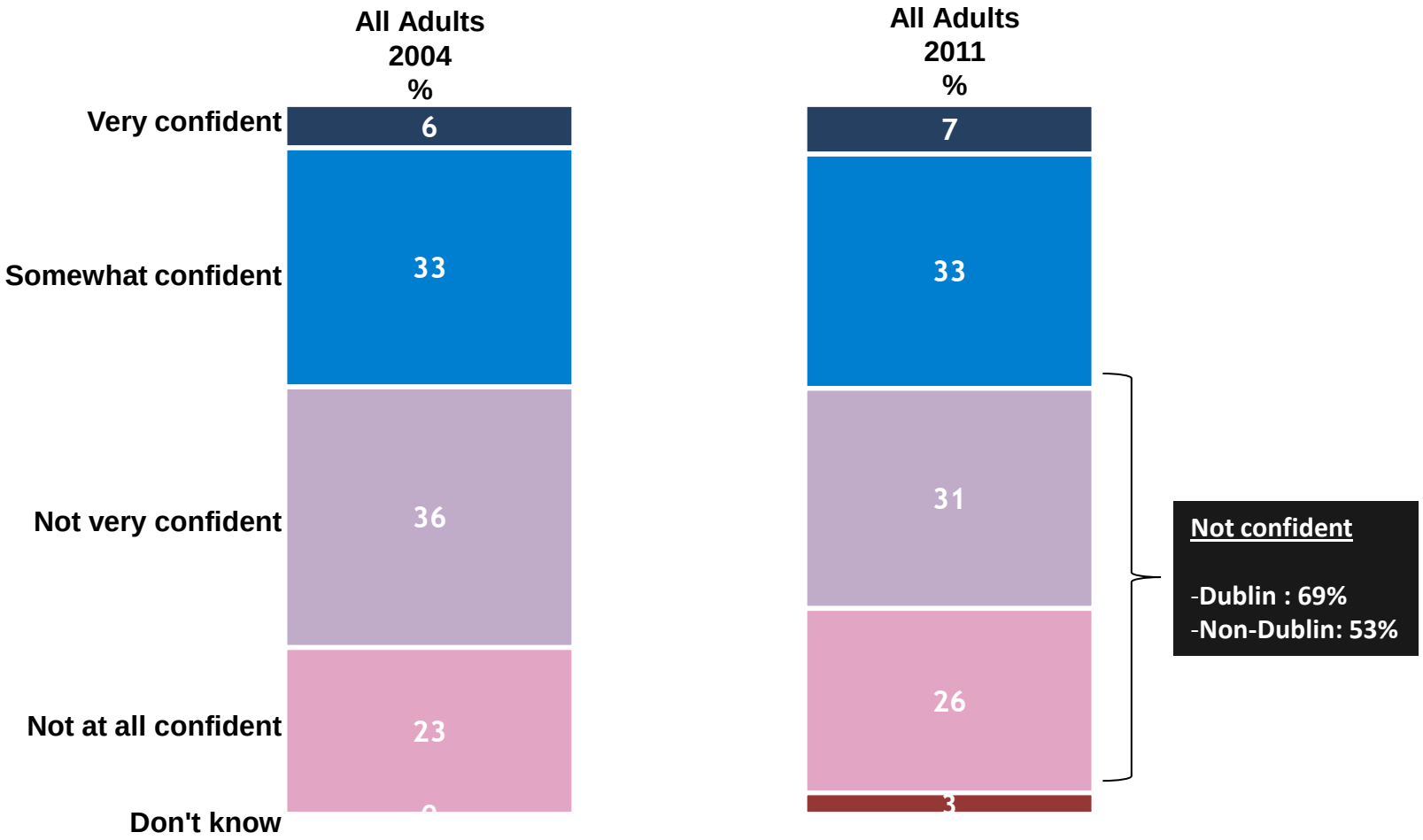
Base: All adults aged 16+: 1000



Marginal erosion of confidence with greatest doubts older, working class, those on medical cards. Privately insured are more positive.

IRELAND DOES A GOOD JOB OF CARING FOR THE HEALTH OF THE MORE VULNERABLE IN SOCIETY

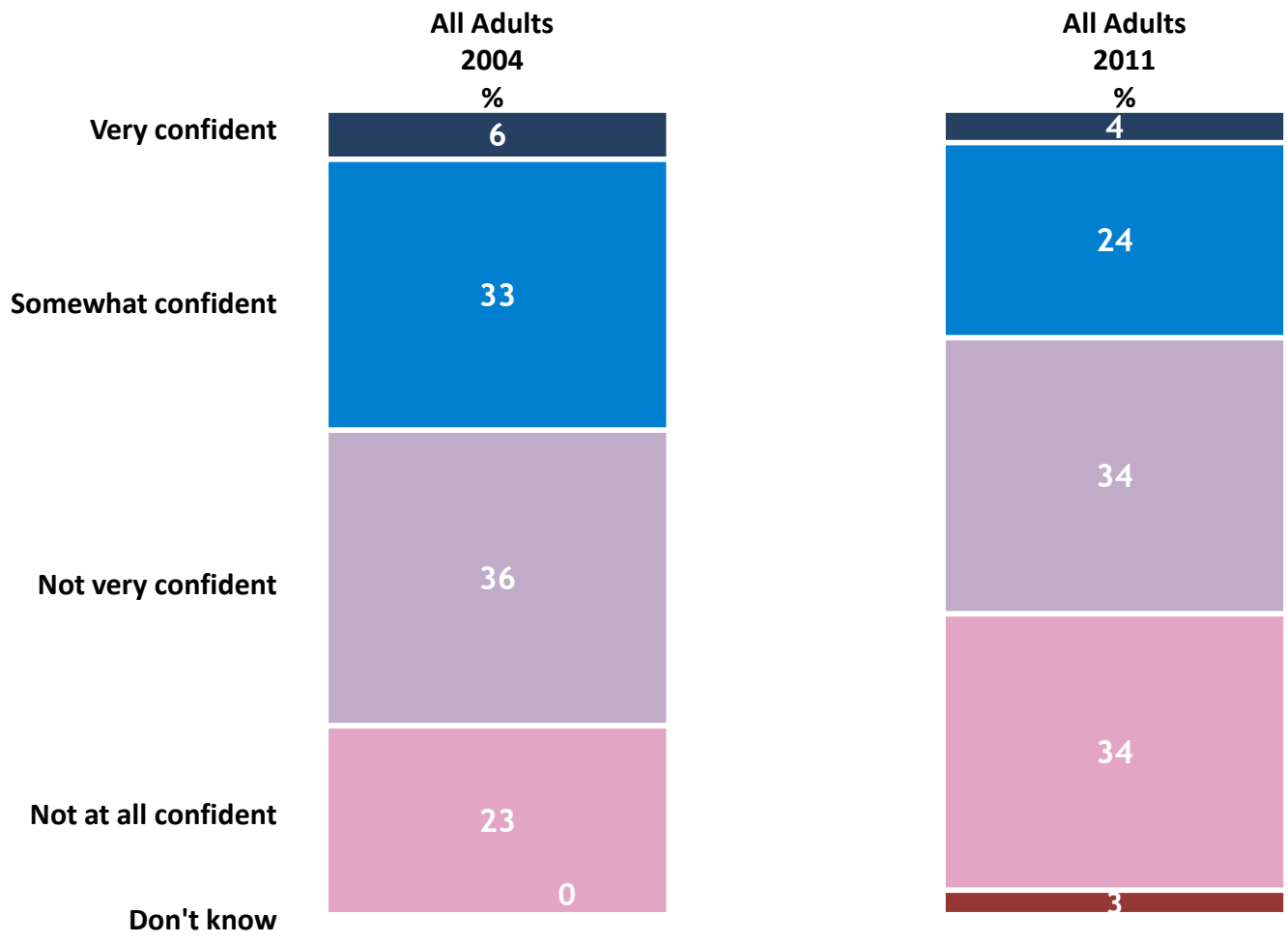
Base: All adults aged 16+: 1000



4 in 10 continue to feel that we look after the more vulnerable, but with more limited confidence in Dublin and in urban areas.

