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Health in social policy and social problems in health policy

Abstract

Recent changes in Poland's classification of scientific fields and disciplines (2018, 2022) have impacted the organisation of research institutions and the direction of studies, particularly in the social and health sciences. Unlike the natural sciences, which rely on stable classifications, the social sciences and humanities deal with complex and evolving subjects, making rigid frameworks problematic.

This article argues that recent classification reforms, particularly concerning the social and health sciences, disrupt cognitive processes, weaken institutional coherence, and hinder the formulation of rational social and health policies. The argument focuses on one crucial dimension of the issue: the marginalisation of integrative approaches that connect social and health concerns. This limitation adversely affects public governance and the effective design of real-world interventions in both domains.

Given the intrinsic overlap between social and health issues in public policy, interdisciplinary research and action are essential. However, current academic administrative practices – including the proliferation of narrow specialisations and the continual emergence of new subfields – discourage genuine interdisciplinarity, despite official declarations to the contrary. Alarmingly, these trends persist with minimal resistance from the academic community, even as their negative consequences are acknowledged.

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The reflections presented in this article stem from the author's research across the fields of health policy (including public health) and social policy. The text is organised into three sections: health-related issues, social policy, and the intersection of the two. The article concludes with reflections and recommendations aimed at scholars and policymakers in both the social sciences and humanities, as well as the health and natural sciences.

Keywords: public health, social policy, evaluation of scientific activity, organisation of science

Introduction

In recent years (2018, 2022), we have witnessed modifications to the nomenclature of fields of science and scientific disciplines in Poland, as well as the introduction of new classifications[2]. This activity did not remain without impact on the organisation of institutions and research teams, as well as on the directions of research undertaken, and consequently on the development of science in general. This applies to a lesser extent to the exact sciences (hard sciences), where concepts and classifications are more stable. They more clearly convey specific contents of phenomena, processes, and activities. In the field of social and human sciences, we are dealing with incomparably greater diversity and variability. The subject of interest for these sciences, namely humanity, communities, and societies, resists universal organisation despite the vast amount of philosophical and generally methodological work, along with carefully conducted reviews and classifications, still only bringing closer to the full clarity of the comprehensive picture.

In this article, I argue that the classifications of fields of science and scientific disciplines made in recent years in relation to social and health issues disrupt cognitive processes, weaken the institutional order, and do not promote the adoption of rational social and health policy. In the argumentation presented in this article, I focus on one dimension of the problem exclusively – the limitation of approaches that connect social and health issues, and the consequences of this for good public governance, and consequently for the proper shaping of the real sphere in both areas.

The coexistence of social and health issues in both health and social policy requires interdisciplinary research and action. Meanwhile, current practices in organising and administering science involve introducing narrow specialisations (fragmenting disciplines), in creating new directions and fields, and consequently discouraging a multidisciplinary approach despite declarations of its necessity. These practices do not encounter strong resistance from scientific communities, despite describing flaws and indicating harm[3].

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[2] Regulation of the Minister of Science and Higher Education of September 20, 2018 (Journal of Laws item 1668) and Regulation of the Minister of Education and Science of October 11, 2022 (Journal of Laws of 2022 item 2202) regarding fields of science and scientific disciplines as well as artistic disciplines.

[3] Among others in Resolution No. 26/2022 of the Main Council of Science and Higher Education dated July 6, 2022.

The considerations presented in this article are the result of reflections that encompass and connect conclusions derived mainly from the research I conducted in both health policy (including public health) and social policy (Golinowska, 2018; Golinowska & Tambor, 2020; Golinowska, 2022; Golinowska, 2024).

The text is divided into three parts: (1) health problems, (2) social problems, and (3) the connection between both topics throughout the life course and in places of living. It concludes with considerations and recommendations addressed to academic communities and policymakers of both groups of disciplines, social sciences and humanities, as well as health sciences and natural sciences, and more broadly, to scientific communities that participate in or influence state regulations concerning the functioning of science.

1. The social dimension of health

When the subject of definition and classification is health, we encounter exceptionally complex problems. Health is a common issue across many disciplines and fields: social and economic sciences, medical sciences and health sciences, as well as natural sciences, which is reflected in the slogan "health in all policies" (Ståhl et al., 2006). The approach that combines requires the creation of common categories, uniform definitions, and appropriate systemic organisational solutions, which is still missing.

Health is also defined in relation to different entities described from the perspective of health status. On one hand, to individuals (people exposed to health risks and sick individuals), on the other hand, to populations and society, and thirdly, to all of nature: humans, animals, and plants. In the first case, we refer to medical sciences, which provide knowledge about the ethology of diseases and their treatment methods, and in the next two cases, we additionally refer to natural and social sciences, which recognise the impact of natural and social environmental conditions (in their continuous variability) on people health condition (population health) as well as that of animals and plants (one health).

A common category for defining health-related matters of individuals and populations is **health protection**. This term has been adopted in Poland as institutionally encompassing the entirety of health matters for both individuals and populations, in both preventive and therapeutic actions.

The health of the population in preventive actions related to the population in specific structures (socio-economic and geographic-ethnic) is the subject of **public health** interest.

