# CONSUMER APPROACH OF HEALTH AND AYURVEDA

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***Abstract:*** The aim of this study was to explore the differences of health interpretation between people with ayurvedic approach and non ayurvedic but health conscious approach. While Ayurveda has a holistic approach to health, the European medicine focuses on its physical aspects (bio-medicinal model). Although theoretically a complex interpretation of health (bio-psycho-social model) is the most accepted in Hungary, we examined whether it prevails on a practical level.

We carried out a representative survey (N=1000) to examine the health-related knowledge and behaviour of the Hungarian population. To achieve deeper understanding of the subject, we carried out two focus group discussions. We selected health conscious people in the first group and ayurvedic oriented people in the second group to compare their attitudes towards health.

The results showed that the majority of the Hungarian population (83,2%) have recognised that health is more than a bio-medicinal approach, it is built up of physical, psychological, mental and social factors, but in most cases we found huge gaps between recognition and action. During discussions the ayurvedic oriented group construed an interpretation that contained all the five health dimensions of WHO and mentioned spirituality as an additional dimension, while the health conscious group mainly emphasized physical health. We also asked the participants about their own health behaviour and found the same pattern.

It can be stated that the Hungarian population theoretically admits an integrative model of health but it does not appear in their health behaviour. It seems that ayurvedic orientation contributes to bringing knowledge to practice. Ayurvedic oriented people have a more complex interpretation of health and are willing to do more for their health, so they are a good target group for prevention campaigns and health care services. It also suggests that the spread of ayurvedic approach could contribute to better health behaviour in Hungary.

***Keywords:*** consumer habit of ayurvedic/non ayurvedic oriented people, health interpretation, health-related behaviour, 1000 questioner

## Introduction

The most ancient health concepts interpret health from a holistic approach. They regard intrapersonal, interpersonal and environmental balance as a unity. The health concept in Europe has gone through on several changes during the past centuries. Along with the development of sciences in the nineteenth century the biomedical view of health became the most accepted view on the Continent. The concept that health is equal to the absence of disease (Almedom and Glandon 2007) leads back to that historical period. During the past century the development of humanities added several aspects to that view. In 1946 the WHO (1992) published a more complex definition: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." We shall admit that it is still the most common definition of health, but several problems occurred when it was attempted to put into practice. It turned out that a state of complete physical, mental and social well-being is very difficult to maintain and it stands closer to the definition of happiness than of health. It has several consequences, for example, while health should be considered as a positive and universal human right it causes difficulties to consider happiness as a positive right simply because it cannot be delivered on a person by any social action (Saracci 1997). The WHO had to reconstruct its definition to emphasize the process and resource characteristics of health. "Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources as well as physical capabilities" (WHO 1984). Today the most accepted scientific definition of health includes several dimensions and the capability to achieve and maintain health. As it is so, to maintain health needs a continuous awareness and activity. "Health is a condition which is characterised by anatomical integrity, ability to perform, personal values, family, work and community involvement, the ability to cope with physical, biological and social stress, feelings of well-being and exemption from risks of diseases and early death" (Tringer 2002).

The multidimensional approach of health is important in practice because these dimensions are is dynamic interactions as well, and interventions that have an impact in one area affects other areas as well. For example it is a proven fact that emotional well-being has a profound impact on cardiovascular health (Williams et al. 1999). The social dimension contributes significantly to understanding the expected health consequences and the treatment of many diseases such

as several types of cancer, cardiovascular disease, immune function (Callaghan and Morrisey 1993; Uchino, Cacioppo and Kiecolt-Glaser 1996). The social support also has a positive impact on health behaviour, self-esteem and optimism (McNicholas 2002). Spirituality had a significant impact on depressive symptom severity in a sample of terminally ill patients with cancer and AIDS (Nelson et al. 2002). Feher and Maly (1999) showed that spirituality can help in coping with breast cancer. Religious and spiritual faith provided respondents with the emotional support necessary to deal with their breast cancer (91%), with social support (70%), and with the ability to make meaning in their everyday life, particularly during their cancer experience (64%). High level of spirituality helps to cope with different forms of eating disorders (Hawks, Goudy and Gast 2003), and finally we would like of mention the study of White, Hawks and Gast (1999) that showed positive correlation between self-esteem, locus of control and health behaviour factors. Thus, certain dimensions of health cannot be interpreted by themselves, the certain factors have special impacts on each other, general health condition and health behaviour as well.