IRELAND'S HEALTH CARE SERVICES ARE AMONG THE BEST IN THE WORLD

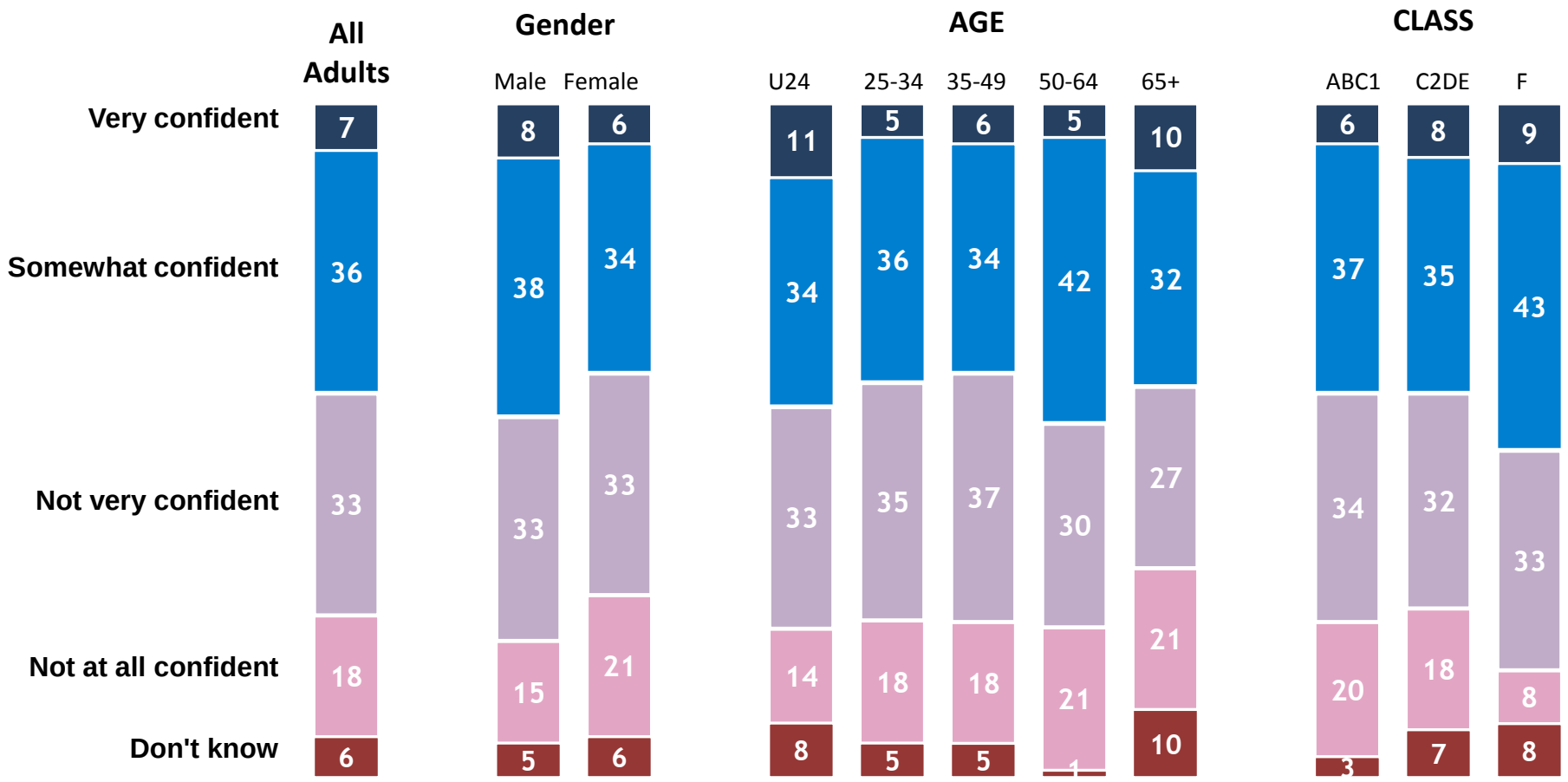
Base: All adults aged 16+: 1,000



A significant reduction over 7 years, with men, older adults and those unwell the least confident: those with medical cover no more or less confident.

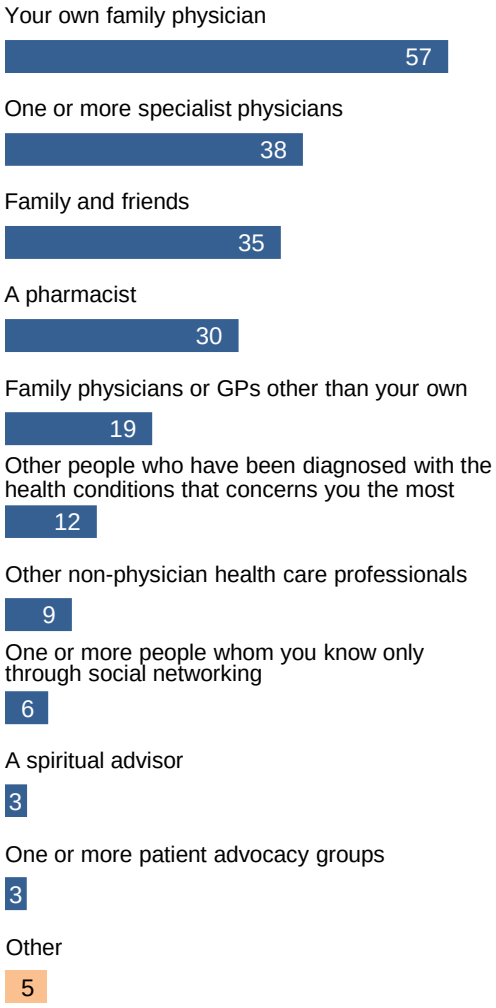
Medical science and pharmaceutical products will be able to solve most, if not all, of the health issues that face Ireland today

Base: All adults aged 16+: 1000



There is reasonable optimism about medical progress but it is clearly an aspect that might be stimulated.

PRIMARY SOURCES OF HEALTH RELATED INFORMATION



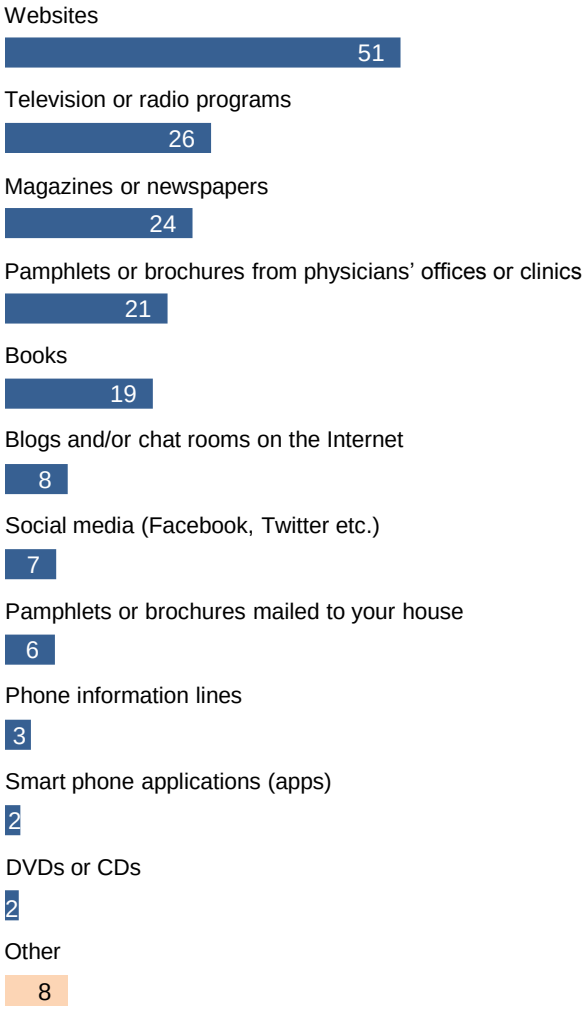
The key perceived source of information about health related topics is the family physician, followed closely behind by specialist physicians and family or friends. Equally the role of the pharmacist is very important and cited by 3 in 10 of the population sampled.

Less centrally regarded as important include patient advocacy groups, spiritual advisors or indeed contacts made through social networking.

About a fifth of the population surveyed would rely on family physicians or general practitioners other than their own and about 1 in 8 on people already diagnosed with a similar condition.

It is worth pointing out that there are considerable variances by country: in Pakistan the spiritual advisor is regarded as a key source of information by 45% of the population.

