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Issues of health rehabilitation in the Hungarian conditions of the 21st century

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Abstract

In today's Hungarian conditions, the efficiency of health care and the optimal distribution of rehabilitation raise important questions. Today, a survey does not always precede the need for a particular treatment.

The aim of the study is to examine the need for how the demand for movement laboratories develops. In other words, how much has the health structure of the population changed in the direction that health rehabilitation can take place in increasing numbers in movement laboratories.

The study assumes that the health status of the population is deteriorating, the number and proportion of people with reduced mobility have increased, so there is an increasing need for these laboratories.

Keywords— disabled people, rehabilitation, health care, education, patient care

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Throughout history, two main models of social perception of people with disabilities have emerged: the medical model and the social model.

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the medical model providing appropriate medical treatment and rehabilitation.

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the second half of the 20th century, disability is not a lack of certain skills, but an obstacle to the social participation of people with disabilities, thus not only individual but also collective, social responsibility. Disability has become important issue as a human rights issue, so the (equal) rights and obligations of persons with disabilities are also guaranteed by laws and conventions at the international level.

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Rehabilitation is an important part of recovery from accidents and injuries, but not all types of rehabilitation are effective in recovery.
Research seeks to answer the question of how much rehabilitation care is needed or whether it would be necessary to reduce its extent.
what areas of development are possible.

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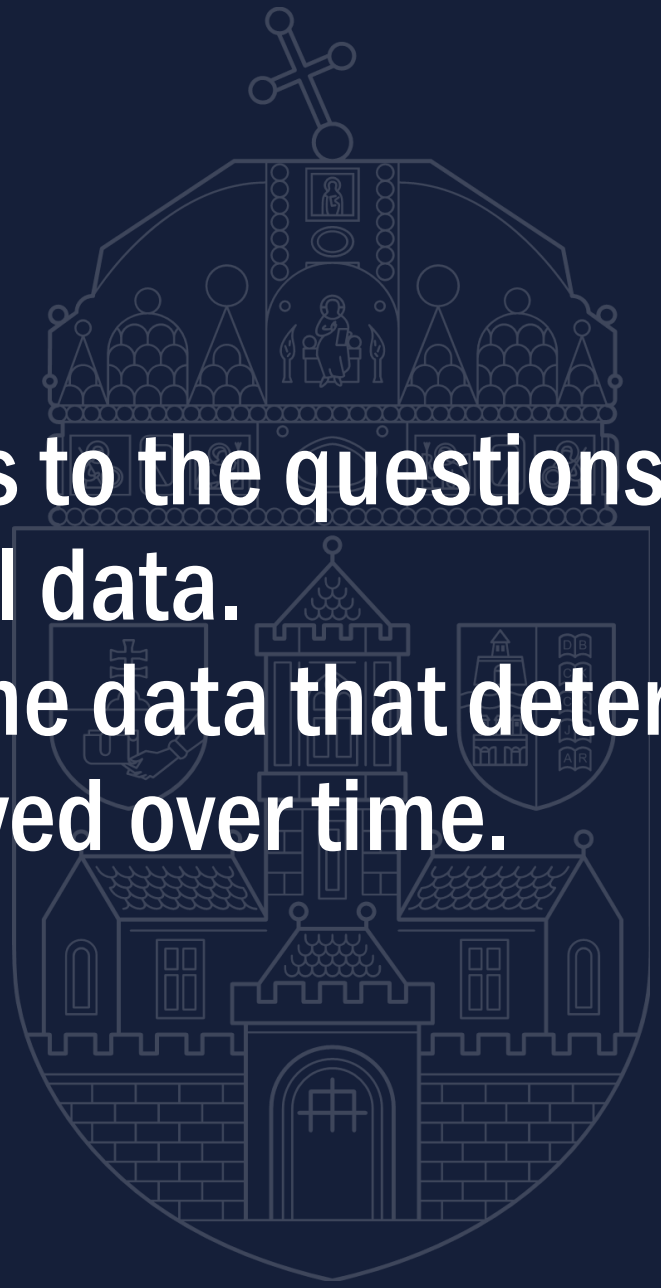

Looking for answers to the questions by comparing and analyzing statistical data.
Investigating how the data that determine the extent of aftercare care evolved over time.

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the number of people with reduced mobility living in marriage increases, exceeding all other categories over the age of 40.

We can see that people with reduced mobility live in marriage rather than alone. 44% compared to 14%.

