19

In and Out of Communism: The Macrosocial Context of Health in Poland

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Poland belongs to the group of European countries distinguished by the worst health indicators. Particularly striking is the difference in mortality indicators related to chronic diseases between Poland and the countries of western Europe. In the beginning half of the nineties, many unfavorable trends stopped or reversed. Still, many consider the present situation to be far from desirable.

Problems of bad health status, particularly the excessive mortality in eastern Europe, are the subject of numerous debates and publications. Most often, these attempts to explain eastern Europe's bad health status consider factors like lifestyle, quality of medical care, exposure to stress, environmental dangers, or the general well-being of society, and, in general, they blame the communist system for the bad health condition of the Poles. Still, it seems that the truth is more complex and requires taking into account other parameters or, at least, adopting a broader perspective that could illustrate 45 years spent under communism. Additionally, a broader perspective would require looking back to the more distant past to find the historically and culturally determined sources of the Poles' current health condition. In this article, the main focus will be on those macrosocial (i.e. political and economic) factors, which in the last half of the century have determined individual choices for better health in Poland and shaped the context in which styles of life, value systems, aspirations, and stressful experiences exist (Cockerham and Ostrowska 1999).

Communism

Poland at the beginning of the twentieth century was an economically backward country which was, for more than 100 years, deprived of its own statehood. Conquerors' policies focused on the exploitation of human and natural

resources rather than on investments, with foreign capital profiting from cheap labor. The development of a modern capitalist economy and a modern social structure with a middle class as the dominant factor of social change was delayed. The respective governments took no care to develop an educational structure and cultural institutions. There was almost no health care development, and agriculture was especially unprogressive. Peasantry, the largest segment of the population, was mostly illiterate and lived in primitive and unhealthy conditions.

The Polish state was re-established in 1918 and the devastated country slowly began to return to a normal life. The government initiated new social policies and reforms. The state also made some efforts to address the problem of the country's health, which was much worse than that of other European countries, by introducing the health insurance law. The average life expectancy in 1931–2, for example, was 49.2 years while it reached 61.3 years in Germany at that time. The main cause of mortality was infectious diseases, particularly tuberculosis.

The existence of Polish independent state lasted only 20 years, and ended in 1939 with Hitler's invasion of Poland. By the time the war ended, the Polish population had suffered an enormous loss of life; out of 35 million citizens of prewar Poland, over 6 million had perished. The intelligentsia, the most educated stratum of society, lost about 35 percent of its members due to particularly severe reprisals from the hostile Nazi government. The Polish boundaries were moved from east to west and millions of Poles were forced to move from the eastern to the western territories. They abandoned their households and belongings and broke traditional local ties. Undoubtedly, these events were an enormous source of social stress on the macroscale and were not without influence on the people's health (Bejnarowicz 1994). The country was in ruins. Poland signed no peace treaty and therefore could not claim any war reparations. The cold war quickly ended aid from international organizations. The only prospect for Poland was very hard work under conditions of extreme hardship and suffering.

The changes that were of paramount importance were those in the political and economic system. Poland became a member of "The Communist Bloc." The new political order aimed at creating a new society, with the dominant role going to those social classes who had been regarded as inferior throughout Polish history (Szczepański 1970). This new social order was founded on a socialized economy that was based on nationalization and central planning.

According to the communist ideology, the main objective of a socialized economy is to provide for all segments of the population. The educational and health needs of society were particularly essential at this time, so free health care and education at all levels were introduced. Initially, the system excluded farmers who owned their farms (as opposed to other socialist countries, Poland did not carry out mass collectivization).