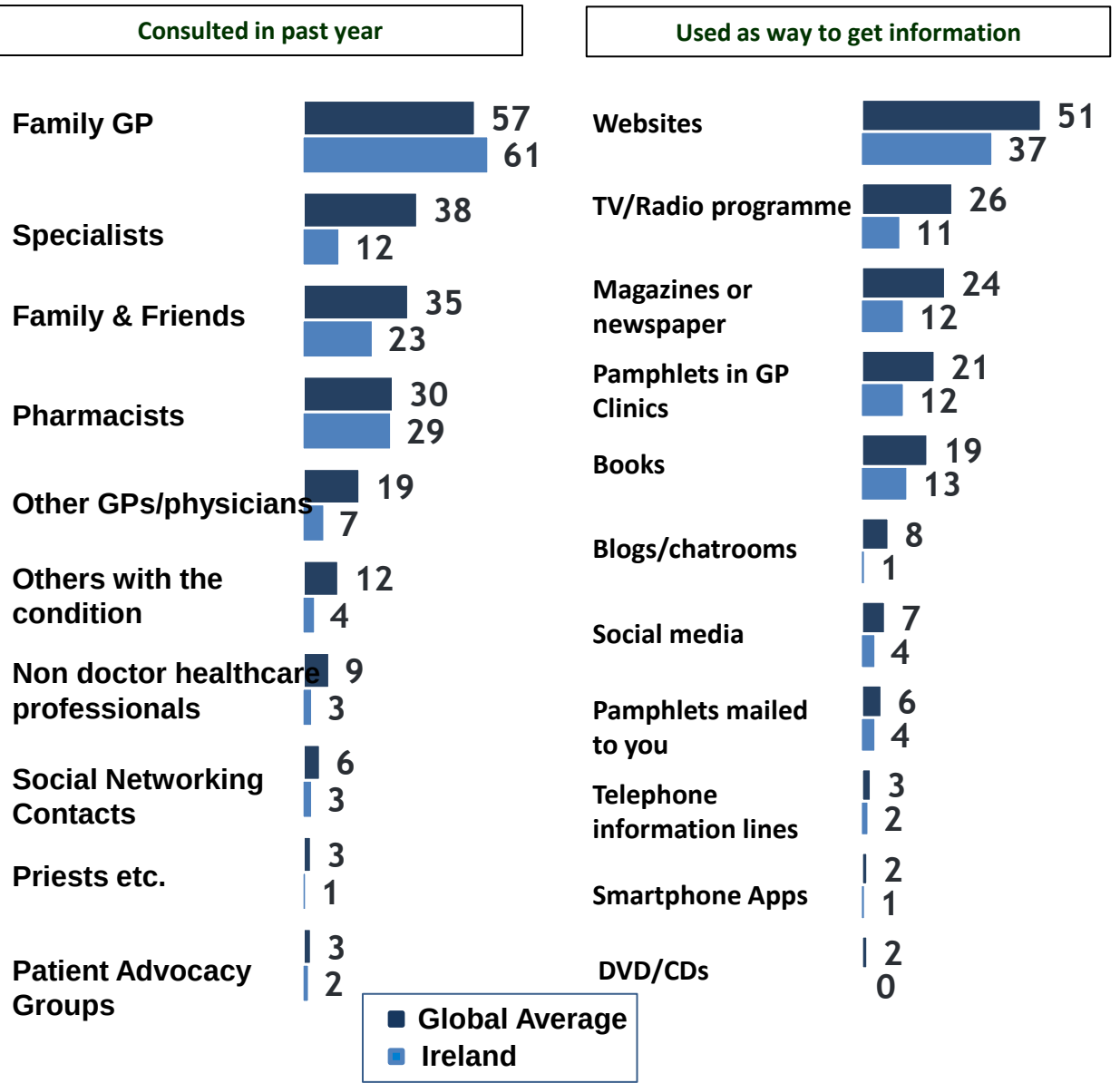
OVERVIEW ON SECONDARY SOURCES OF HEALTH RELATED INFORMATION



Websites tend to be regarded as the key secondary source of information on health matters. Electronic communications and print are also regarded as important sources, with pamphlets available from physicians offices or clinics equally featuring in the top 5 information sources worldwide.

As yet, few seem to be regarding blogs, chat rooms and social media as central conduits of secondary information, and indeed smart-phone apps feature at a low level globally, but notably more highly (at 12%) in China.

CONSULTED IN PAST YEAR ON HEALTH ISSUES THAT CONCERN YOU MOST
USED TO GET INFORMATION ON HEALTH ISSUES THAT CONCERN YOU MOST



Again we have a huge reliance on the GP, and only in relation to pharmacists do we come close to the level of use of other primary information sources.

The internet is a significant secondary source but at a fraction the level in many countries (Germany/UK 71%, USA 79%, China 69%).

Our use of newspapers is close to the UK level but in all other respects we lack, or don't use, the information sources used elsewhere.

It is clear that we don't rely or talk to family as much as other countries do: we don't tend to discus our health in detail.

PRIMARY SOURCES CONSULTED ON KEY HEALTH ISSUES IN PAST YEAR

	All Adults	Chronic Conditions		Funding		
		Yes	No	Med Card	Private	Neither
Base:	1000	191	808	393	426	248
	%	%	%	%	%	%
Your own family GP	61	77	58	68	59	55
A pharmacist	29	37	27	26	34	29
Family and friends	23	24	23	22	23	25
One or more specialist doctors	12	27	8	10	17	8
Family physicians or GPs other than your own	7	8	7	9	9	3
Other people who have been diagnosed with the health conditions that concern you the most	4	5	4	3	6	2
One or more people whom you know only through social networking, such as Facebook, Twitter, a chat group or blog on the Internet	3	3	3	3	4	4
Other non-doctor health care professionals, such as chiropractors, alternative health care providers, etc.	3	4	3	2	5	2
One or more patient advocacy groups	2	1	2	2	2	1
A spiritual advisor	1	2	1	2	1	1
Other	8	3	10	4	12	9
Prefer not to answer/none	9	3	10	8	7	12

Those who fund their own cover are more varied in those that they consult with. Pharmacists and Specialists of greater importance to them.

FOCUS ON PRIMARY SOURCES OF HEALTH RELATED INFORMATION BY COUNTRY

%	Your own family physician	One or more specialist physicians	Family and friends	A pharmacist
All Countries	56	38	35	30
Netherlands	77	29	22	16
France	76	36	29	33
Lithuania	75	54	26	53
Slovenia	74	34	38	32
Romania	71	26	35	48
Germany	71	51	29	18
UK	67	28	31	23
Turkey	64	57	51	61
Italy	63	33	8	14
Ireland	61	12	23	29
Poland	58	54	47	27
Hungary	56	37	24	17
Russia	49	50	35	26
Ukraine	44	33	30	16
Greece	38	46	32	44
Finland	24	37	38	11
USA	69	39	45	20
Canada	69	29	41	43
Chile	32	41	34	13
Colombia	49	34	37	16
Pakistan	73	56	78	43
India	63	25	63	58
Malaysia	31	49	56	34
Indonesia	20	26	45	7
Thailand	8	47	36	38
China	-	60	73	17
Egypt	38	65	26	44
Australia	75	29	32	37

The family physician is the key conduit of health related information in the majority of countries, although relegated into second place in countries such as Russia, Greece, Finland, Chile, Egypt and Malaysia.

Specialist physicians are generally not seen as key information sources but have greater prominence in Egypt, China, Pakistan, Turkey, Poland and Lithuania. The role of family and friends vary significantly and their role is seen as quite central in Pakistan, China and indeed throughout Asia.

The importance of the pharmacist varies substantially by country too and they are seen as more important sources of information in Turkey, India and Lithuania but with quite substantial variances of note too.

SECONDARY SOURCES OF HEALTH INFORMATION USED IN PAST YEAR

	All Adults	GENDER		AGE					Social Class			FUNDING		
		Male	Female	-24	25-34	35-49	50-64	65+	ABC1	C2DE	F	Med Card	Private	Neither
Base:	*1000*	*482*	*517*	*148*	*216*	*268*	*218*	*149*	*447*	*483*	*69*	*393*	*426*	*248*
	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Websites	37	35	39	39	53	44	28	10	48	32	11	29	42	41
Books	13	13	13	7	15	16	13	11	14	13	9	12	15	10
Pamphlets or brochures that you can pick up in physicians' offices or clinics	12	8	15	4	15	14	11	9	15	10	3	11	14	8
Magazines or newspapers	12	9	14	8	9	13	11	17	12	11	15	12	11	13
Television or radio programs	11	9	12	10	13	9	11	9	9	11	13	12	9	10
Pamphlets or brochures that are mailed to your house	4	3	5	1	5	2	5	7	3	5	1	5	4	2
Social media (Facebook, Twitter, etc.)	4	4	3	6	5	6	-	-	3	4	4	3	2	6
Phone information lines	2	1	2	-	3	2	2	0	2	2	-	2	1	2
Blogs and/or chat rooms on the Internet	1	1	2	1	3	1	2	1	3	1	-	1	2	1
Smart phone applications (apps)	1	1	1	2	1	1	-	1	2	1	-	1	1	1
DVDs or CDs	0	0	-	-	-	-	1	-	0	-	-	-	-	1
Other	16	18	14	24	10	11	17	26	13	17	24	16	18	15
Prefer not to answer/none	21	23	18	20	14	17	27	30	17	23	26	24	17	21

Middle aged, middle class and privately insured are much more web reliant overall.