The proportion of widows is significant. 29%
For the total population, 32% are already single, 44% are married, and only 11% are widowed.

From these data, it can be concluded that people with reduced mobility go in better and stay in a relationship, married,

but at the same time the number of widows is significant.

TABLE I. DISABLED PERSONS BY TYPE OF SETTLEMENT, AGE GROUP AND SEX, 2011

Age group, annual	Capital	County seat, city with county status	Other towns	Village, large village	Total
Male					
– 9	220	248	462	503	1 433
10–19	376	447	755	869	2 447
20–29	425	591	896	1 021	2 933
30–39	838	1 119	1 811	1 864	5 632
40–49	1 027	1 751	3 240	3 470	9 488
50–59	2 774	4 909	9 279	9 831	26 793
60–69	3 555	5 391	9 741	9 552	28 239
70–79	2 452	3 575	6 325	6 666	19 018
80–	1 785	1 795	3 055	2 959	9 594
Total	13 452	19 826	35 564	36 735	105 577
of which:					
–14	401	454	787	928	2 570
15–39	1 458	1 961	3 137	3 329	9 875
40–59	3 801	6 660	12 519	13 301	36 281
60–	7 792	10 761	19 121	19 177	56 851
Female					
– 9	165	209	373	363	1 110
10–19	304	351	610	709	1 974
20–29	336	527	734	726	2 323
30–39	586	796	1 304	1 255	3 941
40–49	844	1 312	2 519	2 698	7 373
50–59	2 537	4 539	8 478	8 069	23 623
60–69	3 719	5 178	9 691	9 603	28 191
70–79	3 985	5 589	10 535	11 922	32 041
80–	4 344	4 814	8 367	8 528	26 053
Total	16 820	23 325	42 611	43 873	126 629
of which:					
–14	304	355	660	684	2 003
15–39	1 087	1 528	2 361	2 369	7 345
40–59	3 381	5 851	10 997	10 767	30 996
60–	12 048	15 591	28 593	30 053	86 285

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that these people are more committed, accepting solitude to a lesser extent than the general population, where the unique way of life is present with 32%.
Widowers live for a shorter period of time than the entire population.

TABLE II. DISABLED PERSONS AGED 15 AND OVER BY MARITAL STATUS, AGE GROUP AND SEX, 2011

Age group, annual	Unmarried, single	Married	Widow	Divorced	Total
Male					
15–19	1 304	3	2	1	1 310
20–29	2 823	99	3	8	2 933
30–39	3 846	1 372	10	404	5 632
40–49	3 501	3 933	109	1 945	9 488
50–59	4 690	15 042	1 187	5 874	26 793
60–69	2 128	19 012	2 491	4 608	28 239
70–79	790	13 444	3 390	1 394	19 018
80–	241	5 508	3 442	403	9 594
Total	19 323	58 413	10 634	14 637	103 007
of which:					
15–39	7 973	1 474	15	413	9 875
40–59	8 191	18 975	1 296	7 819	36 281
60–	3 159	37 964	9 323	6 405	56 851
Female					
15–19	1 078	2	–	1	1 081
20–29	2 139	157	4	23	2 323
30–39	2 201	1 287	46	407	3 941
40–49	1 667	3 685	370	1 671	7 373
50–59	1 867	12 685	3 827	5 244	23 623
60–69	1 417	12 672	9 488	4 614	28 191
70–79	1 198	8 555	19 341	2 947	32 041
80–	960	2 398	21 179	1 516	26 053
Total	12 527	41 421	54 255	16 423	124 626
of which:					
15–39	5 418	1 446	50	431	7 345
40–59	3 534	16 350	4 197	6 915	30 996
60–	3 575	23 625	50 008	9 077	86 285

