

Utilization of non-medical healing methods as a way of coping with life difficulties in the socially deprived 'losers' of the systemic transformation processes in Poland

Włodzimierz Piątkowski^{1,3}, Michał Skrzypek^{2,3}

¹ Department of Medical Sociology and Family, Institute of Sociology, Maria Curie-Skłodowska University, Lublin, Poland

² Department of Sociology of Ethnic Groups and Civil Society, Institute of Sociology, John Paul II Catholic University of Lublin, Lublin, Poland

³ Independent Medical Sociology Unit, Medical University, Lublin, Poland

Piåtkowski W, Skrzypek M. Utilization of non-medical healing methods as a way of coping with life difficulties in the socially deprived 'losers' of the systemic transformation processes in Poland. *Ann Agric Environ Med*. 2012; 19(1): 147-157.

Abstract

Introduction and Objectives. One of the features of systemic transformation are its social costs. This is also the case with the Polish transformation initiated in 1989. Social processes connected with it are a kind of accelerator which increases the range of health needs realized outside the medical system. Utilization of non-medical healing methods may also be perceived as a way of coping with negative, i.e. sociopsychological consequences of transformation, including the fact that many people's health needs were not met within institutional medicine. Such a situation results in a deepening of social inequalities in health. This problem will be presented from the perspective of 'ordinary people' in accordance with the leading research directive in medical sociology. Following the directives of humanistic sociology, the sources of information on the subject were personal documents.

Materials and Methods. The paper presents selected results of the sociological qualitative analysis of 1,311 letters received by the editorial section of public Polish Television's Channel Two in 1991 in connection with the broadcasting of a series of programmes conducted by the unconventional therapist Anatoly M. Kashpirovsky, who had a viewership of eight to nine million, on average. The presented and commented-on material consists of spectators' statements on the adverse consequences of the systemic transformation, concerning health and illness.

Results. The post-1989 political-system transformation is the most thorough-going social change in post-war Poland. It triggered off a number of both positive and negative processes. The negative ones include the deepening of social inequalities in health as a result of, inter alia, the progressive pauperization of society and also the growing utilization of non-medical healing methods. The negative effects of transformations are especially felt by typical 'clients' of Anatoly M. Kashpirovsky: poorly educated, indigent, residents of villages and small Polish towns: 'the transformation process losers'.

Conclusions. Systematic sociological knowledge on the ways of description and interpretation of health and illness by 'lay people' enables a more complete understanding of phenomena related to inequalities in health, including their social and structural causes.

Key words

medical sociology, socioeconomic factors, health inequalities/disparities, complementary therapies, social justice

INTRODUCTION

The problems of systemic transformations in Poland, the logic of the accompanying changes, sociological theoretical models explaining the mechanism of social change or interpretation of its various results, were the subject of systematic studies carried out by Polish general sociologists, including Jadwiga Staniszkis [1], Piotr Sztompka [2], Henryk Domański and Andrzej Rychard [3], Edmund Wnuk-Lipiński [4], and others. In view of the structure and objective of further analyses it should be emphasized that those studying

the process of systemic transformation in Poland point out that it also applies to the area of health and illness, and to the functioning of the medical system [5].

A negative result of the Polish systemic transformation is the progressive economic polarization and pauperization of society, carrying with it deepened and consolidated health inequalities. It is common knowledge that societies characterized by more evenly distributed economic resources and greater social cohesion (higher indices of social capital and solidarity) are marked by lower health inequalities and, moreover, by better general health, compared with communities where social inequalities are more pronounced [6].

Address for correspondence: Włodzimierz Piątkowski Samodzielna Pracownia Socjologii Medycyny, Uniwersytet Medyczny w Lublinie, Szkolna 18, room 303-304, 20-950 Lublin, Poland
E-mail: piatk@bg.umlub.pl

Received: 10 January 2012; accepted: 16 March 2012



Social Costs of Polish Transformation as Described in Sociological Investigations