Public health has been forging its way as a discipline in the science and practice of public actions for about five decades now. This is an exceptionally difficult path, as it goes against contemporary trends. They focus on solving the problems of individuals; people threatened by a specific disease and those who are ill ("patient in the spotlight," patient at the centre of attention). In diagnosis and therapeutic actions, references relate to a specific organ and its functioning, deviating from the norm. Medical specialities have developed, including cardiology, oncology, diabetology, orthopaedics, etc. What is often overlooked in this process is the patient, as the focus is mainly on the

malfunctioning organ. For this reason, a new trend in medicine, namely, holistic medicine, emerged, which encompasses the patient rather than their sick parts.

Public health requires a comprehensive view of the multitude of factors that shape health and pose threats to it, not only for individual human beings but for populations in their multidimensional structure and dynamic changes. The COVID-19 pandemic halted the trend of devaluing (neglecting) public health, which had visible successes concerning infectious diseases (vaccinations!). Meanwhile, the health of the population remains at risk due to the increase in chronic diseases (sometimes referred to as social or lifestyle diseases) and external threats arising from environmental degradation and climate change, as well as behavioural reasons, i.e., an increase in stress-inducing, aggressive, violent, and forceful behaviours.

Considering the social dimension of health in medical and life sciences research is not obvious. Cognitive interest in health and its care usually arises in connection with illness. The need for constant health care, even when pain is absent and no illness or accident is requiring life-saving intervention, is not widely recognised, and actions that promote disease prevention are insufficiently valued. History shows that public actions concerning health care, undertaken by public authorities (local, state, and international) aimed at the general population, were taken for two main reasons.

On one hand, due to the emergence of epidemics or other mass health problems. Public actions were based on identifying the causes of infections (dirty water, impurities, miasma, lack of personal hygiene) and taking actions that resulted from scientific discoveries in biology and medicine, which involved identifying bacteria, viruses, or other pathogens and applying measures.

On the other hand, public authorities began to influence health by improving the living conditions of society due to the need to keep the population in good condition; men for military reasons (the health of soldiers) and women for the "quality" of children and the need to care for them. Public concern for health during the period of industrialisation was supported by labour movements and the activities of trade unions, as well as the paternalistic attitude of employers interested in increasing work efficiency and social peace.

The increase in prosperity and the development of new medical technologies, leading to significant progress in the treatment of infectious diseases, have contributed to the rise, largely in the average life expectancy lived in good health. Infectious diseases broke out in areas distant from the main economic centres of the world, and thanks to successes in their treatment and prevention, they were quickly extinguished. The importance of public health decreased, and consequently, efforts in this field were limited.

Meanwhile, new challenges have emerged for public health. In countries with growing prosperity, health threats primarily arise from the expansion of non-communicable chronic diseases, known as lifestyle diseases[4], the emergence of epidemics of new infectious diseases, and the neglect of social and ecological health determinants.

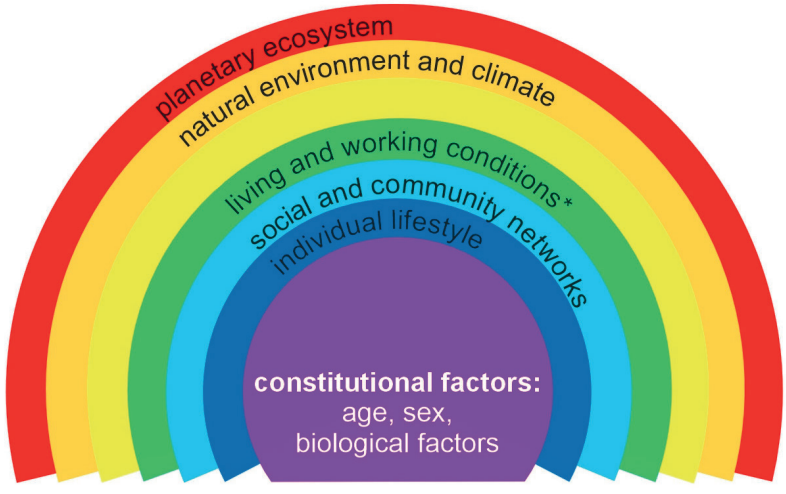
[4] The category of "lifestyle diseases" (and lifestyle medicine) narrows the scope of the issue by relating the matter to individual behaviours rather than to the system that promotes it.

1.1. Health determinants

The Minister of Health and Social Services of Canada, Marc Lalonde, published a report on the health of Canadians in 1974 – A New Perspective on the Health of Canadians (1974), highlighting the importance of social and environmental determinants of health for the population and individual citizens, which are equally important (if not more important) than the biological characteristics of humans and the quality of healthcare. His concept, outlined in the form of what is referred to as **health fields**, contributed to a new perspective on public health, where the health status of the population is determined by activities in many areas of people's lives, and not just progress in the treatment of diseases.

The complexity of the impact of various factors on health has been presented in the form of diagrams (graphs), also showing the ranking of health determinants. The concept most frequently cited today is that of Goran Dahlgren and Margaret Whitehead (1991), prepared for the European WHO Division. The authors presented it in the form of a graphic called the rainbow of health. Biologically described people (age, gender, and genes) primarily influence their health through their individual lifestyle, and then through relationships with people in their immediate surroundings (family and local social network). Only after that do living conditions and social institutions, including health services, become important. On the outer ring, we have more general factors of living conditions: socio-economic (level of welfare and its social distribution), cultural (values, tradition, norms), and environmental. In the health rainbow model (see below), two additional circles are drawn. In one, environmental health and climate are distinguished, excluding them from the set of general socio-economic and cultural factors, and in the next circle, global health factors are introduced, including the planetary ecosystem.