WEBSITES USED FOR MEDICAL INFORMATION IN PAST YEAR

	All adults	FUNDING		
		Med Card	Private	Neither
Base:	*1000*	*393*	*426*	*248*
	%	%	%	%
Health directory sites (such as Wikipedia)	12	8	13	15
Sites devoted to a specific disease	11	10	15	10
Nutrition sites	6	3	8	8
Government health-related sites	6	5	5	7
Exercise sites	5	3	5	8
Television health channel sites	3	2	3	5
University or hospital/clinic sites	3	2	4	3
Physician association sites	3	2	3	3
Sites sponsored by a pharmaceutical company	2	3	4	1
Sites sponsored by patient advocacy groups	2	1	3	1
Sites that show how physicians are rated by their patients	1	2	1	1

37% use internet. A third of these (12% of the population) go straight to Wikipedia, while specific disease sites are almost as popular.

VARIATION IN USE OF SECONDARY SOURCES OF HEALTH RELATED INFORMATION BY COUNTRY

%	Websites	TV or radio	Magazines or newspapers	Brochures from physicians' offices or clinics
All Countries	51	36	24	21
Slovenia	87	23	33	26
Poland	83	15	28	28
Finland	74	15	21	20
UK	71	13	14	25
Germany	71	9	18	18
Netherlands	62	12	13	11
Greece	51	31	37	33
Lithuania	43	34	23	23
France	39	44	29	39
Hungary	38	28	22	30
Ireland	37	11	12	12
Russia	36	32	26	22
Ukraine	33	21	16	7
Romania	30	22	26	13
Italy	24	11	8	5
Turkey	21	69	37	33
Colombia	82	22	17	20
USA	79	17	28	34
Chile	79	15	15	16
Canada	72	18	18	29
China	69	61	47	23
Pakistan	64	66	66	18
Malaysia	63	41	54	43
Thailand	38	29	25	24
Indonesia	8	63	42	25
India	7	51	33	7
Egypt	40	41	18	6
Australia	70	14	14	28

The prominence of websites as health information sources varies widely by country. 7 or 8 people in every 10 use websites in a range of countries including Slovenia, Poland, Columbia, USA, Chile, Finland, Canada, UK, Germany, Australia and China. Conversely, levels of use are much lower in countries such as France, Hungary, Ireland and Italy.

America, Australia and significant elements of Europe do not rely so much on TV or radio programmes when it comes to health related issues, whereas the importance of this type of electronic communication is much greater in Turkey, Pakistan, Indonesia and China.

Magazines and press are valued more in countries in Asia: Pakistan, Malaysia, China and Indonesia.

Pamphlets and brochures in physicians offices or clinics are consulted widely by people in Malaysia and France particularly. Conversely usage of these types of pamphlets is much more limited in countries such as Ukraine, Italy, India or Egypt.

OTHER SECONDARY SOURCES OF HEALTH RELATED INFORMATION

%	Books	Blogs and/ or chat rooms on the Internet	Social media (Facebook, Twitter etc.)
All Countries	19	8	7
Russia	31	10	9
Slovenia	26	27	6
Greece	25	15	5
Turkey	24	2	3
France	24	8	4
Poland	24	19	8
Germany	18	6	5
Hungary	17	9	8
Finland	16	7	4
UK	14	9	4
Romania	13	5	2
Ireland	13	1	4
Lithuania	11	8	1
Ukraine	11	3	13
Netherlands	10	4	2
Italy	3	1	2
Canada	22	8	3
Colombia	22	8	5
USA	21	9	3
Chile	17	7	7
China	53	23	25
Pakistan	37	16	59
Malaysia	32	18	25
Thailand	27	7	9
India	21	1	2
Indonesia	17	2	4
Egypt	8	6	13
Australia	18	8	5

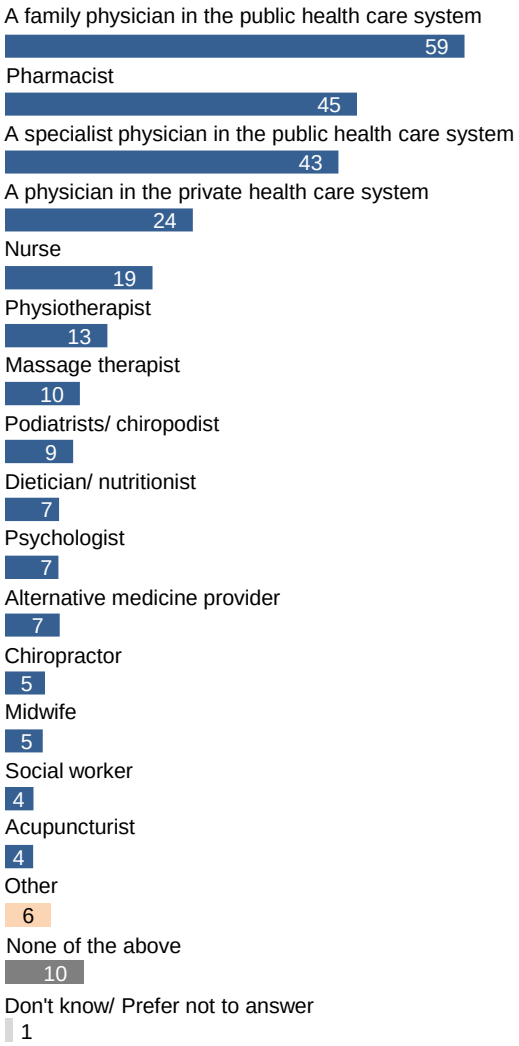
China and Russia are the territories in which books are more prominent as a reference for health matters.

In Slovenia and China, but to some extent in Greece, Poland, Pakistan and Malaysia there is greater reliance upon blogs and chat rooms than in other areas. Conversely consideration of these media is almost non existent in a health context in Ireland, Italy and India.

Social media has yet to establish itself significantly in this context, although evidently much more prominent in Pakistan, but with some currency too in countries such as China and Malaysia.

Interaction with Healthcare Professionals

USE OF MEDICAL SPECIALTIES OR HEALTH CARE PROFESSIONALS



Of all the different medical specialities, the family physician is the most used, followed by the pharmacist and then by other specialist physicians or doctors in the public healthcare system.

Roughly a quarter of the surveyed populations visited a physician in the private system in the past year.

Usage of other healthcare professionals such as physiotherapists, massage therapists, dieticians and psychologists is much more limited.

7% use practitioners of alternative medicine.

As expected, usage patterns vary substantially by country, as documented over the following pages.

PAST YEAR USAGE OF MAIN HEALTHCARE PROFESSIONALS BY COUNTRY

%	A family physician in the public healthcare system	A specialist physician in the public healthcare system	A physician in the private healthcare system
All Countries	59	43	24
Russia	86	73	45
Slovenia	85	55	20
Germany	80	71	19
Hungary	78	63	21
Lithuania	76	51	16
Netherlands	76	46	4
Poland	75	50	30
Romania	73	35	17
Turkey	71	80	52
UK	68	33	9
Italy	65	43	35
Ireland	65	18	13
France	62	51	17
Ukraine	47	43	9
Greece	35	47	45
Finland	29	41	44
Canada	75	44	7
Colombia	53	48	29
Chile	42	25	55
USA	27	17	37
Pakistan	73	51	53
India	66	37	24
Thailand	56	23	15
Malaysia	37	42	26
Indonesia	26	28	10
China	-	54	12
Egypt	6	9	22
Australia	71	40	20

As commented earlier, the majority of the surveyed populations attend family and specialist physicians or doctors in the public healthcare system. Usage of these however is much more modest in countries such as Egypt, Indonesia, the USA, Finland, Greece and Malaysia.