The peasantry constituted the largest part of population. Hence, it fell to this class to repopulate the destroyed cities and to supply the labor force necessary for industrialization and restoration of Poland. This brought about a new wave of large migrations from the countryside to the cities. For these migrating populations, which were relatively uneducated and not skilled, the migration was a challenge and an opportunity for upward mobility, a better life, better

education and health care. However, the first years of this often forced migration were the source of considerable stress and social tensions. The new representatives of the working class experienced many hardships of adaptation. They were not accustomed to life in a city and work in industry. Additionally, they often left their families in the countryside deprived of basic social support. Therefore, at the moment communists started their rule, the society was devastated by war, poorly educated, socially destabilized, had no specialists or infrastructure, and was subject to poor health.

Despite this situation, the postwar years in Poland were marked by many achievements. In addition to the reconstruction of the country destroyed by the war, one can even find apparent effects of activities targeted at health and health care. Although many would raise objections to some of the political and economic decisions of the time, one cannot disregard the fact that during the years 1945–66 over 405,000 individuals completed university studies, which was five times greater than the number during the 20-year-long period between wars. The number of qualified medical professionals also grew substantially. In 1938 there were around 12,900 medical doctors; in 1946 there were only 7,700. However, in 1965 their number rose to 39,600 with the indicator of doctors per 10,000 inhabitants reaching the value of 12.6. This dynamic growth in the number of medical personnel shows the emphasis that was put on the creation of the new and effective socialist health care system, which was seen as a key to the health of the society.

Despite the fact that the development of health care was subordinated to the goal of industrialization, the first years of the socialist regime brought some measurable health results. In 1948, the average life expectancy was 58.6 years (55.6 for men and 61.5 for women). In the next two decades it increased by 12 years (67 for men and 73.5 for women). In the mid-sixties, the indicators of average life expectancy equaled those of the Federal Republic of Germany.

When interpreting this fact, one has to take into account the above-noted advance by substantial parts of the population, especially those which were previously the most vulnerable in this respect. The improvement of living and sanitary conditions, mass employment and education, and the appearance of health care that was the most universal and accessible in Polish history all had important effects. Centralized health care was particularly effective in organizing national health programs like the popularization of hygiene, health screenings, and mass vaccinations. These last two programs were particularly effective in fighting infectious diseases.

These forward-moving trends did not last long, however. They stopped in the same decade and then reversed in the mid-seventies. The average life expectancy, particularly for men, reached its lowest value (66.1 years) at the beginning of the nineties. The amount of sick leave that workers took increased by about 80 percent between the years 1970 and 1992 (Bejnarowicz 1994). This situation leads to many questions, such as: What influenced the decline of health indicators in the second half of the sixties? What happened in Polish society that could influence these changes? Was it a reaction to new situations or was it the result of processes which started much earlier and manifested later? In order to answer these questions, one needs to refer to social determinants of health on different

levels of societal organization: politics and ideology, the concept of social development, living standards, functioning of institutions, and also individual behavior and lifestyle which was the consequence of all macrosocial determinants.

First, it is worth noting that the spectacular achievements of centralized socialist health care came mostly from fighting infectious diseases. After successes in this respect, it became more and more clear in the seventies that new health dangers were appearing; these were mostly so-called "civilization diseases," in particular diseases of the blood, circulatory system, and cancer, but also obesity, diabetes, rheumatism, and others. During a ten-year period (1978–88), the percent of people receiving disability benefits increased from 4.1 to 8.6. It turned out that the old mechanisms of taking care of societal health, based on mass programs effective in fighting infectious diseases, were not satisfactory. New problems required a new social policy that would focus more on molding pro-health behavior and habits in the population, as well as on more individualized health care (Kirschner and Kopczyński 1999).

Development of the health care system, which started only in the postwar period, began to stagnate and was not able to react to the changing needs of the society. At the same time, as the population was becoming more and more educated, health demands increased. Services offered to people for whom they were never before provided and for whom every contact with medical science was beneficial, ceased to be satisfactory when their general knowledge and health culture improved. It is worth adding a reflection of a more general nature here: in all countries aiming for communism, a precarious, "claiming" relationship between the individual and the state appeared. Full employment, free health care, low cost of living, and other welfare benefits began to be taken for granted as a right of citizens and an obligation of the state. Often, workers did not think about the relationship between one's productivity and the scope of services obtained. On the other hand, reliable efforts rarely were properly rewarded by the system. What resulted was a sense of hopelessness, bitterness, and a lack of perspective. Imposed egalitarianism obstructed people's aspirations and promoted mediocrity. A certain kind of fatalism developed that was also visible in the sphere of health care. This fatalism was characterized by the idea that "it is not worth it to try and strive, because in the end the results of our actions are outside our control."