Figure 1. The Rainbow Model of Health



Source: Dahlgren & Whitehead, 1991.

1.2. Ecological-social model of health

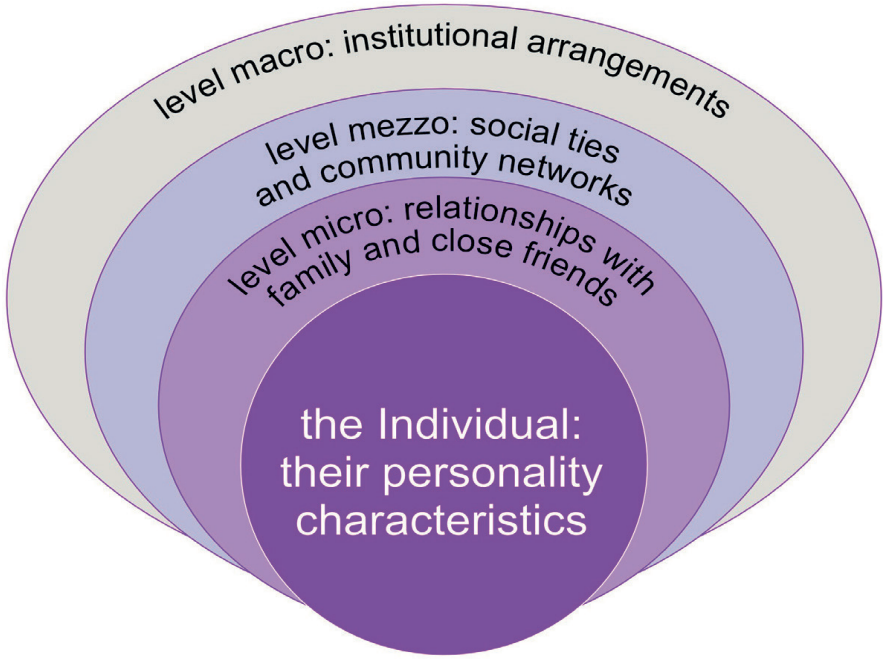
Alongside the findings related to health determinants, research deepening their specific types within the framework of scientific workshops of individual social sciences disciplines, primarily psychology and sociology, was developed.

In the field of social psychology, the ecological-social model of health was developed. It was presented by Urie Bronfenbrenner (1979), an American developmental psychologist who, as early as the 1970s, analysed and published works on human development in ecosystems and over time (in the chronosystem). By introducing the adjective "ecological" into the category of development, he was not only referring to the natural environment but more broadly to the social environment, which in contemporary times is also a product of human activity.

Environmental factors constitute a category of **environmental health**, which considers the impact on health of such factors as clean air, access to drinking water, uncontaminated land, safe food production, and safe living conditions.

Social factors are considered to have their variability throughout a person's life. Bronfenbrenner's concept is illustrated by a nest diagram (see below), which is extended (new circles are added) with development. In the last circle of the nest, we have a system of public institutions with legal regulations as well as media and political influence.

Figure 2. The ecological and social model of human development



Source: Based on the concept of ecological human development by Bronfenbrenner (1989).

The influence of society on health is the subject of the developing sociology of health and illness. This field initially developed alongside public health, both in the environment of social sciences and medical sciences[5]. Its full recognition came from medical research on human susceptibility to currently dominant diseases (cardiovascular, cancer, and diabetes), indicating that in the aetiology of these diseases, a social factor is also present. Considering a wide range of social variables became the basis of what is referred to as social epidemiology[6]. Over the years, social factors were grouped, classified, and assigned to specific diseases. Scholars who organised and classified these factors were Bruce Link and Jo Phelan in 1995. The social factors recognised as fundamental were presented in the handbook by Lisa F. Berkman and Ichiro Kawachi (2000).

Australian social epidemiologist Zahid Ansari and his collaborators developed a classification of variables grouped into three categories: (a) institutional factors used officially and in statistics, such as education, profession, income, origin, religion, and place of residence; (b) factors characterising communities, e.g. social networks and support structure, participation in community life, civic and political engagement, trust in people and institutions, tolerance of diversity, altruism, crime, domestic violence, and unemployment; (c) psychosocial risk factors, e.g., lack of or non-participation in a social network, low self-esteem, self-efficacy, depression, tensions, loss of a sense of security, loss of a sense of control, entitlement, chronic stress, social isolation, anger/hostility, (in)coping, as well as expectations (Ansari et al., 2003).

1.3. Anthropocentrism and one health

The consideration of the distinct circle of natural environment and climate factors in the health rainbow model was influenced by studies that allow us to observe, experience, and measure their impact. They were included in scientific facts about the health impact. This turned out to be problematic, as contrary to the threatening natural phenomena to humans due to their disturbances and transformations, ideological arguments gained strength, supporting the philosophy and belief in anthropocentrism, i.e., the conviction of man as the ruling centre of the universe, who can "make the earth submissive to him without fear that this is happening against the will of God".