It can be established on the developmental line of health definitions that it has been enriched by several scientific perspectives during the past century, but in its view it turned back to the holistic approach. The question might arise: if the scientific way of thinking has gone through such an impressive development then why the Hungarian healthcare does not apply the holistic therapies. We argue that it is one issue to solve the problem on the level of scientific discussion, and it is another one to change the therapy practice in the national healthcare and people's attitude towards health and healthcare.

Ayurveda is very special from that aspect. In the ayurvedic practice we cannot draw such a developmental line of health definitions since it is based on 5000-year-old knowledge and it has not changed in any relevant aspects either on theoretical, or on practical level. It is essential to establish when examining ayurveda that the holistic view of human health and therapies has never been separated into solely physical, psychological treatments (Frawley 2006). From the ayurvedic perspective the Atman (Self in Euorpean psychology) is surrounded by five "sheathes" or koshas, they contain physical, vital, mental, intellectual and conscious qualities of the person. This concept is probably the closest to Carl Jung's (Jung 1936) personality theory in European psychology. Ayurvedic diagnosis and treatment never loses sight of the basic principle that in all human beings these koshas are in dynamic interaction and the disease occurs when the balance is broken within or between the koshas. Ayurveda also emphasizes the importance of general prevention, so it belongs to the positive health approaches.

The aim of this study was to explore the differences of health interpretation between people with ayurvedic approach and non ayurvedic but health conscious approach. While Ayurveda has a holistic approach to health, the European medicine focuses on its physical aspects (bio-medicinal model). Although theoretically a complex interpretation of health (bio-psycho-social model) is the most accepted in Hungary, we examined whether it prevails on a practical level. In our research we examined the health concepts and healthcare activities of the Hungarian population to find out which of the above mentioned levels are the consumers' actual health concepts. We also examined the health concepts of an ayurvedic oriented group to see how the perspective of ayurveda appears amongst the ayurvedic oriented Hungarians and how they consider the further introduction of ayurveda in Hungary.

## Method

In order to get a complex understanding of the topic our research contained both qualitative and quantitative methods. We examined the health interpretation and health-related behaviour with a questionnaire. 1000 respondents were involved in a nationwide representative survey. The sampling was carried out by random walking. Within the households the interviewer chose the respondents with a so-called birthday key in order to ensure the randomness. The data collection was carried out personally in the homes of the interviewees. The interviewer entered the replies on the questionnaire in order to avoid misunderstanding and unfilled questions. To increase reliability the interviewers were randomly checked by supervisors. The survey contained closed questions only (polar questions and scale questions). The data were analysed by SPSS 20 statistical software.

In the qualitative part we carried out two focus group discussions. We selected health conscious people in the first group and ayurvedic oriented people in the second group to compare their attitudes towards health and to examine their health-related behaviour. The scenario contained three main topics: interpretation of health, health-related behaviour and ayurveda.

## Results

### *Results of quantitative research*

The questionnaire contained three blocks of questions beside the background variables. The first block of questions referred to the health interpretation of the respondents. We offered 12 interpretations and asked the participants to tell what they mean by health concept out of the listed interpretations. They were allowed to mark more than one option. *Diagram 1* shows the results of this question block.

According to the answers illustrated by *Diagram 1* it can be assumed that the respondents do not have an outstanding preference towards any of the interpretations. Most of the consumers marked the family health, healthy lifestyle, absence of disease, child health and healthy nutrition followed by the complex interpretations of health like physical, psychological, and mental harmony and the physical, psychological mental and social harmony. The results prove that the concept of health is in relation with the concept of family, and that the