At the same time in the macrosocial perspective, it was increasingly clear that many social and health problems resulted from the excessive concern of the state about the economic development of the country. Accelerated industrialization was integral to the socialist development, because socialist states fought to challenge capitalist economies. Competitive development was measured by the rate of economic growth and other economic indicators. A large proportion of the state budget was allocated to huge industrial projects. Unfortunately, the price of focusing on industry was serious underfunding of "non-productive" spheres such as health care. The priority given to economic objectives impinged on issues of a healthy living environment and occupational health (Firkowska-Mankiewicz et al. 1990). For several years, industrial enterprises preferred to pay relatively low penalties for environmental pollution rather than to adopt more costly measures that would reduce environmental pollution. In Poland, there were high rates of mortality from accidents and poisonings. Policies

dictated by economic priorities also distorted the health consciousness of the population. Employees were willing to work overtime or in hazardous conditions as long as they were financially compensated.

Despite the fact that the government established a special system of industrial medicine responsible for providing health care to the working class (parallel to the national health system), the material base of health services was insufficient, and sometimes the country experienced acute shortages of basic medical equipment. The medical profession was underpaid and became gradually subject to corruption because of the scarcity of appropriate care. Still, quality health care was better assured for workers than for peasants (private farm owners) who were not covered by a national health insurance system until 1972 and who could participate without charge only in selected health programs.

The People's Republic of Poland had some spectacular health outcomes during its first postwar period. However, when evaluating the general contribution of health care to shaping the health of society during the years 1960–90, it is necessary to point out that the rate of decline in mortality related to conditions amenable to medical care was still a few times lower than in the countries of western Europe (Kirschner and Kopczyński 1999). The health care systems were not prepared, either in organization or in infrastructure, to make use of the advances of modern medicine. This was not only a result of the underinvestment of health care at the expense of the industry development; an important role was also played by the organizational structure, which preferred specialist medical centers and neglected primary care. In the first postwar period a large number of first-line physicians contributed effectively to the improvement of health. However, as Poland developed more specialization and a tendency toward spectacular and costly medical institutions, doctors were slowly losing interest in primary care medicine. They preferred instead highly specialized institutions that could guarantee more prestige and the possibility of gaining additional income from patients' informal payments.

However, these changes in health care cannot be charged with too much responsibility for the worsening health of Polish society. The structure of morbidity and mortality indicators shows that from the beginning of the seventies there were increasing risks of heart disease and cancer. Therefore, elements of a changing lifestyle must be considered. The health policy of the time must also be judged on the basis of activities that could influence the development of healthy lifestyles.

Alcohol overuse has a tradition of over one hundred years, dating back to the partition of Poland. Even at the beginning of the nineteenth century, alcohol production reached 10 liters of pure spirits per capita (Rozenowa 1961). Additionally, traditional Polish cuisine was heavy and based on high consumption of fat and carbohydrates, and low consumption of vegetables and fruits. The rural and urban poor could consume meat only on special occasions. The main diet consisted of products made of flour, potatoes, and cabbage. Physical activity was mostly related to one's job or simply to the activity of getting around.