In the philosophical debate, in which representatives of biological sciences and other earth and natural sciences also participated, the central role of humans was confirmed, but **as a destroyer, not as a source of natural harmony**. The thesis is even formulated that humans have caused an ecological crisis on such a scale that they have changed the Earth's ecosystem, leading to the formation of the Anthropocene, the geological epoch of humans (Gałuszka, 2021). As part of the discourse, the interpretation began to change, from a normatively understood role of humans in the universe (they can build and destroy) to a limited role that arises from human rights – the right to a clean environment and health.

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[5] Recognition and identification of socio-economic factors affecting health emerged simultaneously from both the medical and social environments, from reports from experienced doctors and nurses, as well as social workers.

[6] John Cassel (1976) is considered the initiator of social epidemiology.

As for the environmental issues and the role of humans in interacting with the environment, there is also the topic of "one world – one health", a concept linking the health of humans, animals, and plants as interdependent, immersed in a global ecosystem. The idea of one health is represented by the graphic presented below.

Each of these three groups of life in one world is negatively affected by air and water pollution, deforestation, loss of biodiversity, and climate change. In the world of humans, health is threatened by reduced food security and an unhealthy diet, as well as excessive mobility through modern means of transport (airplanes, cars, etc.) and due to conflict-generating inequalities.

Figure 3. "One health" concept

Source: ISGLOBAL figure, as modified by the author.

The world of plants is being destroyed by contaminated and depleted land due to the intensity and monoculture of agricultural practices, exploitative logging, climate change, and natural disasters, fires, hurricanes, and floods. The world of animals is threatened, on one hand, by the reduction of wild animal species, and, on the other, by intensive farming for the nutritional needs of humans and animals in the food chain. The interactions occurring in the biologically imbalanced worlds have additional destructive consequences.

The slogans and calls for global unity and health began to be proclaimed with greater intensity upon recognising the sources of new infectious diseases, particularly, the occurrence of epidemics and pandemics of viral diseases in the 21st century: SARS (Severe Acute Respiratory Syndrome), bird flu, Ebola in West Africa, Zika virus in the Americas, MERS-CoV (Middle East Respiratory Syndrome coronavirus), and recently the COVID-19 pandemic. They drew attention to the transmission of infections from wild animals to humans.

Along with the export of food and the movement of people, animal-origin viruses spread to humans in many places simultaneously. Global interdependencies became

evident, encompassing the entirety of the natural world, animals and humans in every corner of the earth[7].

As knowledge accumulated, the idea of "one health" started to be promoted. A close collaboration was declared among institutions dealing with agriculture and food (FAO), animals (World Organisation for Animal Health – OIE), health (WHO), and the environment (UNEP), and a plan of action was established.

The process of further accumulating knowledge may slow down due to the influence of both traditional ideologies regarding the place of man in the ecosystem and interest groups of large corporations and the oligarch class, which amass enormous fortunes from the destructive extraction and exploitation of the earth's resources and its nature.

2. Health in social policy

By the subject of social policy, I refer to the needs and the so-called social questions or problems[8]. The category of social problems originates from the period of the Industrial Revolution. It involves pointing out the troubling issues of human existence that require intervention; the need for assistance from a wide range of different institutions, from family through numerous social organisations to local, state, and international.

The main social problems, such as poverty, unemployment, poor working conditions, homelessness, also included health-threatening behaviours (health risks), particularly alcoholism and drug addiction. Kazimierz Frieske addressed these recent issues in his works (1984, 1987) as new social problems, although alcoholism had a long history (Daszyńska-Golińska, 1905[9]).

The subject of social policy in the context of health is, therefore, the social consequences of "unhealthiness" (poor health, disability) and risky health behaviours that affect the individual and collective living conditions of people. The aim of social policy from a health perspective is to mitigate these effects and assist affected individuals in living normally and in a socially integrated manner, without discrimination, exclusion, or isolation.

In the history of social policy, the approach to sick, oppressed, and disabled people has come a long way. The norms of human community responses to health issues were shaped by religions, resident communities, labour unions, paternalistic employers, and finally, the state and international organisations.

An undeniable achievement on this path was sickness insurance (or health insurance), which created conditions for treatment and recovery by financing the costs of absence from work and covering the costs of treatment and rehabilitation[10].

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[7] For example, an agreement has been signed within the framework of WHO to improve surveillance of infectious diseases transmitted from animals to humans and to support the development of integrated public and veterinary health systems.

[8] In English, it translates to the category of social problems or social questions, in German it is Sociale Frage, and in Dutch – *sociale vraagstuk*.

[9] Pioneering research and work by Zofia Daszyńska-Golińska on the health, social, and economic dimensions of alcoholism in Polish lands at the turn of the 19th and 20th centuries (in Galicja) is presented by Tomasz Kamiński (2012).

[10] This refers to what is called tertiary prevention – actions taken after treatment: improving the body, preventing complications, and monitoring the process of recovery.

A milestone in considering social conditions and the consequences of ill health was the creation of equal rights and the treatment of people within human rights. This resulted, among other things, in the UN Convention on the Rights of Persons with Disabilities (in the 21st century).

The voice of people with disabilities currently leads to the development of various forms of support and assistance, as well as openness towards individuals with limited abilities, enabling them to live actively and integrated within society (Masłyk, 2019).