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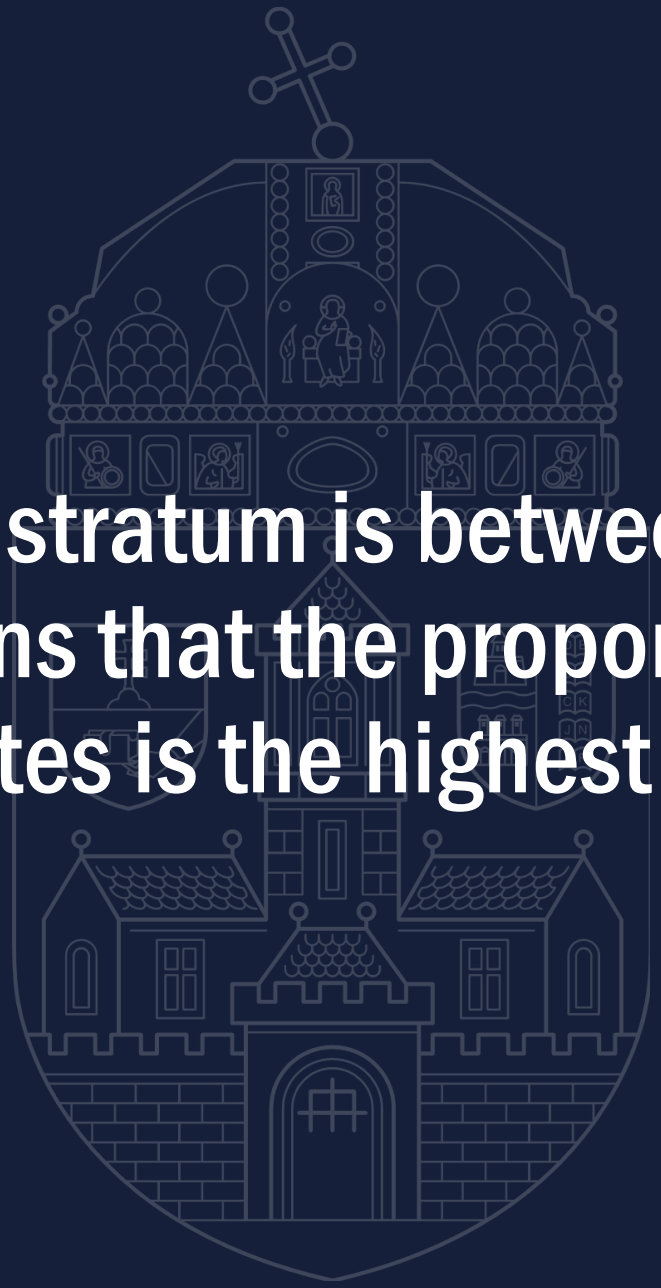

The most educated stratum is between the ages of 60 and 69, which means that the proportion of university and college graduates is the highest there,

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the number of visits in health care is constantly increasing. Physiotherapy and special care are the ones that are most significant within care, i.e., inquiries with musculoskeletal problems are constantly increasing. Disability and musculoskeletal problems occur in significant proportions.