Equally access to specialist physicians in the public system is much more limited in Ireland, Thailand, Chile, The United Kingdom or Romania, but common in Russia and Turkey.

Private sector physicians are used on a much more limited basis in many countries and feature at low levels in countries such as Netherlands, Canada, Ukraine, Indonesia, China, Ireland, Thailand, Lithuania, France, Romania and Germany.

Chile, Pakistan and Turkey stand out as the countries where people are more likely to visit a private sector physician rather than a public sector one.

PAST YEAR USAGE OF MAIN HEALTHCARE PROFESSIONALS BY COUNTRY

%	Pharmacist	Physiotherapist	Dietician/ nutritionist	Psychologist
All Countries	45	13	7	7
France	85	39	9	12
Turkey	72	19	8	14
Lithuania	68	7	1	3
Netherlands	64	30	11	11
Greece	63	14	10	7
Germany	55	22	3	9
Poland	49	13	5	8
Romania	47	3	3	3
Slovenia	40	15	3	7
Hungary	40	11	7	5
UK	38	16	6	5
Russia	37	35	5	12
Ireland	36	10	3	2
Italy	25	9	6	3
Finland	18	20	5	10
Ukraine	14	3	0	3
Canada	58	17	7	8
USA	52	3	6	8
Chile	30	3	27	26
Colombia	19	21	22	12
India	64	3	2	2
Malaysia	42	6	7	3
Pakistan	30	8	36	11
Thailand	26	3	3	1
China	19	9	12	7
Indonesia	7	2	4	0
Egypt	78	14	16	3
Australia	46	17	8	12

The Pharmacist occupies a very important role in the healthcare system in a variety of countries. Their role is quite central in France, Turkey, Lithuania, The Netherlands, Greece and Germany and they are equally very prominent in Canada, the USA, India and Egypt. Visits to a pharmacist in Ukraine, Finland and China are much more limited.

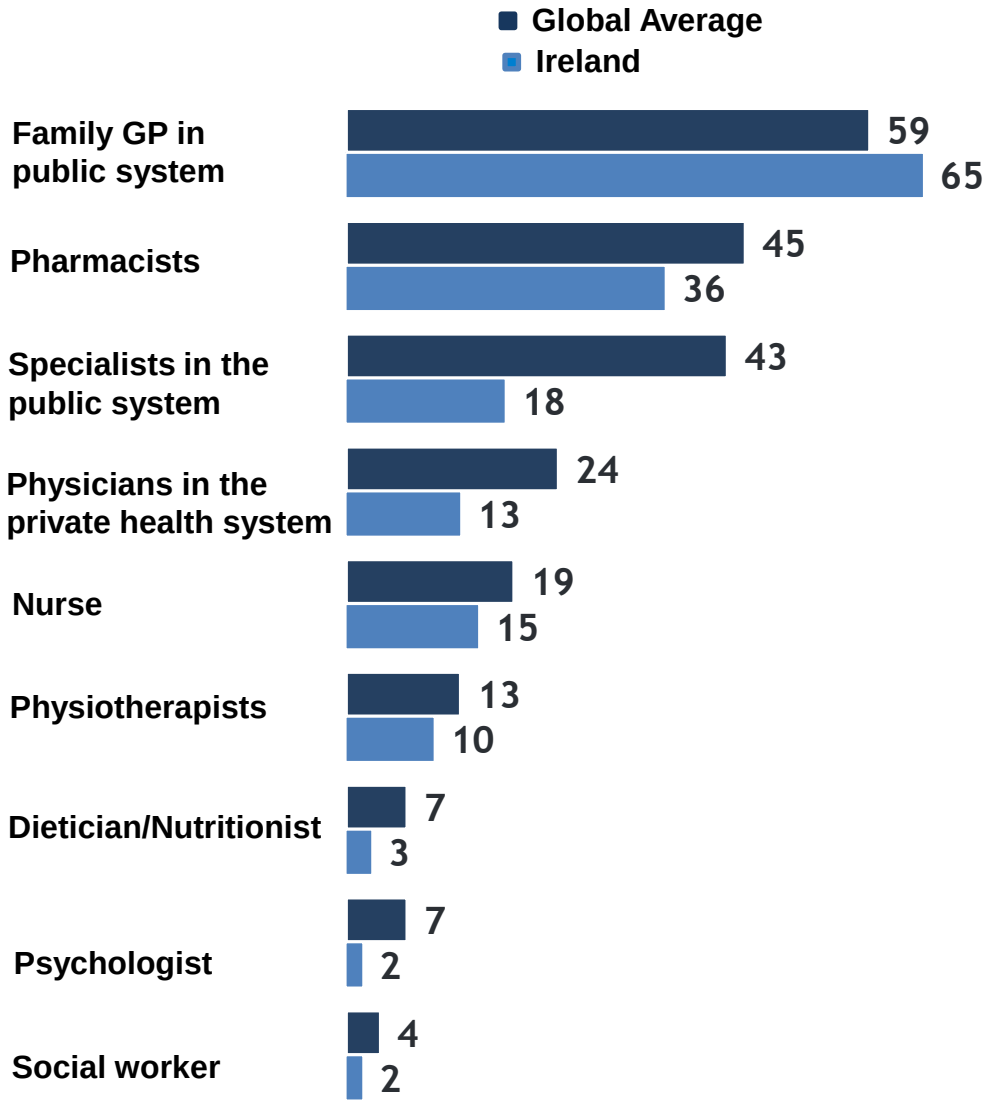
The use of physiotherapists is more prevalent in France, Russia and the Netherlands, with indeed Germany, Turkey, Finland and Colombia following relatively close behind in this regard.

Nutritionists are visited on a much more limited basis although they are evidently more prominent in Colombia, Chile and Pakistan.

Visits to a psychologist are comparatively uncommon although more prominent in Chile and a small number of other countries, but featuring at 10% or lower incidence in most territories.

In some countries visits to Health Care Professionals are confined to a narrow group. The family physician and the pharmacist presumably take on much more central and consultative roles. This is apparent of Ireland, Lithuania and Poland, for example.

USAGE OF KEY HEALTHCARE PROFESSIONALS FOR HEALTH RELATED SERVICES IN PAST YEAR



In Ireland we substantially over-index in our usage of the GP. The system is clearly structured around them, with the pharmacist equally a key, but marginally under utilised, conduit of services.

All other possible options are singularly under-employed here. Then comparable levels for the UK are markedly higher.

Visits to specialists in the public system are almost double in the UK (33%) but as high as 71% in Germany, 46% in the Netherlands.

The range for use of public specialists in Europe, excluding Ireland runs from 33% in UK to 80% in Turkey and 73% in Russia.

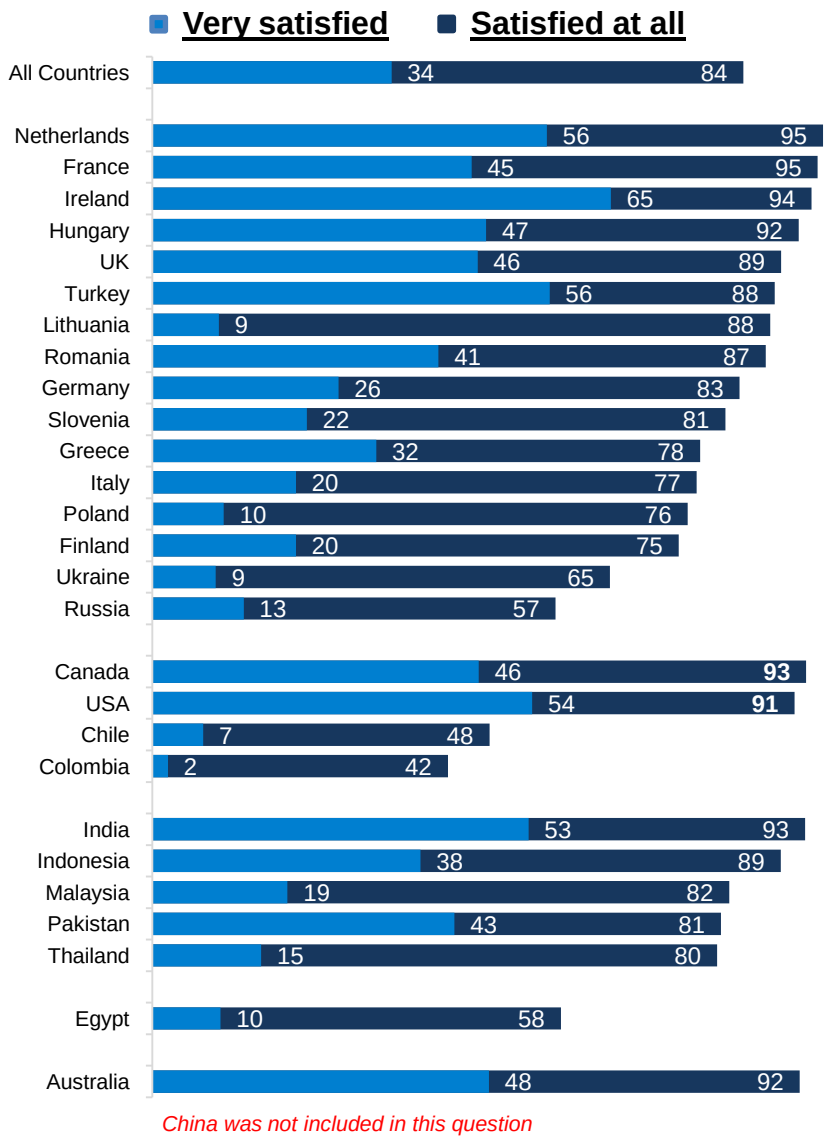
HEALTH SERVICES USED IN PAST YEAR (SELF OR SOMEONE CARING FOR)