Social policy in the context of health has increasingly focused on actions directed towards the elderly. As people age, their health deteriorates, which is indeed a natural phenomenon, but it is currently being modified. As mentioned earlier, when the standard of living increased and the living conditions of people improved (hygiene, adequate nutrition, protection against cold and heat, limiting excessive physical effort, protection against aggression, and accidents), there was also progress in the treatment of diseases, extending human life.

The main area of social policy actions towards older people is concerned with income security (pensions and retirement benefits). As a result, income poverty among the elderly ceased to be the dominant type of poverty. Social insurance also covered the costs of medical services for the older population[11].

The ageing process, which increases the number of elderly people in welfare state countries, has led to the political empowerment of seniors (a large and growing electorate). This undoubtedly improves their material situation, but not necessarily their health. Healthy ageing is primarily influenced by access to health and social services, and a less lonely life.

In social policy, there was essentially no space for actions aimed at the health of the population, based on the conscious need to care for it. The concept of caring for health, maintaining and nurturing it, was born within public health as health promotion. Since the announcement of the Ottawa Charter (in 1986), this concept has been present in significant documents and reports from the World Health Organisation (WHO), which have become a guide for developing international and national actions, before the disease manifests itself and medicine begins to struggle with it using its knowledge, technologies, and professional staff. Health promotion started to be incorporated into health education programmes in schools and universities, and it also became the focus of many non-governmental organisations and social movements for healthy living. New professions emerged, health educator, health promoter, or prevention specialist.

In promoting a healthy lifestyle, the danger of developing a new ideology called healthism has arisen. Robert Crawford, an American sociologist from Washington University, in an essay dated 1980, suggested that the middle class in the USA demonstrated health-promoting behaviours in daily life, which fostered the development of products for monitoring physical activity (e.g., counting daily steps) and an appropriate diet (e.g. counting calories and/or nutrient content).

[11] Even in the USA, there is a special public health insurance system for people aged 65+ (Medicare).

Crawford also attributed a moral significance to this, drawing attention to the creation of self-disciplining, entrepreneurial individuals striving to maximise control in daily life marked by uncertainty. Over time, he noticed in this behaviour an element of neoliberal ideology (Crawford, 2006), which is also focused on the development of the marketisation of healthcare and the development of individual health care concerns in the context of efforts to establish public health protection to the necessary extent. Healthism in the USA has hindered the pursuit of social reforms in the name of freedom and individual responsibility for health.

Social policy, by limiting the subject of its interest in relation to population health, inadequately appreciated the problem of health inequality (Marmot, 1996; 2000; Wilkinson & Marmot, 2003). Meanwhile, a characteristic and consequence of the new form of capitalism (neoliberalism) was increasing inequality.

Health inequalities in European countries (Central and Eastern European countries, including Poland), documented based on mortality and morbidity indicators and considering three main risk factors: smoking, alcohol consumption, and an unhealthy diet, contributed to the formulation of the thesis about what is called the paradox of welfare countries with a developed welfare state (Mackenbach, 2002, Wilkinson & Pickett, 2009). The interpretation of this "paradox" suggests that health inequalities do not yield to compensatory redistribution efforts through traditional welfare state tools, such as income and in-kind benefits. The growing importance at present is attributed to intangible variables associated with the process of limiting (closing) intergenerational vertical social mobility, which leads to achieving a higher social position. It would mean that health inequalities are entrenched in the population, weakening its life potential, diminishing social engagement, trust, and social mobility. They correlate with dysfunctions in family and public life, an increase in addictions, mental disorders, violence, and crime.

Addressing health inequalities has taken the form of a social movement initiated by Michael Marmot (2000), who believes that there is nothing worse in societies than inequalities in health. In this context, we must state that social and health policy, within its institutional framework, does not take on the challenge essential for improving people's condition and motivation to care for their individual biological and social development, one of the effects of which has been the ongoing lack of improvement in average life expectancy for several decades. This trend, as Marmot demonstrates in his works, has its roots in social exclusion, beginning in early childhood (2015).

3. Combining health and social issues

The integration of both spheres of human life: health and social well-being can take place in two ways: (1) based on the life course perspective or (2) places of residence (settings). These are not mutually exclusive approaches. With each phase of life, specific places of everyday presence are associated. Both approaches reflect the socio-ecological model of health, providing an opportunity for a systematic understanding of all health and social issues in their multidimensional reality.

3.1. Health and social problems from the perspective of the life course

The perspective of the life course has been institutionalised against the backdrop of human biological development (Kohli, 2023) with a division into periods: caregiving (early human development), education, active work, and retirement.

Several types of social policies have been identified, which concern social issues of population groups by age: addressed to children, youth, young adults and older adults, and seniors. The extraction of phases (stages) during life, based on the psychophysical development of a person, generally aligns with the public tasks required at various stages of human life. It can be proven that the welfare state influences the course of life through a differentiated approach to subsequent life stages and by modelling transitions between them (Kohli, 2023).

Life course epidemiology was developed (Wagner et al., 2024), demonstrating that the effects of poor living conditions and lack of healthcare accumulate over a lifetime. Relevant specialities emerged in the medical sciences, such as paediatrics, family medicine, and geriatrics.

The differences observed around the world in the occurrence of various stages of life and the social policies addressed to them reflect the influence of specific natural, cultural, and institutional factors that organise the education system, labour market, and social security. However, this does not change the universal concept.