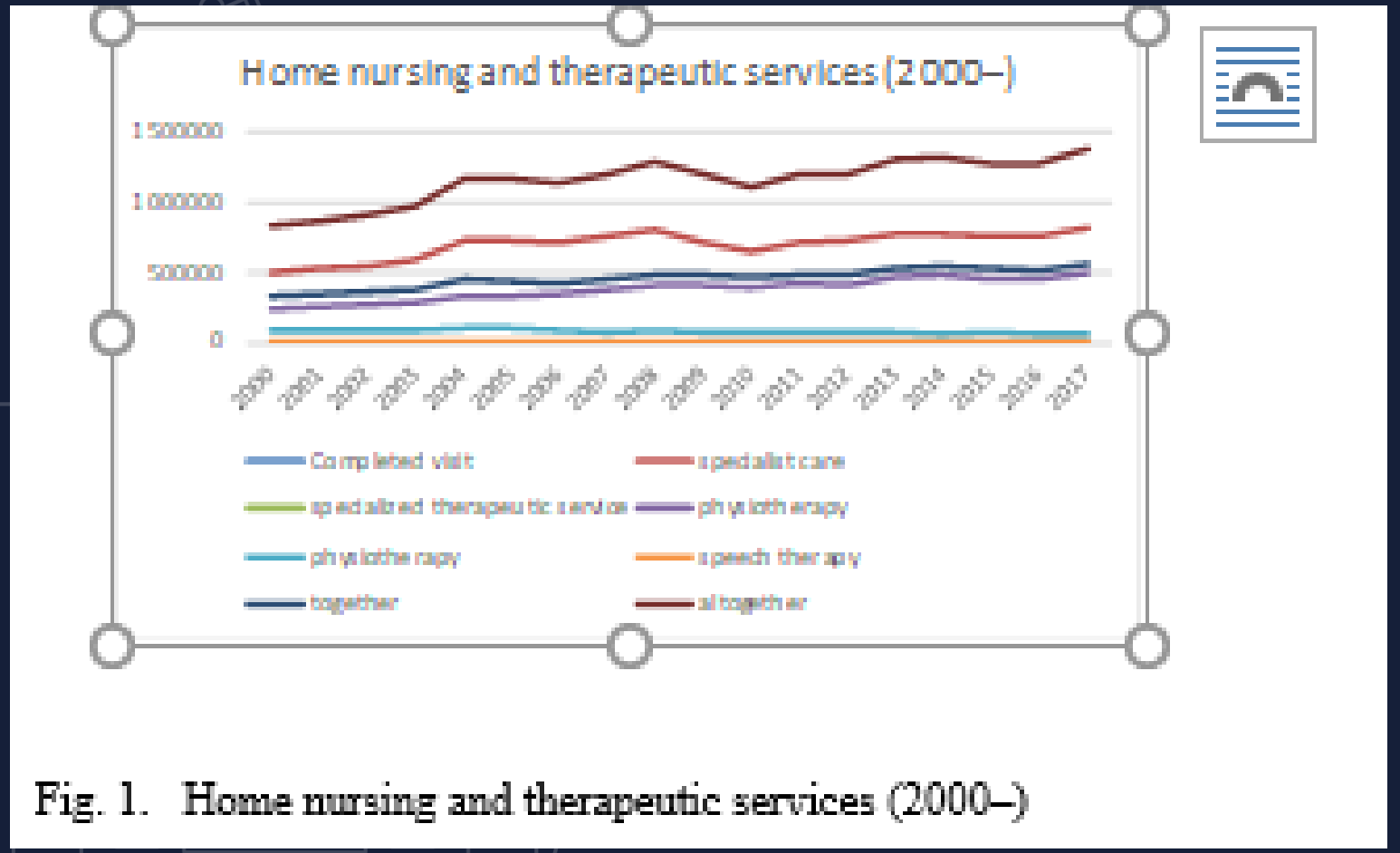

Fig. 1. Home nursing and therapeutic services (2000–)

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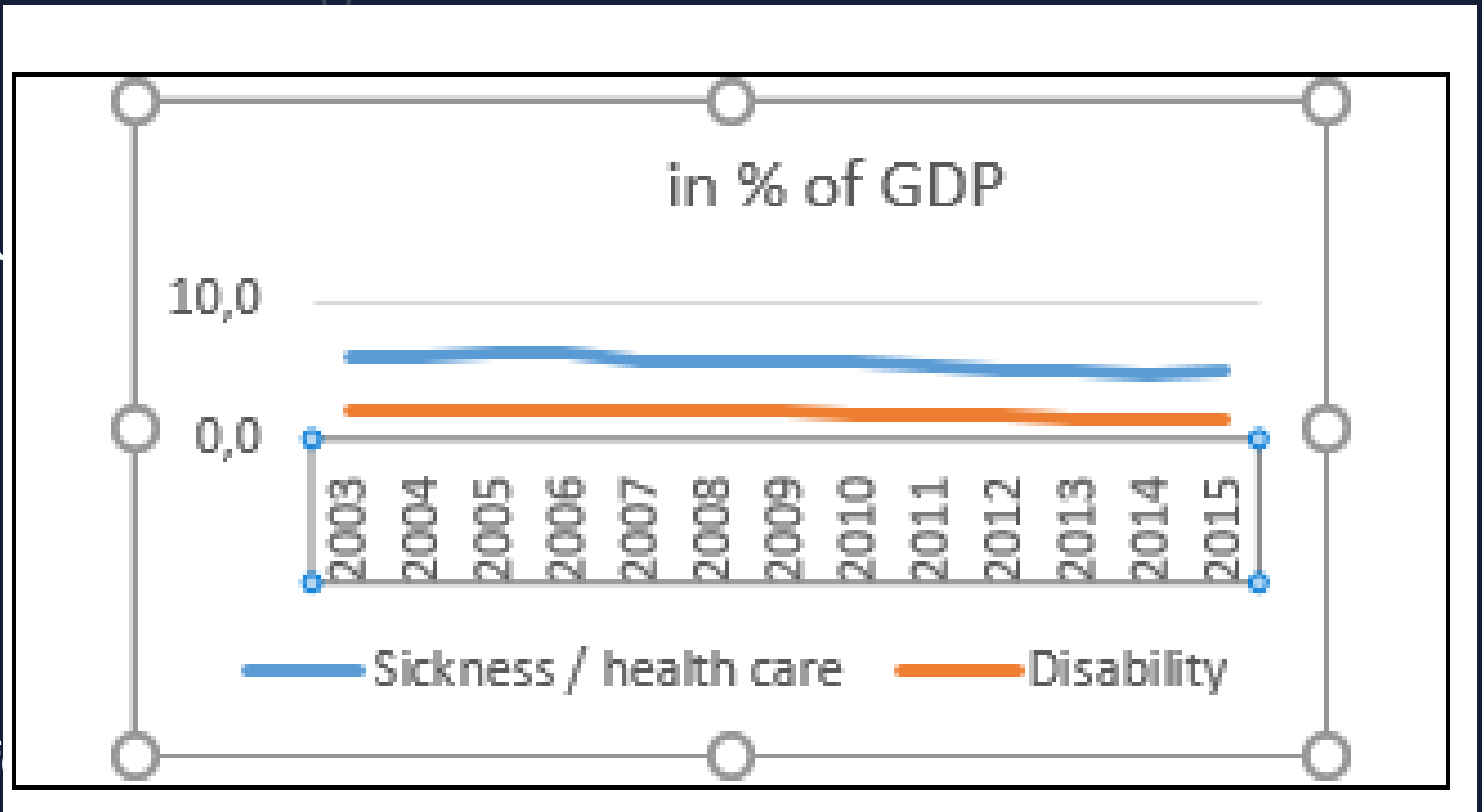
The insured contribution in 2015 (HU
652 billion), which was HUF 220
billion higher than in 2010.