Base: All adults aged 16+: 1000

	All Adults	GENDER		AGE					FUNDING		
		Male	Female	-24	25-34	35-49	50-64	65+	Med Card	Private	Neither
Base:	*1000*	*482*	*517*	*148*	*216*	*268*	*218*	*149*	*393*	*426*	*248*
	%	%	%	%	%	%	%	%	%	%	%
A family doctor in the public health care system	65	60	69	55	61	62	71	76	76	56	61
Pharmacist	36	32	39	26	31	34	42	48	40	36	33
A specialist doctor in the public health care system	18	16	20	12	15	24	16	22	23	17	14
Nurse	15	11	19	9	15	16	15	21	19	14	12
A doctor whose services were not covered by the public health care system	13	11	14	7	12	13	17	13	6	22	9
Physiotherapist	10	10	10	10	11	10	9	12	11	10	9
Dietician/nutritionist	3	2	5	1	2	4	5	4	4	4	2
Midwife	3	2	4	3	7	4	1	-	2	4	4
Podiatrists/chiropodist	3	2	3	2	1	2	2	9	4	3	1
Chiropractor	3	4	2	1	4	2	2	4	2	3	4
Acupuncturist	2	2	3	4	4	3	2	-	2	4	1
Massage therapist	2	2	3	2	4	2	3	-	1	3	3
Social worker	2	1	2	-	2	3	1	1	3	1	1
Naturopath/homeopath/alternative medicine provider	2	1	2	1	1	2	3	1	1	4	1
Psychologist	2	1	2	1	2	2	1	2	2	2	0
Other	2	2	2	2	1	4	-	1	2	3	1
None of the above	18	23	13	25	23	20	10	8	12	20	22
Don't know/Prefer not to answer	1	2	1	3	2	1	2	-	1	1	2

Those with private cover much more likely to have availed of the services of a doctor not covered under the public system. Those with no cover have seen far fewer doctors.

SATISFACTION WITH THE FAMILY PHYSICIAN



China was not included in this question

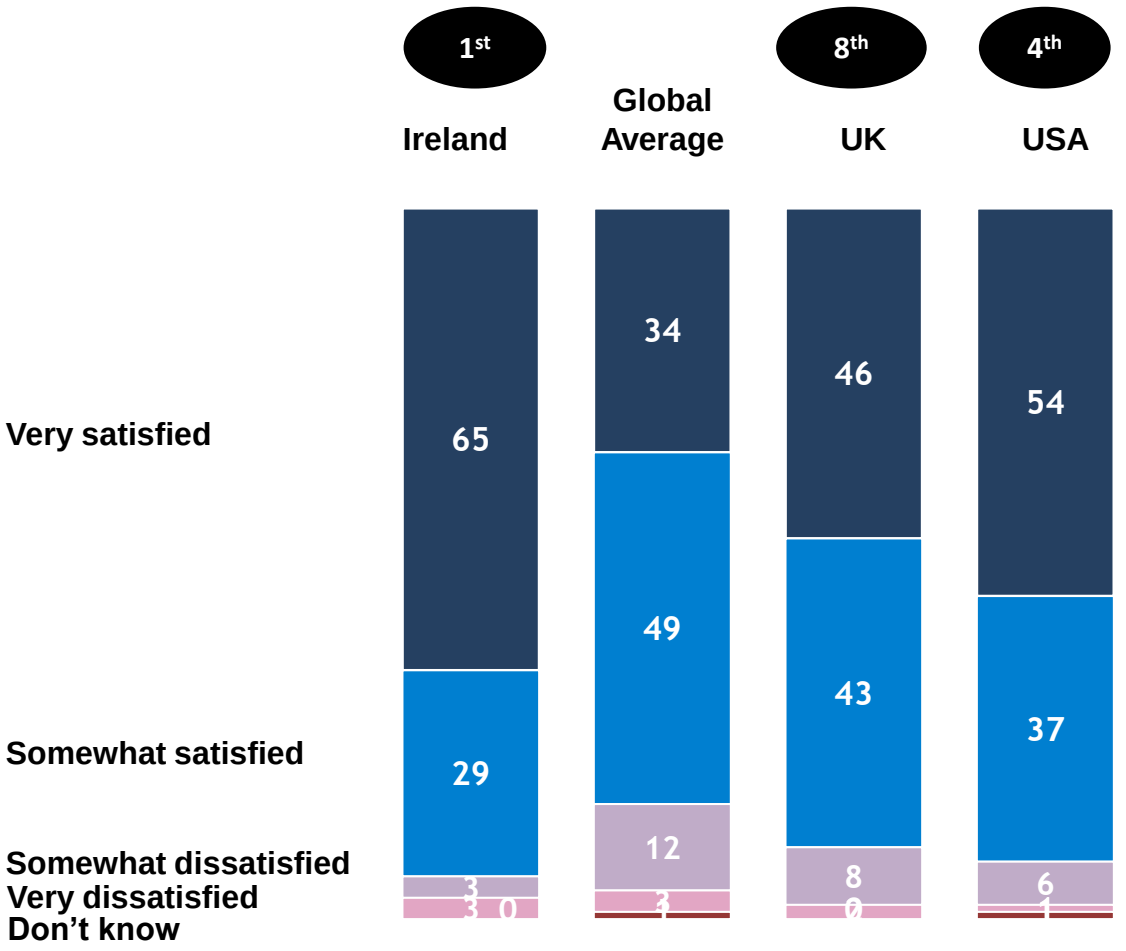
The family physician is obviously a particularly important agent in the medical systems of most countries. When asked to assess satisfaction with ones most recent visit, they tend to be highly rated, with more than 70% satisfied in 22 of the 27 countries under investigation in this context.

Interestingly there are still countries such as Colombia, Chile, Russia, Egypt and Ukraine where just half of the population declares itself content with the family physician relationship.

It is quite striking that satisfaction with the family physician is particularly high whereas in many instances, the perspective of the quality of the healthcare system itself is low.

There tends to be a predominant view of systemic shortcomings, compensated for to some extent by the quality of the individuals working within the system. In this context there is a tendency towards respect and sympathy perhaps, but maybe a failure to be objective about the role of physicians and their possible contribution, if any, to such systemic failings.