Social policy aimed at children, taking health into account, includes the living conditions of the mother during pregnancy, the living and family situation in the early period of the child's life, and the quality of care in childhood. The unfavourable influence of living, behavioural, and environmental factors occurring in the early stages of life affects the emergence of diseases in later stages, such as late adulthood and old age. The explanation of this phenomenon is based on hypotheses about many different causes, the occurrence of which may take place even during the prenatal period.

Another theory emphasises what is called the **critical phases of the life course**. In addition to the earliest period, attention is drawn to the **adolescent period**. Adolescence and the social demands associated with reaching adulthood led to educational problems and health risks. In recent decades, social policy has begun to pay more attention to children and youth[12], along with specific health disorders related to the earlier onset of biological maturation and the intensification of behaviours harmful to health, including the use of new psychoactive substances (the so-called "legal highs") and drugs, the practice of non-medical body modification, the use of diets that disrupt food intake, addiction to social media and computer games, or various forms of gambling[13]. During the COVID-19 pandemic, mental disorders among young people intensified due to isolation and the introduction of remote education.

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[12] Many longitudinal studies have already been conducted around the world, allowing for the observation of phenomena in the same cohort of the population. The United Kingdom leads in these studies. Since 1985, international cross-sectional studies (HBSC) of 15-year-olds have been organised, to which Poland joined in 1990.

[13] The beginning of the accumulation of health threats during adolescence, if not interrupted later in life, becomes a dominant cause of the development of the most serious chronic diseases (cardiovascular, cancers, respiratory, and metabolic diseases) in the future.

On the road to adulthood, there is a stage referred to as **emerging adulthood** (Halfon et al., 2018). It is also characterised as critical due to the uncertainty of the future in both personal and social terms. In response to the sensitivity of young people to the massive changes they are undergoing, for which they were not adequately prepared, there has arisen a need to create new types of interventions and social support. In traditional public policies, there were programmes supporting entry into the labour market, situated either in the education sector or within the responsibilities of employers, but also in the system of special schools, if there were serious health problems and risky behaviours.

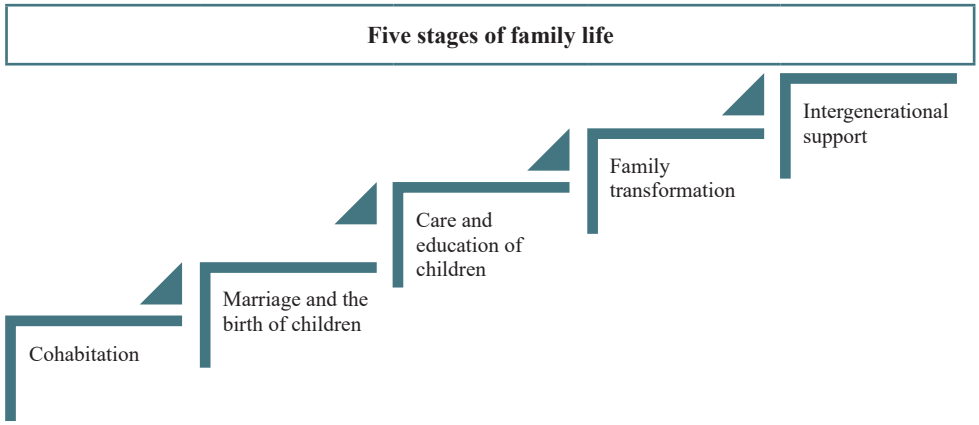
The phase of adulthood is most often defined by a person's ability to function in society and to fulfil the expected social roles associated with this stage of life, linked to the five golden events, also known as the big five. They are: completing education, starting regular work, leaving the family home, entering a relationship, and the birth of offspring (Settersten, 2007).

The adult phase, which is a time for starting one's own family, is the axis of a distinct **family policy**. However, family policy is not a field that has been developed only recently. It was formulated in the 19th century; however, it was based on a different model of family functioning, namely, the model of a single breadwinner family. The state's tasks were limited to income support and protection of the breadwinner of the family under the labour law when children arrived.

Currently, over a century later, the tasks of the state's family policy are more complex. They are based on a different model of the family, which is the employment of both partners and in the context of the changing structure of families in terms of formation (Daly et al., 2023; Bahle, 2023).

The diagram below illustrates the typical stages of family development in Western culture.

Figure 4. Five stages of family life



Source: Daly (2023, 15).

As a result of the dynamic demographic changes of the post-war decades (from the baby boom phase to the 21st century), characterised by a systematic decline in fertility, the state's family policy has included goals related to halting this decline. The considerations and actions encompassed the connections between three issues: women's employment, the family model, and the type of welfare state institutions.

Family policy that would simultaneously respect the equal rights of women and men in the labour market as a dimension of generally accepted gender equality in the public sphere, as well as partnership in the family (in the private sphere), with investment in the development of pro-family welfare state institutions, despite declarations and promotions (especially in European countries), are still difficult to achieve in practice. The problem is the denial of causal relationships between changes in each of the three mentioned areas. Therefore, the social policy of many countries around the world (including Poland) implements what is referred to as conservative family policy that goes against the rights and aspirations of women and is accompanied by limited development of health and social services related to childcare, allowing parents to balance their professional activities with family life.