***Diagram 1.*** Health interpretation (N=1000)

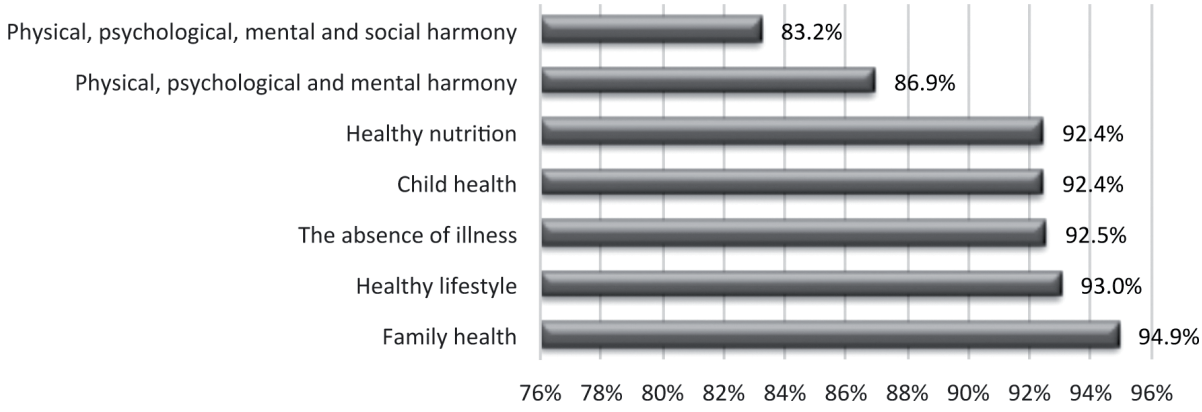
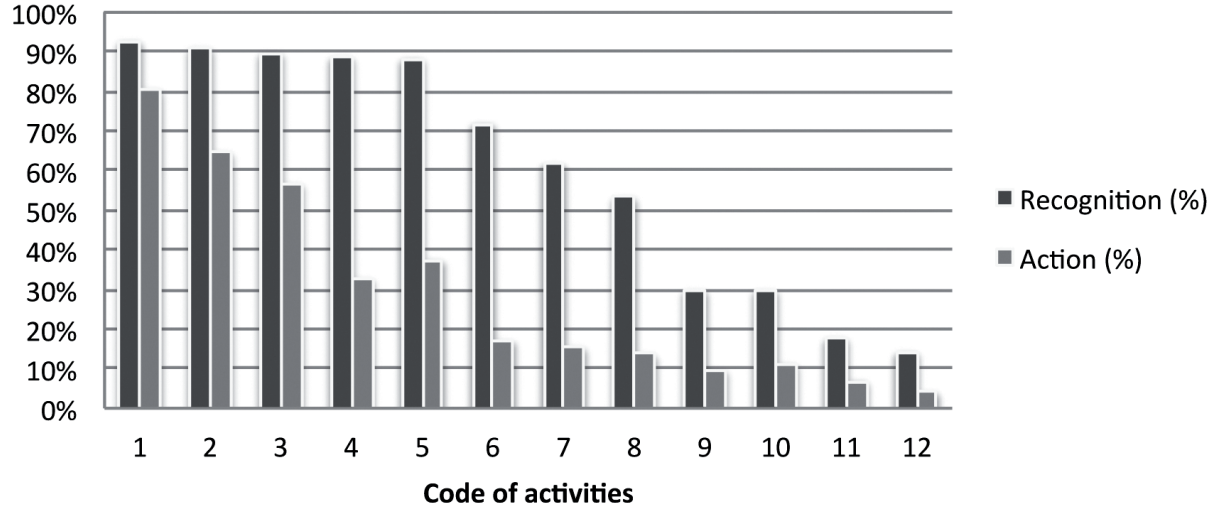



***Diagram 2.*** Gap between recognition and action (N=1000)




complex health interpretations are considered almost as accepted as the basic definition: absence of health.

In the next section we examined whether the consumers recognise the importance (Recognition) of different healthcare activities listed in *Table 1*. The other issue was that even if they recognise the importance of these activities, what percentage of the respondents practise them on a regular basis (Action). *Diagram 2* illustrates that there is a remarkable gap between recognizing and attaining different activities.

According to the trend lines of *Diagram 2* it can be stated that the gap between recognition and action is the biggest in the middle section of the diagram. It means that the respondents attempt to practise those activities that they consider to be the most important regarding to their health. These are related to physical health (amount of liquid, vegetables and fruit consumption and duration of sleep). On the other end of the diagram we find those consumers who may be a possible target group of ayurvedic services. Although they are fewer in number, they believe that alternative therapies, meditation and yoga are important in order to maintain health, and they also tend to act in accordance with their beliefs. The critical zone is the middle area of the diagram where the social and psychological activities take place. There are also some activities

***Table 1.*** Explanatory Table to Diagram 2 (N=1000)

| Code of Activities | Activity | Recognition (%) | Action (%) |
|---|---|---|---|
| 1 | An appropriate amount of liquid | 93% | 81% |
| 2 | Vegetable and fruit consumption | 91% | 65% |
| 3 | Sufficient duration of sleep | 90% | 57% |
| 4 | Exercise | 89% | 33% |
| 5 | Avoiding stressful situations | 88% | 37% |
| 6 | Recreation, relaxation | 72% | 17% |
| 7 | Social life | 62% | 15% |
| 8 | Health-protective food consumption | 53% | 14% |
| 9 | Consumption of food supplements | 30% | 10% |
| 10 | Alternative therapies | 30% | 11% |
| 11 | Meditation | 18% | 7% |
| 12 | Yoga | 14% | 4% |