SATISFACTION WITH THE FAMILY DOCTOR

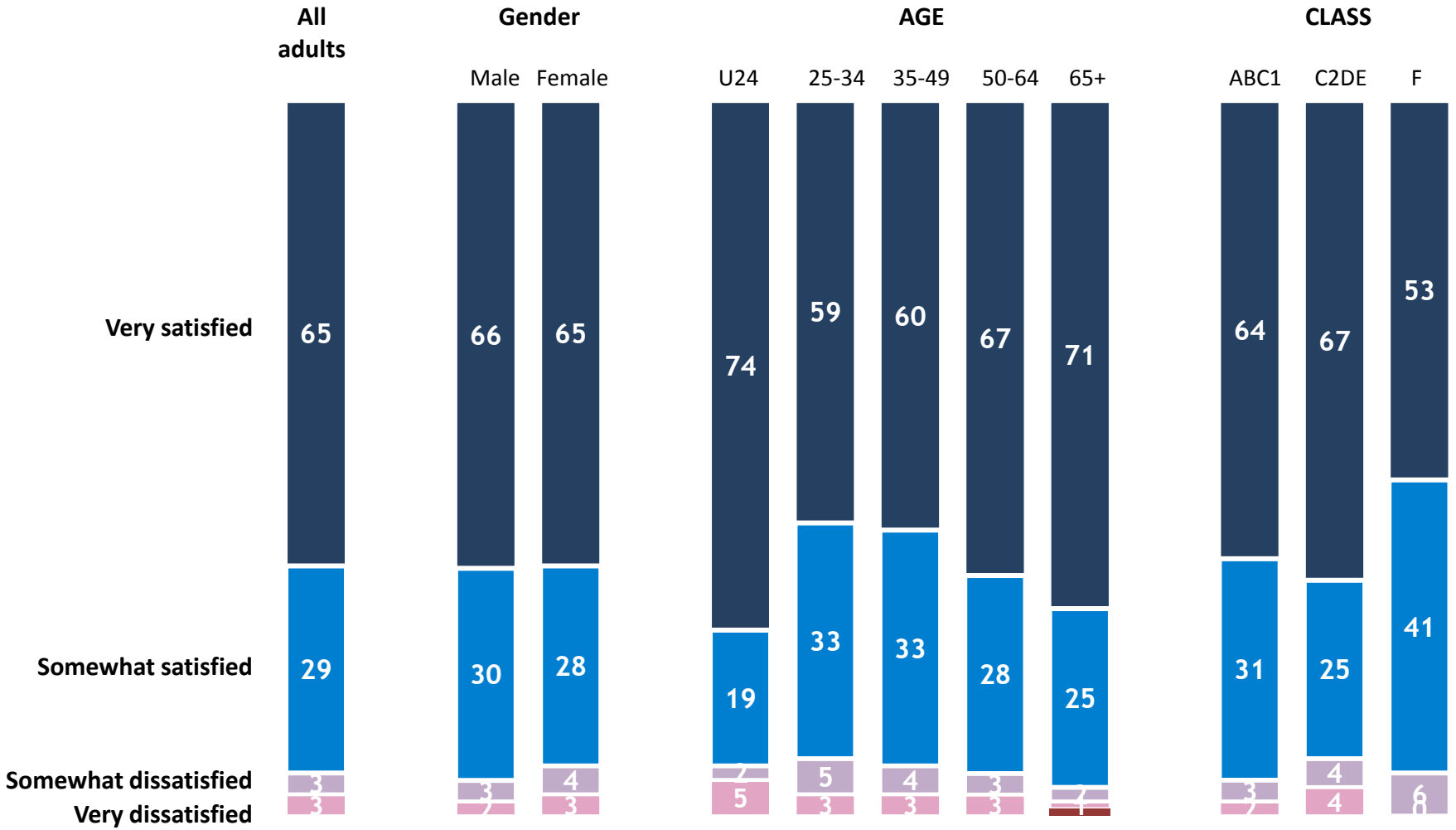


In Ireland the highest proportion globally claims to be very satisfied with "the services delivered to them when they visited a family physician or GP in the public healthcare system". Among the lowest levels globally are Ukraine (9%), Poland (10%), Lithuania (9%), and Russia (13%).

The sharp contrast between happiness with doctors (and, we assume, other healthcare professionals) and extreme dissatisfaction with the system is common to many developed economies, and may suggest a degree of short sightedness or of simplistic analysis of the heroes and villains in healthcare.

SATISFACTION WITH SERVICE DELIVERY BY FAMILY PHYSICIAN IN PUBLIC HEALTHCARE SYSTEM

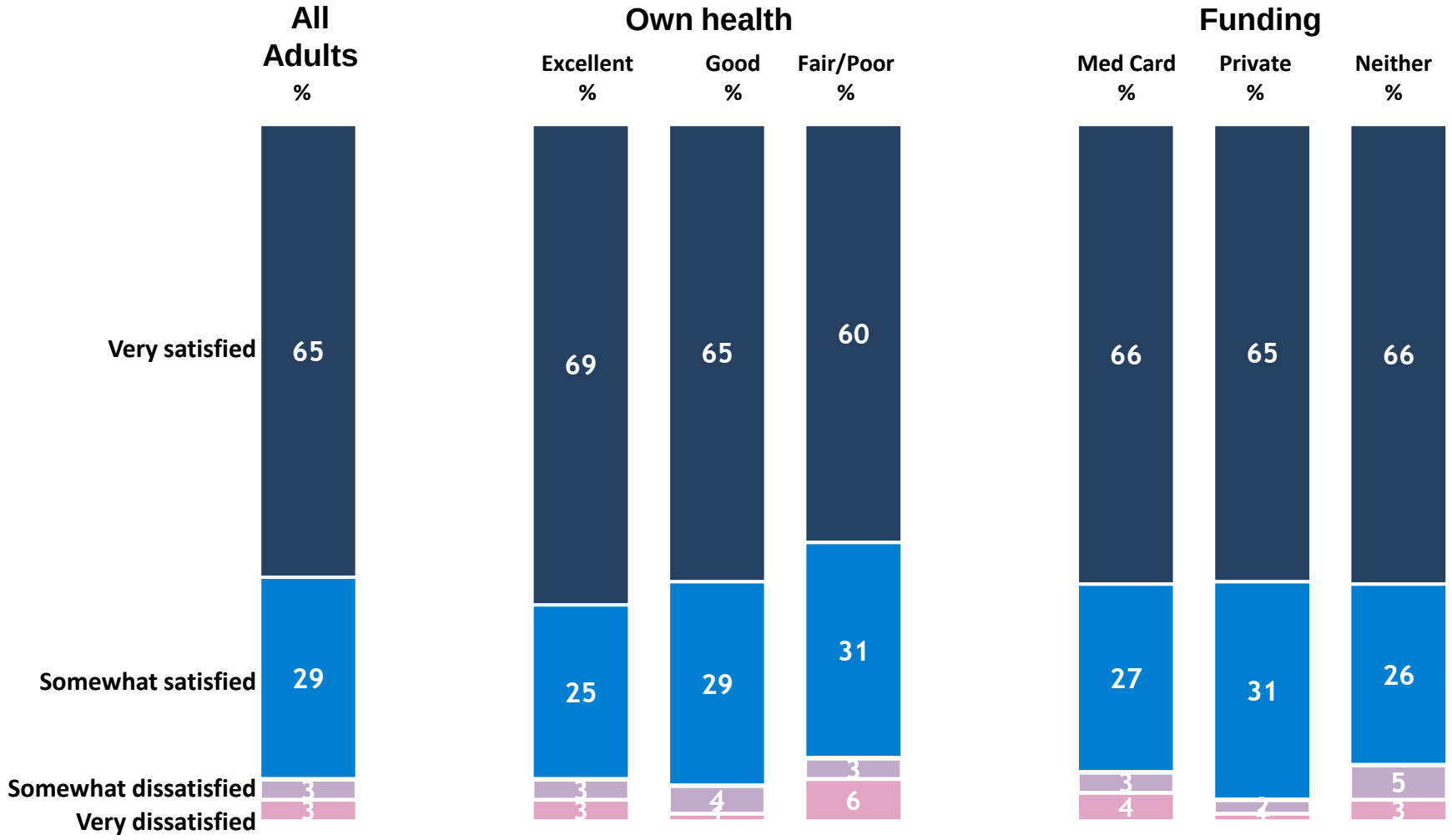
Base: 650 adults who have visited their family physician this year



Satisfaction generally very high and dented (only slightly) middle age, middle class/farming (self funding?)

SATISFACTION WITH FAMILY PHYSICIAN X HEALTH STATUS AND FUNDING

Base: 650 adults who have visited their family physician this year



No material differences except for those who feel unwell.

KEY POINTS

Significant dissatisfaction with health system, particularly in developed, Western countries.

Approval of system management generally very poor, except for Asia.

Most in developed economies assume problems stem from bad management.

General global preference, except France, Germany & America for central funding of individual cases.

Ireland's rated slightly worse than in 2004 and only strong than USA's (of the developed economies).

A third approx in Ireland, strengthening marginally since 2004.

The conviction that this is the case in Ireland matches that of Eastern Europe and Germany.

This holds in Ireland: 65% worldwide central funding.

Very limited confidence in quality of system.

A quarter globally have been troubled by suicide, depression/mental illness.

7 in 10 feel it is commonplace.

In general disease incidences are higher in most developed economies than in Ireland.