The next phase in the life course – **late adulthood** – does not arouse significant interest in public policy, including social policy. Nevertheless, in this phase, problems related to social limitations arise, e.g., the inability of previously acquired professional skills to keep pace with the needs of the modern labour market, both in new technologies and work organisation. The institutions designated for continuing education often lack the support in appropriate regulations and sufficiently effective actions. In this area, numerous private training and education organisations operate; however, they respond more to the targeted demand of the strongest employers than to the needs of employees adjusted to their potential and life circumstances.

Interest in health issues in late adulthood is sometimes publicly stimulated through voluntary participation in public health (e.g., screening) programmes[14]. Participation in voluntary screening programmes is generally low. This does not bode well for the effectiveness of the prevention of dominant chronic diseases, especially in critical periods of life. It provides access to preventive examinations only for those individuals who are characterised by what is called health literacy.

Demographic changes involving the accelerated process of population ageing have directed social policy attention to the situation of **older people**. The first institutional problem was determining the age that could be considered the beginning of old age. In social policy, this boundary is usually associated with the moment of **retirement**. In northern welfare countries, the period of professional activity in the labour market is generally subject to systematic extension, while in others, it is significantly more difficult[15].

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[14] In Poland, there is a programme called "Prevention 40 Plus", which allows for free screening tests and will be extended to the entire adult population starting from the age of 20 in 2025.

[15] In Poland, we have a situation that significantly deviates from the trends observed in other welfare state countries. Two characteristics have influenced this: (a) the disregard for equality in the period of professional deactivation by gender (women can retire 5 years earlier; at the age of 60, while men at age 65), b) the withdrawal from the phased programme of raising the retirement age for both genders to 67 years.

The shifting of employees' rights to the so-called state of rest (de facto setting an institutional boundary for old age) has resulted in traditional social policy losing interest in health during old age, focusing instead on combating poverty. The proposed slogan of **healthy ageing** (Behr et al., 2023) has become a subject of attention primarily in public health, formulated in WHO programmes (Rudnicka et al., 2020).

As part of national social policies, the so-called **senior policy** was formulated. Its hallmark was emphasising activity as a continuation of the existing course of life. First, extending professional work, and if not, engaging in social-cultural and sports-recreational activities in the local environment (European Union, 2022).

The extraction of senior policy in Poland was more of an expression of the "victory" of a politically significant group of the population (a growing electorate) that has the strength and assets to ensure its well-being in the period of an "early" old age[16].

Senior policy brings undeniable benefits primarily to groups that are more active after retirement, relatively younger and aware of the health needs of an ageing organism. As part of the senior policy, the task of addressing the issue of long-term care in the final stage of a person's life is not being undertaken for now. In Poland, the burden of long-term care is mainly borne by families. Some individuals rely on social assistance facilities or private centres when they do not have the necessary resources. In the absence of a universal long-term care system, dependent old age becomes a dramatic period.

Meanwhile, in welfare countries, interest in social policy regarding the issues of elderly people has increased due to their progressing dependence as life expectancy continues to rise, making care and nursing services necessary (Comas-Herrera et al., 2025). In several countries around the world, long-term care systems have been established as part of social insurance (Germany, Japan, South Korea, the Netherlands) (Rothgang et al., 2021).

3.2. Settings

Another theoretical approach to integrating social and health issues, compared to the life course approach, as reflected in social policy and health care practice, is the concern for health in everyday living environments. The concept of health in settings where people spend their daily lives was articulated in texts written in connection with the preparation of the Ottawa Charter, justifying the concept of health promotion. It is written there that "Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (WHO, 1986).

A healthy setting for daily living has become the subject of analyses and public health programmes (Tyszko, 2024). As part of this approach, research is being conducted to determine and control the conditions of daily life in terms of health, to what extent these conditions are safe and not harmful to health. These actions include cities, villages, and other local places, homes, workplaces, schools, universities, cultural and entertainment venues, hospitals, care facilities, prisons, etc. Health in places of

[16] For the agricultural population, ideas for creating what is called care farms in the countryside have been formulated (Wojciechowska-Solis et al., 2023).

residence is the main approach in health promotion (WHO, 1998; Paton et al., 2005).

The history of research and interventions related to health threats in settings began during the times of intense industrialisation. It encompassed factories and workers' homes, leading to the development primarily of **occupational medicine** and the institutionalisation of activities termed **occupational safety and health** (OSH). Over time, other health-related specialities emerged in healthcare settings, such as school hygiene, road safety, health protection in agriculture, and military medicine. Within the framework of the WHO, definitions and standards have been developed for places recognised as healthy (WHO, 1998). At the same time, it was established that poor living conditions exert a negative impact on health when:

- they occur for a long time (time factor);
- the quality of the place in terms of physical aspects is dangerous to health, as the place and objects are made of harmful materials, the space is limited (crowding), there is improper ventilation, no access to daylight, and no access to greenery;
- there is a lack of available places to meet biological needs: toilets, showers, and laundry facilities, and seating areas;
- there is no health-safe (with supervision of sanitary standards) and economically accessible places to eat meals outside home;
- there is no safety on the roads[17]: sidewalks and pedestrian crossings, when speed limits are not respected and when the quality of motor vehicle transport is insufficient.

Safety and health standards of settings have been incorporated into building law regulations in the areas of residential and public utility construction, sanitary equipment in educational and care facilities, road safety, and working conditions subject to labour law.