***Table 2.*** Description of consumers who consider alternative therapies important (N=298)

| Background variable | Most common answer | Frequency (%) |
|---|---|---|
| Sex | female | 63.5% |
| Highest level of education | secondary education | 73.2% |
| Marital status | married | 39.8% |
| | single | 21.3% |
| | partnership | 14.9% |
| Average gross earnings | under average | 67.3% |
| Change in financial status during last year | worsen | 64.5% |
| Type of settlement | county seat | 27.2% |
| | capital | 23.7% |
| Age | 18–29 years | 23.6% |
| | 30–39 years | 18.6% |
| | 40–49 years | 17.8% |
| | 50–59 years | 18.8% |
| | 60–75 years | 21.1% |
| Main activity | manual worker | 31.0% |
| | brain worker | 25.3% |
| | retired | 25.5% |

related to physical health that require greater energy investment (exercise, health-protective food consumption). We can assume that although consumers claim that these factors are important (see *Diagram 1* as well) they do not act according to their beliefs in their daily life.

The questionnaire did not cover the issue of ayurveda because a previous research (Nagy 2010) showed that negligible part of the Hungarian population has knowledge of ayurveda. We used alternative therapies as an umbrella term and we assume that the members of this group could be the possible target group of ayurveda in the future. For this reason we tried to describe this consumer group according to the background variables (see *Table 2*).

According to the results, the typical consumer who is interested in alternative therapies is a married female who completed secondary education, has an under average earning, her financial status has worsen recently. She lives in the capital or in a county seat she can be of any age and can have several types of jobs.

## *Results of qualitative research*

Into the first focus group we selected health conscious, but not ayurvedic oriented consumers (6 persons) to discuss their health associations and behaviour. In the second group we discussed the same topics with ayurvedic oriented consumers. *Tables 3 and 4* illustrate the differences between the groups.

Considering the patterns given by the number of mentioned associations it can be stated that the ayurvedic oriented group has a more complex view of health, especially on the level of spontaneous knowledge. We assume that their spontaneous knowledge is associated with the personal habits of the respondents. In the next section we asked the participants to tell about their health-care activities in their everyday life. The health-conscious group mentioned activities for physical health (diet and exercising), while the ayurvedic oriented group, besides diet and exercising, also mentioned meditation, solving problems in their relationship, positive thinking and humour. At the end of the section both groups had to find a

***Table 3.*** Health associations in the health-conscious group (N=6)

| Dimensions | Physical | Psychological | Mental | Emotional | Social |
|---|---|---|---|---|---|
| Spontaneous knowledge | body, sports<br>genetics, avoiding harmful habits,<br>nutrition,<br>exercise,<br>lifestyle,<br>diet, purity | soul,<br>integrity,<br>harmony,<br>balance | knowledge,<br>broad-mindedness,<br>information | happiness | |
| Conducted knowledge | body-weight,<br>reaction,<br>detoxification,<br>chemical-free products | demureness,<br>stress relief | | tranquillity<br>openness | privacy<br>family<br>job<br>friends |

***Table 4.*** Health associations in the ayurvedic oriented group (N=7)

| Dimensions | Physical | Psychological | Mental | Emotional | Social |
|---|---|---|---|---|---|
| Spontaneous knowledge | physical and psychological balance, nutrition, exercise, healing self healing, organic dishes, sleep, moderation sex, recreation | physical and psychological balance, harmony with oneself, healthy self-esteem, stress-management attitude | thinking | empathy, happiness, love | communication, caring for others, responsibility, sympathy, caring for yourself and others |
| Conducted knowledge | vitamins, prevention, condition, herbs | ability to change, will | positive thinking, dreams, goals | goodwill, openness | loyalty, assistance |

common definition for health. The health-conscious group construed: "Physical, psychological and mental balance", while the ayurvedic oriented group construed: "Physical, psychological and financial independency".

In the last section of the discussion we asked the participants to collect the most advantageous characteristics of ayurveda that would help to introduce ayurvedic products and services in Hungary. They mentioned that "ayurveda helps to develop healthy lifestyle; it also helps to create inner harmony; ayurvedic diet is based on natural ingredients. It pursues physical and psychological balance; it accumulated a lot of experience during the millennia; the ayurvedic diet emphasizes the role of flavours".

The participants were also asked to collect characteristics that obstruct the spread of ayurveda in Hungary. They mentioned:" ayurvedic treatment does not have an immediate effect; people might consider it esoteric or mystic; the amount of available information is not enough; it is difficult to access ayurvedic services in Hungary".