The two largest items of central
budget contributions in 2015 were
funds received from the central
budget as contributions and funds
received to cover disability
rehabilitation benefits, accounting f
29% of revenues (HUF 565 billion).

The share of central contributions was
still 47% in 2014 (HUF 897 billion)
and 52 in 2013 (HUF 967 billion), but
in 2010 it was higher than at present.



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care for people with reduced mobility is about half of all care, indicating that the weight of the issue is significant. These people make the most of the maintenance entitlement. This places a significant burden on the system

TABLE V. RECIPIENTS OF DISABILITY BENEFITS (2001-)

Year	Beneficiaries			
	female	male	total	musculoskeletal disability
2001	16 737	21 201	37 938	18 865
2002	28 332	31 450	59 782	28 055
2003	45 682	41 282	86 924	33 397
2004	51 282	45 413	96 695	39 492
2005	54 140	47 220	101 360	42 961
2006	57 150	49 470	106 620	46 584
2007	58 676	50 493	109 169	48 646
2008	59 838	51 000	110 838	50 339
2009	60 958	51 689	112 647	51 890
2010	61 616	52 293	113 909	53 163
2011	61 947	52 678	114 625	54 142
2012	61 435	52 343	113 778	54 345
2013	61 562	52 447	114 009	55 239
2014	62 751	52 790	115 541	56 772
2015	61 859	52 207	114 066	56 315
2016	62 148	52 367	114 515	56 797
2017	61 324	51 563	112 887	55 976

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CONCLUSIONS

People with disabilities need more than average social transfer income (disability pension, annuity, allowances, etc.) in addition to their income from work, which compensates for the additional costs of disability (such as higher drug costs, home care, care needs).

People with disabilities are increasingly affected by territorial and urban inequalities.
People with disabilities, especially in villages, are in a difficult position in terms of employment opportunities, free choice of school and living conditions. [9]

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CONCLUSIONS

To overcome all these disadvantages, the resources of the current social care system are insufficient and would require a broader social policy intervention.

The implementation of social integration cannot be reduced to the issue of removing obstacles, as the problems are rooted primarily in the unrealization of declared rights and social attitudes.
The statistical surveys show that, based on the available data, people with disabilities, including those with reduced mobility, use significant resources and are significant.
Their ratio to the total population is increasing, while the supply system and the number of available professionals is decreasing.

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CONCLUSIONS

Fewer and fewer students are graduating from school, who in many cases leave the field in hopes of better pay and conditions.

A movement laboratory is an effective tool that can determine which therapeutic tool is expected to be effective for a patient, so it can significantly increase the efficiency of the care system.

In order to increase cost efficiency, it is recommended to utilize and use it as widely as possible.

By using and disseminating it more widely, patient care and rehabilitation can be optimized. These were supported by statistical tables and their trends.

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Thank you for your attention!

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