The postwar victory of the "people's government" and the social promotion of the "working masses" set in motion for the average citizen a longing for a better life. Many understood "better" as the abundant consumption of once scarce products, such as sugar, meat, and fat. In the years 1950–90 the consumption of

fat rose, on average, from 700 calories to 1100, mostly due to animal fats (Bejnarowicz 1994). With the increasing affluence of the country, consumption of these products increased. Usually, they were supplemented by alcohol, which was not in shortage and which was relatively cheap and affordable. Also, because of the stresses and scarcities resulting from war devastation in addition to migration and the cost of accelerated industrialization, society began to accept alcohol and cigarettes as popular cures for all problems. These products expanded to take root in society and became an element of everyday reality. In the years 1960 to 1991 alcohol consumption increased by two and a half times and the number of cigarettes smoked doubled. It must be added that, until recently, Polish cigarettes were characterized by a high content of toxic substances and their filters violated quality standards. Although official health policy nominally appreciated the impact of living standards on health, the government generally believed that progress in the sphere of health would take place through medical interventions. This attitude was popular among citizens as well, and they demanded a greater number of medical services.

For a long time, the government did not acknowledge officially that alcoholism and the growth of alcohol consumption were a social problem. No one published data concerning these problems, because it was not in line with the vision of a society aiming for communism. The first sign of an official anti-alcohol policy came in 1956, when the Polish Parliament passed the first anti-alcohol act. However, at that time the sinister effects of alcohol overuse were perceived as a bothersome social pathology rather than a health hazard.

When western European countries began to promote healthy lifestyles in the seventies as a result of epidemiological research pointing out the dominant role of lifestyle in determining life expectancy, Poland was still using a model of societal health that consisted of contacting health care (Ostrowska 1980). This trend prevailed until the nineties. One study undertaken in 1996 revealed that during the three months in which research was conducted, half of adults consulted a physician at least once in health-related matters. This system was not conducive to the creation of pro-health habits through taking individual responsibility for health. In particular, as mentioned earlier, securing health was seen as the duty of the state. Proper nutrition and reducing alcohol and cigarette consumption were the subject of broad educational campaigns, but the campaigns were not accompanied by activities on the part of the state that would facilitate these goals for everyday life. Vodka and cigarettes were cheap, and fresh fruits and vegetables were accessible only some parts of the year. In fact, reducing the consumption of meat was more regulated by economic problems and limited supply than by a deliberate policy of molding consumption decisions. It is noteworthy that there were unquestionable efforts to popularize physical culture and sports. However, to a great extent, they were addressed only to children and youths.

Out of Communism

In 1990, Poland initiated a transformation of the political and socioeconomic system, the goals of which were the introduction of democratic principles and

a market economy. The first years of the transformation, long awaited and commonly expected to solve all of the country's problems, brought many disappointments. Unemployment, inflation, the sudden impoverishment of a large part of the society, and the lack of basic social security as guaranteed by the former system, were the source of new, previously unknown stresses. Public opinion polls conducted during the years 1990 to 1993 revealed decreasing feelings of security, increasing fears about the threat of poverty and, in general, decreasing optimism about both the individual's future and the future of the country. This social anxiety was also accompanied by the rise of social pathologies of all kinds, like suicide due to the inability to adapt to a new situation and economic crime committed by more "entrepreneurial" individuals who took advantage of loopholes in the still-in-flux economic system. For example, during the beginning of the nineties, there was unprecedented importation of large amounts (millions of liters) of cheap alcohol that was out of state control. Easily accessible alcohol, together with the stresses experienced by a substantial part of society, led to an abrupt growth in alcohol consumption (from about 6 liters of pure spirit annually per capita in 1988 to 10 liters in 1991 [Zatonski 1996]). The society also faced problems of drug addiction in schools, and spontaneous growth in the market for narcotics.