In the case of the workplace, health and social issues are particularly interconnected and are fundamentally important in a person's life, as they last the longest. The analyses and regulations encompass both the conditions and the effort (load) of work adjusted to age, gender, and work ability, as well as the methods of managing work, and the relationships between supervisors and employees, as well as among employees. Phenomena such as bullying, mobbing, staffing, sexual harassment, and violence currently pose as frequent threats to psychosomatic health, as workplace accidents and the occurrence of occupational diseases. These issues are being studied and analysed within the framework of established occupational medicine, which contributes its findings to occupational safety and health regulations (OSH).

In a young market economy (such as the Polish economy), the enforcement of legal regulations in the field of working conditions and relations is not a strong point of the functioning quality. This is facilitated by the general approval for deregulation, which has gained strength in the neoliberal trend of market system development.

[17] The National Road Safety Programme in Poland was developed only in 2013.

4. Final considerations (discussion) and conclusions

In the institutional (regulatory, administrative, and financial) sphere of the welfare state, we are dealing with the separation of social questions and health.

In each of the two fields, there are additional divisions. In healthcare, on one hand, we deal with a separate area of health concern (health promotion and prevention), and on the other hand, with the area of disease treatment (medicine). Medical treatment, in turn, is subject to an increasingly deeper division into specialisations. Appealing for a holistic approach is highly ineffective and does not change separatist tendencies.

In the area of social policy, we have problems that are positioned separately within the disciplines of social sciences (economics, law, sociology, social psychology, and political science). Additionally, institutional divisions are used in sectoral, territorial (national, regional, local) structures, in state administration (ministries in governments), as well as according to political directions, which can differentiate separate systems of social values and represent distinct goals and interests. In the real sphere, the relationships and dependencies between social situations and health conditions, which also consider the perspective of consequences (over time), are so numerous and complex that their systemic and holistic grasp hinders and even prevents the effectiveness of public interventions undertaken. As a result, segmental actions burdened with the resignation from providing people with achievable goods are more effective.

Overall, in a situation of increasing tendencies to divide and simultaneously technological possibilities to deepen research in selected areas, a combined approach is an action "against the current". To overcome this, what would be needed are broad cognitive horizons and acceptance of collaborative connections. In addition, it is necessary to create appropriate institutional tools that enable the management of separately functioning areas of social and health affairs. The literature on this topic indicates three types of integration methods in public management: integration, coordination, and the so-called networking (a network of contacts and cooperation) (Bache & Flindres, 2004; Osborne, 2010; Golinowska & Tambor, 2020).

Integration means the functioning of one institution for both types of matters. For instance, one ministry at the government level, such as social and health policy, or at the local government level, similarly – one department.

Coordination is based on formalised cooperation between separately managed social and health institutions. At the governmental level, many countries then establish an additional institution for coordinating both fields (Golinowska et al., 2024).

Networking organisations are voluntary institutions that come together to cooperate in the framework of periodic ventures (joint ventures). They are often motivated to cooperate by creating extra public funds (at the international, national, and local levels) that finance multidisciplinary projects. Social networks complement formal institutions, and in social and health issues, they are an essential element of the social convoy theory (Tobiasz-Adamczyk, 2024). Social networks are rated positively because they create social capital (Lin, 2001). One could argue that they are building bridging institutional capital, analogous to bridging social capital in Robert Putnam's concept (Putnam, 2000).

The most effective and democratic methods seem to be coordination tools. However, one of the persistent institutional problems, even in wealthy Northern countries with developed welfare state institutions, is the deficiencies in coordination according to the principles of good public governance. In practice, we are dealing with "silos" and tendencies to reinforce them, and even to further fragment them. One of the reasons is the functioning of the political sphere, which favours the division of spoils (appointing positions according to merits in winning elections).

Other coordination difficulties are also significant. These include the organisation of public life in vulnerable institutional structures: without the establishment of lasting rules, bridging social capital, or appropriate qualifications among those in management.

The challenges of contemporary times, requiring innovative, effective, and global actions, indicate an urgent need to develop multidisciplinary approaches and cooperation among various activities in their real conditions and many contexts. An example is the development of activities within the life sciences. We have a multidisciplinary approach here, encompassing biological, medical, and technical sciences as well as sectoral partnerships (private and public) for practical actions in the field of new technologies applied in diagnostics and personalised medicine.

An important, if not the most important, foundation of effective coordination within the principles of good governance is **the proper organisation of scientific institutions**. Meanwhile, both social policy and health issues are often placed in an inadequate or random manner, devastating the meaning and development of both fields. For example, social policy in Poland has been integrated into political science, focusing on the study of the "struggle for power" toolkit, offering social programmes to candidate parties, investigating their support, and forecasting winners.

Health policy and public health have been incorporated into what is known as health sciences, which focus on preparing personnel for practical skills in allied medical professions: nursing, midwifery, physiotherapy, and emergency medical services, pushing aside the issues of public health and the systemic formulation of health policy tasks[18]. On the other hand, public health is the science of the conditions for healthy living of people in their dynamically changing natural and social environment. The practical dimension of public health is, therefore, related to shaping the environment and behaviours within that environment. This is a different area of issues than those covered in academically organised health sciences.

[18] This solution was proposed by Lesław Nieborój, a bioethicist; a graduate of the Pontifical Academy of Theology in Kraków and subsequently an academic teacher at the Silesian School of Health Sciences (Nieborój, 2014).

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