The last task of the ayurvedic oriented group was to think out how they imagine the application of ayurveda in Hungary. They considered: "the basic principles and ingredients should definitely be kept unchanged; the specifications that could easily be considered mystic should not be emphasized; the identity of the mediator is very important, he/she should be familiar with western and eastern medicine alike; there is a need for scientific research of the ancient wisdom; it is well-suited as an alternative therapy".

## Conclusion

Examining the results of the first question block (see *Diagram 1*) the health interpretation of the Hungarian population followed the changes of the scientific approach. The population has a multidimensional health definition. Considering the results of the next section it also appears that there is a significant gap between recognising and achieving certain healthcare activities. The respondents consider physiological activities as the most important, which is in line with Maslows's (1970) motivation theory, and they also make a remarkable effort to satisfy these needs. The gap between recognition and action is the biggest in the middle section of the diagram (see *Diagram 2*) where physical activity, psychological and social needs take place. It is consistent with the results of the health-conscious focus group in the sense that the physical dimension was overemphasized in the spontaneous associations while it became more balanced when conducted association, was applied. At the end of this section they formulated just as complex definition as the ayurvedic oriented group. It means to us that it is not the lack of information that determines the population's health approach. The answer is deeper in the culture and the structure of the Hungarian healthcare system. As we have already established in the introduction the healthcare system of Hungary is based on the biomedical approach, and the availability and respect of psychological treatment or supplementary therapies is reasonably low, whereas in ayurveda diet (even for mental diseases) massage, yoga, meditation, aromatherapy etc. are integral parts of treatments.

The results illustrated in *Table 1* show that the alternative therapies, meditation and yoga are not so well known amongst the Hungarian population, but the gap is slightly narrower in these cases. It means that if the consumers recognise the importance of these treatments, then they are likely to apply them in practice. The size of the gap influences the potential future tendencies of the behaviour. The bigger the gap between cognitive and conative components of an attitude is, the more likely it is that the cognitive dissonance reduction appears because the costs of behavioural change become too high (Greenwald and Ronis 1978). The most common strategy of prevention campaigns in Europe is to prevent the leading causes of death while ayurvedic prevention focuses on general maintenance of health (Szalkai 2012). By placing the causes of death in the centre of attention the campaigns often highlight terrifying death statistics and deterrent pictures of pathological organs, although, it is well known in the literature of persuasion that people tend to ignore the high degree of fear. The most effective combination to cause behavioural change is minimal presence of fear and guidelines for possible solutions (Hovland, Janis and Kelley 1973). It appears that an alternative therapy like ayurveda seems to provide a good option because it focuses on maintaining health and not preventing the greatest risks of diseases, and it also provides a wide range of treatments.

It is not surprising that the typical consumer of alterna-

tive therapies is female, living in the capital or in a county seat, but by positioning the services of alternative therapies it should be considered that only 3.3% of the respondents who are interested in alternative therapies earn a higher than average income. Most of them have an under average earning and their financial status has worsen during the past year. Previous researches showed that changes in financial status have serious effects on health (Payne and Jones, 1987), and social classes with under average income level will definitely not be able to afford private treatment. Probably these reasons contributed to their turning towards alternative therapies. To define the possible target group of alternative therapies the decision between red and blue ocean strategy (Kim and Maughborgne, 2005) should be made. Namely is it worth providing premium services only and competing for that 3.3% of the respondents who are interested in alternative therapies, which means 1% of the population, or is it worth winning new consumers from the 67.3% of the respondents who are interested in alternative therapies with lower than average income, which is still almost 25% of the Hungarian population? The reason why this social group would be responsive to a wide range of services is that their income level has changed only recently, so in terms of social values they still belong to a higher social class and they strive to maintain their values and prove to themselves and their environment (Törőcsik, 2012). The number of this group has been increasing since the economic crisis, so consumer segmentations should count with them.

In the European and American societies the sustainability of the public health care systems is increasingly questioned. Considering the reform options the individualistic values of these societies is often an obstacle of building an effective and sustainable system for health care, prevention and health literacy because "Public health means not only the health of the public but also health in the public and by the public." (Ye Sun, 2014).As the value system of the Indian society is typically collectivist, there could be found many possible consequences that could help the transformation of health approach in practice as well.

Finally, after analysing the results of the qualitative research of the ayurvedic oriented group it has to be stated that ayurvedic services would fit well into the system of the existing health maintenance activities. Further scientific research, reliable mediators trained both in European and Indian medicine and more reliable information provided on the subject are indispensable to the spread of ayurveda in Hungary.

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