Increasingly poor health indicators accompanied the general anxiety experienced by citizens. The years 1990–1 were the most critical, because many health indicators reached their worst values during the postwar period. Mortality rates grew considerably in general, but particularly in men aged 15–64. The sudden change in rates was related to an increase in mortality due to sudden causes (which is associated with alcohol consumption) and circulatory system diseases, which are hypothetically related to the strength of macrostressors. The first years of the nineties were also characterized by the highest percentage of infants with a birth weight below 2,500 grams, which indicates a decline in living standards of women. During the years 1990 through 1993 an increased occurrence of tuberculosis was noted, which for many years had ceased to be a problem in Poland. Concurrently, underfunded health care, now in a state of organizational disorder, decreased the quality of its services. According to World Bank estimates, almost one-third of providing units did not meet necessary standards. Doctors' income, which in the West is higher than average, was about the same as average in Poland. Sociological research done in 1992 revealed that every seventh patient made informal payments for health care that was supposed to be still nominally free of charge (Kopczyński and Halik 1997). In this context, comprehensive reform became necessary instead of temporary measures. However, the process of reaching consensus about what the principles of reform should be and how it should be implemented lasted for almost a decade.

Official explanations for the worsening health status of Poles emphasize the price that societies must pay for abrupt and deep social changes, to which society takes time to adjust. In what had been a materially egalitarian society, the processes of polarization began and social inequalities appeared more and more clearly, especially in the sphere of health. While in the seventies and eighties there was no significant correlation between self-reported morbidity and indicators of social position, research conducted in 1991 found such an

association in regard to income and general perception of one's material situation (Ostrowska 1992). The greatest cost of the economic transformation was shouldered by families with many children, the older and disabled, and workers and farmers in general. The lack of state policies concerned with the impoverishment of a substantial part of the population suggested that what was already an unfavorable health status might deteriorate.

However, against this pessimistic outlook, a decrease or at least a stabilization of many of the unfavorable health indicators appeared, starting in 1993. It was particularly visible in the case of mortality rates. For example, the infant mortality rate decreased from 17.9 per 1,000 live births in 1991 to 13.6 in 1995. There was also a sharp drop in deaths caused by circulatory diseases, the main cause of premature deaths in Poland. In this same period of time, the standardized indicators of circulatory diseases per 100 thousand inhabitants decreased from 609 to 532. A comparison of subjective health status for the years 1992 and 1995 also revealed improvement in people's evaluations, in particular where psychological frame of mind is concerned. This puzzling, "accelerated" reversal of trends in health raises questions about its underlying factors.

When analyzing the macrosocial context of Poland's change, one has to note that during this particular period of time definitive improvement in the country's situation did not yet appear. After 1992 there was an increase in GDP and industrial production and a decrease of inflation and budget deficit, unemployment was still growing in 1993 and started to decrease only in the next year. Health expenditures remained at a similar level (5 to 5.3 percent of GDP), and indicators of health risks in the work environment did not improve. Crime was increasing and the number of suicides did not decrease.

Despite this, public opinion polls in 1993 and 1994 noted a sense of social stabilization connected to people's acclimatization to the new socioeconomic reality and the principles of market economy (Marody 1996). General feelings of insecurity and uncertainty diminished as the public learned new strategies for dealing with life under new rules. One can presume that feelings of normalization combined with increasingly effective individual mechanisms of adaptation influenced and lowered what was for years a major societal health risk – social stresses. The shadow economy could also have played a certain protective role not seen in statistics. This phenomenon, difficult to estimate in numbers, is usually seen as a socioeconomic pathology. However, the existence of a shadow economy undoubtedly counteracted the impoverishment of some part of society. According to existing estimates, illegal work was an important source of income for the unemployed, narrowing the official extent of poverty (Beskid 1997).

It is worth noting that changes in the economic system, particularly the introduction of a market economy, led to important modifications of the Poles' lifestyle. The range of available food products, weakly diversified in socialist times, changed radically. Diversity, attractive packaging, and commercials appeared in the market, extending the possibility of choice. It is worth adding that commercials for food often utilized health-related arguments and cited known and respected medical professionals (one example could be arguments for changing animal fats to vegetable ones).