7 in 10 globally are in excellent or good health.

Growing trend globally far greater involvement in treatment decisions and direction.

Ireland just marginally little lower than the global level.

Figure for Ireland almost 8 in 10. We feel it is common but we have more limited experience of it.

19% unwell here in comparison with levels of 40-50% in USA and Canada.

84% in Ireland feel this well: highest globally and consistent with previous standards.

In Ireland 1 in 10 want to decide themeselves and 54% to work with the doctor.

We rely heavily on GP and pharmacists for health service delivery but use other types of healthcare professionals much less than in other countries.

We praise the GPs we deal with very highly.

Online is substantially underutilised when compared with other countries as a source of medical information.7

DEMOGRAPHICS

GENDER

%	Male	Female
All Countries	49	51
Finland	50	50
France	48	52
Germany	50	50
Greece	49	51
Hungary	47	53
Ireland	49	51
Italy	48	52
Lithuania	47	53
Netherlands	50	50
Poland	55	45
Romania	48	52
Russia	45	55
Slovenia	50	50
Turkey	48	52
UK	49	51
Ukraine	47	53
USA	49	51
Canada	49	51
Chile	48	52
Colombia		
China	50	50
India	52	48
Indonesia	49	51
Malaysia	50	50
Thailand	50	50
Pakistan	59	41
Egypt	53	47
Australia	49	51

AGE

%	Under 18 y.o.	18-29 y.o.	30-44 y.o.	45-59 y.o.	60+ y.o.
All Countries	0	25	31	26	17
Finland	-	22	27	30	21
France	-	19	25	27	29
Germany	-	18	29	26	27
Greece	-	24	34	27	16
Hungary	-	16	27	30	26
Ireland	4	21	31	21	23
Italy	-	16	28	25	32
Lithuania	1	24	29	30	16
Netherlands	-	24	25	26	26
Poland	-	43	17	31	9
Romania	-	25	38	33	4
Russia	-	26	27	24	23
Slovenia	3	26	31	28	13
Turkey	-	26	32	28	14
UK	-	19	28	24	30
Ukraine	3	31	32	34	-
USA	-	18	30	23	29
Canada	-	20	28	28	24
Chile	-	30	38	27	6
Colombia					
China	-	37	36	23	4
India	-	36	41	20	2
Indonesia	-	29	41	23	7
Malaysia	-	39	43	17	1
Thailand	-	22	33	33	11
Pakistan	2	60	28	9	1
Egypt	1	42	49	8	1
Australia	-	25	28	40	8

DEMOGRAPHICS

LEVEL OF EDUCATION

%	Some high school	Completed elementary/ grade school	Some elementary/ grade school	Prefer not to answer
All Countries	40	41	18	1
Finland	35	51	11	3
France	37	49	13	1
Germany	39	49	12	1
Greece	50	33	16	0
Hungary	26	50	22	1
Ireland	19	50	29	1
Italy	11	28	60	-
Lithuania	23	65	11	0
Netherlands	34	53	13	-
Poland	40	46	15	-
Romania	35	45	20	0
Russia	55	44	1	-
Slovenia	15	76	7	2
Turkey	15	40	46	0
UK	46	40	13	1
Ukraine	81	19	0	-
USA	68	31	1	1
Canada	68	26	5	1
Chile	23	73	3	1
Colombia				
China	70	21	8	-
India	20	32	48	1
Indonesia	20	72	8	-
Malaysia	50	44	5	1
Pakistan	35	39	26	0
Thailand	65	18	17	-
Egypt	81	13	5	0
Australia	35	46	18	1

MARITAL STATUS

%	Single, never married	Married/ living as a couple	Widowed	Separated/ divorced	Prefer not to answer
Finland	17	67	3	11	3
France	23	59	9	8	0
Germany	20	68	4	7	1
Greece	35	58	2	5	1
Hungary	22	64	8	6	1
Ireland	31	57	6	6	-
Italy	20	70	7	3	-
Lithuania	23	63	8	6	0
Netherlands	30	57	3	10	-
Poland	34	57	1	5	2
Romania	30	61	4	5	0
Russia	22	57	10	10	-
Slovenia	30	58	1	7	4
Turkey	24	71	4	1	0
UK	23	65	2	9	0
Ukraine	26	60	4	10	-
USA	26	59	3	11	1
Canada	24	61	3	10	1
Chile	40	46	2	12	0
Colombia					
China	28	70	2	1	-
India	24	73	2	0	0
Indonesia	20	75	4	1	-
Malaysia	43	53	1	1	1
Pakistan	49	49	1	-	0
Thailand	41	50	3	6	-
Egypt	8	89	1	1	1
Australia	26	57	3	13	1

DEMOGRAPHICS

HOUSEHOLD INCOME FOR 2010, BEFORE TAXES

%	Low	Medium low	Medium	Medium high	High	DK/NA/ Prefer not to answer
All Countries	18	21	22	14	10	14
Finland	16	26	20	12	9	16
France	25	16	14	12	24	9
Germany	5	19	25	16	14	22
Greece	15	25	20	14	12	13
Hungary	15	28	44	4	0	8
Ireland	10	19	11	14	5	41
Italy	23	21	12	4	6	35
Lithuania	22	-	40	19	12	7
Netherlands	23	22	33	14	8	-
Poland	20	32	19	10	4	16
Romania	11	15	14	16	14	31
Russia	2	11	61	19	3	5
Slovenia	7	32	27	20	6	7
Turkey	13	21	27	17	13	10
UK	24	23	23	17	2	11
Ukraine	7	27	62	3	1	-
USA	7	12	18	24	23	16
Canada	23	29	16	11	4	16
Chile	10	24	14	16	28	8
Colombia						
China	24	19	23	20	15	-
India	45	37	12	4	1	2
Indonesia	20	20	20	20	20	-
Malaysia	15	20	17	14	17	16
Pakistan	11	24	9	5	25	26
Thailand	21	16	37	15	11	-
Egypt	20	20	19	30	9	2
Australia	22	25	13	12	7	21

CHILDREN UNDER 18 Y.O.

%	Yes	No
All Countries	34	63
Finland	29	70
France	34	66
Germany	19	80
Greece	28	71
Hungary	26	73
Ireland	35	64
Italy	30	70
Lithuania	37	63
Netherlands	24	76
Poland	25	74
Romania	35	65
Russia	42	57
Slovenia	28	71
Turkey	41	59
UK	29	71
Ukraine	38	62
USA	20	79
Canada	24	75
Chile	43	56
Colombia		
China	39	61
India	51	24
Indonesia	61	39
Malaysia	43	57
Pakistan	41	29
Thailand	27	73
Egypt	71	26
Australia	40	50

DEMOGRAPHICS

EMPLOYMENT STATUS

%	Employed full-time	Employed part-time	Independent worker/ self-employed	Unemployed	Homemaker	Student, not employed	Student, working part-time	Retired	Prefer not to answer
All Countries	44	7	8	6	10	6	4	15	1
Finland	52	4	2	8	2	4	4	21	2
France	40	8	4	12	-	6	3	28	-
Germany	48	10	10	2	4	2	3	21	2
Greece	32	5	13	13	11	7	4	15	0
Hungary	38	5	5	6	3	7	0	35	1
Ireland	28	11	5	13	18	10	1	14	0
Italy	28	7	11	5	17	6	1	25	-
Lithuania	60	3	10	3	8	-	15	-	0
Netherlands	31	17	5	8	11	3	7	18	-
Poland	43	3	8	9	4	13	5	11	4
Romania	66	1	5	4	6	6	-	12	1
Russia	42	5	4	3	11	2	7	26	2
Slovenia	45	3	3	8	0	14	5	19	3
Turkey	22	2	15	4	31	6	-	19	0
UK	35	15	4	8	8	3	1	26	1
Ukraine	56	5	7	6	5	7	5	8	0
USA	48	8	4	6	4	-	4	22	4
Canada	48	8	8	4	5	3	3	20	1
Chile	42	5	19	4	7	10	8	5	1
Colombia									
China	71	4	3	2	1	6	6	8	-
India	47	7	4	5	28	7	1	1	-
Indonesia	34	12	-	3	38	9	1	3	-
Malaysia	58	4	5	5	8	13	4	3	-
Pakistan	32	9	14	1	21	12	8	1	2
Thailand	59	1	22	1	6	5	1	4	-
Egypt	60	10	4	4	20	0	0	1	0
Australia	39	17	3	9	9	3	4	12	3

THANK YOU!

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