Because of these changes, the average Polish diet began to "Westernize" and to improve. Polish people consumed more citrus fruits, fresh vegetables, and other fruits as they became available throughout the year. Also the new price structure seemed to favor pro-health products; for example, the price of poultry is now lower than the price of either pork or beef. The average energy value (daily intake) of food consumed decreased from 3489 calories in 1989 to 3172 in 1976. The patterns of alcohol consumption changed as well. Although average consumption of alcohol did not change, the distribution did. In the years 1992 through 1995 the share of people annually drinking more than 10 liters of alcohol decreased, and the percentage of those who drink only a small amount (less than a liter) increased. This shift in drinking patterns was definitely influenced by the growing supply and commercial promotion of beer, which slowly started to appear in social situations where vodka would have previously been present. The health consequences of this fact, although not affecting all strata to the same extent, can be generally judged as positive.

Two other important factors that modified the lifestyle of Poles were the opening of eastern Europe to the West and the country's growing aspirations for joining the European Community. Stimulating new lifestyles can create the background for changing attitudes and behaviors (Cockerham and Ostrowska 1999). The growing health awareness of the society plays a role as well. Consumers increasingly check the expiration date of products, along with their chemical content or the possibility of hazardous packaging. It seems that the Polish people are coming to value health itself, and using it as an important attribute for improvement in one's life situation.

Obviously, it is hard to judge to what extent the changes presented, occurring in such a short period of time, could influence the improvement of Poland's health status (e.g. in the years 1991–7 the male life expectancy rose from 66.1 to 68.5). Even if these socioeconomic changes have not yet contributed, they are likely to have a positive impact in the long run. Still, it must be emphasized that these positive changes affect only the wealthier and better-educated part of society. There is a rising danger of increasing social inequalities in the realm of health and health care. It is also hard to predict whether health indicators will continue to improve and whether the change in trends will be merely temporary. The Polish lifestyle has generally become more rational, but it is still worse than those in western Europe. Will it improve further? At what pace?

In 1999, the long-awaited health care reform has finally come. However, it has not been a source of patients' satisfaction; rather, it deprived Polish society of the privilege of free access to medical services. Despite the fact that this privilege was never fully realized, it gave the people an elementary feeling of security in the sphere of health. According to a survey conducted after the introduction of reform, the majority of respondents awaited the new health care system with anxiety and only a few with hope. In principle, it is supposed to change the system of medical financing through the introduction of health insurance and a new institution called "Sickness Funds," which will mediate between the patient and the health care system. For most Poles, their insurance premium equals 7.5 percent of their income. It is collected from employers as a part of income tax, and it entitles insured people to a package of basic services. Regional Sickness

Funds receive premiums and contract services from providers (state-owned or private hospitals, clinics and outpatient units).

The reform prioritizes primary care, reinstates the role of family doctors, delegates authority over primary health care to local governments, and creates a system of financial incentives that are expected to prevent corruption. The government expects also that changes in health care provision will reduce the excessive use of high-cost treatments.

The reform implementation, which coincided with the reform of the administrative and pension systems of the country, was not prepared well enough and hence resulted in organizational chaos and conflicts between doctors, patients, and Sickness Funds (at least in the first few months). These conflicts were magnified by the fact that the creation of new regional bureaucracy turned out to be very costly, and the salaries of insurance managers are several times higher than the salaries of doctors. This fact causes dissatisfaction among patients (who believe that their money is being wasted) and makes the negotiations of contracts between Sickness Funds and health providers more difficult. However, because the new institutional rules have been functioning only a short time, it is impossible to evaluate their long-term effects.

Sociology of Medicine

Sociology of medicine as a separate scientific discipline has existed in Poland since the mid-1960s. In the beginning, it developed exclusively within the academic framework of sociology. It constituted a domain of knowledge about society, similar to the sociology of law, politics, or religion. From this perspective sociologists analyzed illness behavior, health culture, and the institution of medicine as a social system (Titkow 1974; Bizon 1976; Sokołowska and Kosinski 1978; Uramowska 1980). The study of health care utilization and the related attitudes and expectations of patients also has a relatively long tradition. The fact that medical services in Poland were only partially nationalized (medical cooperatives and private practice existed) allowed for analyses of different aspects of health care delivery in various sectors (Sokołowska 1969; Ostrowska 1975; Titkow 1983). During the 1980s studies of the health care system became openly critical, indicating discrepancies between medical sector capabilities and social requirements, as well as indicating organizational pathologies and growing corruption (Halik 1988).

Another area of interest in Polish medical sociology has been the emerging health problems of the population. In general, epidemiologists studied public health problems rather than sociologists. Still, there were some topics that became the subject of sociological investigations. For example, sociologists focused much attention on the problems of health inequalities, workers' health in heavy industry, and the impact of living and working conditions on health (Sokołowska et al. 1965; Sokołowska 1980; Tobiasz-Adamczyk 1984; Wnuk and Lipinski 1987; Wnuk-Lipinski, and Illsley 1990; Bejnarowicz 1994). Gender-related inequalities in health were also examined within this framework. More recently, the relationship between lifestyle and health became a subject of

research interest. It has been conceptualized as a sociological category – as everyday behavior which identifies individuals' social position, aspirations and motivations, and also their structural and macrostructural determinants (Gniazdowski 1990; Ostrowska 1999).

The increasingly visible deficiencies of health care directed the attention of researchers to the family as a social system that has to compensate for insufficient medical care of the chronically-ill and disabled. Frequently, researchers studied coping mechanisms and the various consequences of illness for the functioning of families (Butrym 1987; Radochoński 1987). Another interesting concern for sociological analysis was the expansion of unconventional alternative healing methods, positioned to a greater or lesser extent against official medicine and receiving growing criticism (Piatkowski 1990a, 1990b). These studies also helped to penetrate the lay concepts of health and disease that existed in the Polish society (Puchalski 1994).

The impulse for the development of medical sociology that came from the medical side was more oriented toward concrete problem solving. It originated among psychiatry and rehabilitative medicine representatives. They tend to understand better than other doctors that the life problems of their patients are equally medical and social in nature. The alliance with psychiatrists influenced the development of community psychiatry and changed mental hospitals. The collaboration of sociologist and rehabilitative medicine specialists in 1978 helped to prepare the National Report on Disability and Rehabilitation, which became an important tool for shaping social policy. Further studies on this subject were devoted to social attitudes toward handicapped people and structural factors causing their social marginalization (Rychard 1983; Gorczycka 1992; Ostrowska and Sikorska 1996).

In the 1990s the impact of sociopolitical and economic transformation on the health and well-being of the society became a concern of medical sociologists. It particularly brought attention to the consequences of "socialist welfare state" withdrawal and to health problems associated with poverty and unemployment (Ostrowska 1992; Bejnarowicz 1994). Also, researchers investigated subjects related to planned health care reform (Włodarczyk 1995). The new trend toward public health is blooming as health promotion finds many enthusiasts among Polish medical sociologists. The scientific quarterly "Health Promotion, Social Sciences and Medicine" has been in publication since 1994.

Sociology of medicine has been inspired by general sociological theory, rather than by the specific theoretical concepts of western medical sociology. The structural-functionalist theory was most popular among researchers. This theory was especially attractive for eastern European societies. The Marxist emphasis on conflict could not be applied to the analysis of a socialist society, which was expected to be conflictless. Parsons's vision of cooperation, goodwill, and the mutually complementary components of a system met the ideological pattern of a socialist society in many respects. Paradoxically, in Poland there were very few medical sociology studies that could be directly derived from the traditions of Marxist sociological theory. In 1970s some empirical studies were inspired by symbolic interactionism, and in 1980s there were some analyses located within phenomenological and ethnomethodological traditions. However, the majority

of empirical studies tended to neglect theory, or to use it only to a limited degree. Mainly due to financial reasons, in the 1990s medical sociology became increasingly institutionalized within medicine rather than sociology. Because of this, the de-theorizing of medical sociology became progressively worse.

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