Sociological investigations of transformation processes showed comparatively early that one of the essential traits of such phenomena are their social costs. They were sometimes treated as a marginal phenomenon and a kind of necessary though undesirable side-effect, or as an immanent, significant feature of the 'Polish imperfect model of political-system changes'. Commentators and interpreters of transformation changes presented varied opinions on the scale, character and causes of the accompanying phenomena which were described as 'pathological or dysfunctional' [7]. The causes of the problems were sought both in the speed, radicalism and scale of the transformation, as well as in the backwardness and neglect under the previous system. A symbol of the negative outcome of transformations was many groups of the excluded, marginalized and isolated Poles who felt a sense of multidimensional deprivation [8]. It was pointed out that this group of people were no longer 'a marginal underclass' because its numbers continue to grow, while poverty and passivity increasingly often tend to be inherited and deeply rooted. These phenomena are particularly shocking and painful when they concern children and young people, both in large cities and in the rural areas and small towns [9]. The questions were then asked, with the simultaneous awareness of the social significance of the problems studied, whether for example, the excluded (for various reasons) rural areas or old industrial regions and members of local communities should have to pay 'the inevitable transformation costs', or whether this burden could at least be reduced? It appears that the opinion is slowly beginning to prevail that the scale and intensity of pathological phenomena stem from specific mistakes of transformation policies, rather than from the objective logic of necessary but painful systemic changes. As a result, criticism was leveled more and more often not only at the direction but also the pace and range of reforms. In the early second decade of investigations on the transformation, the studies described the emerging 'system pathologies', including scandals involving business, the media and politics, which revealed the superficial character of Polish democracy, the scale and impunity of corruption taking place at various levels of power, the hidden symbiosis between 'political and economic elites', and pathologies in privatization processes, etc. Some social scholars turned to analyzing the phenomena of clientelism and economic nepotism, and to identifying the network of connections and relations. A separate factor which speeds up social inequalities accompanying the 'great change', according to some authors, is the progressive 'paralysis of the State and weakness of its institutions'. Obviously, social diagnoses stemming from sociological studies were not, as a rule, known to the part of society known as 'transformation losers', although it should be stressed that it is owing to the 'anti-system opposition' and the growing role of Internet communication that the awareness of being abandoned and deprived of opportunities, of the selfishness of 'political-economic elites', and of the reduction of State functions (especially in assistance and social welfare) seems to have reached the increasingly large masses of so-called 'ordinary people'.

Social Determinants of Inequalities in Health and Illness: An Outline of the Problems from the Perspective of Sociology of Health, Healing, Illness and Medicine

The problems of social inequalities in health have been treated as one of the key research themes in the sociology of health, healing, illness and medicine since at least the mid-twentieth century [10]. The high importance of these issues in medical sociology is evidenced by one of the more recent attempts to systematize the subject of sociomedical research, made by L. Pearlin, in whose opinion 'structure seekers' (studying the links of social structure and health/illness) were one of the two largest research groups among medical sociologists already in the early 1990s [11]. Sociological studies on social inequalities in health emphasize the social, cultural and behavioural factors which account for the development of 'distances' [in respect of health condition] between individual social groups [11, 12]. As part of this analytical approach, the role of the fundamental cause of social inequalities in health [13] is ascribed to the socioeconomic status (SES) measured in terms of income, level of education and profession/occupation, which is treated as the operational index of the individual's position in the social structure [14]. In W. C. Cockerham's opinion, the socioeconomic status is 'one of the strongest and most consistent predictors of a person's health and life expectancy' in all regions of the world [15]. In light of the current knowledge, one's position in the social structure highly differentiates individuals and social groups in terms of morbidity and mortality rates. Elements of social structure with a low socioeconomic status (classes and strata) run a greater risk of death, both from cardiovascular disease and from all other causes of mortality [16]. The risk of chronic disease and premature death in persons of low socioeconomic status is at least twice as high as the risk level in well-off persons [17]. As a result, there is a markedly strong relationship between the low socioeconomic status and a shorter life expectancy, this difference between persons in the extreme segments of social structure being 4-10 years [18].

Sociological interpretations of social inequalities in health point out that the socioeconomic status determines the degree of exposure to most health risk factors, including behavioural, mental and environmental; moreover, it strongly influences the availability of resources enabling the preservation of health. This applies, inter alia, to financial resources, knowledge of health and ways of protecting it, the amount and quality of social ties, access to medical care, etc. [19, 20]. These types of approaches to the phenomenon in question emphasize the importance of the broad, sociocultural context of individuals' and social groups' life as the starting (distal) cause of health, which is associated with the origin of civilization diseases, including coronary artery disease, inter alia, through individual health behaviours. In this interpretation, they are placed in the context of complex and multi-directional effects associated with the individual's position in the social structure, and with culture (with reference to this issue, inter alia, Phelan et al. write about 'the contextualization of risk factors' [20]). These influences determine both real (greater or smaller) opportunities of the individual's own actions concerning health and the subjective significance attributed to health and illness by 'ordinary' people, which are the starting point for behaviours in health and illness. More recent analytical interpretations which explain the origin of social inequalities



in health from the perspective of a life-cycle approach, point to the possibility of accumulation of adverse socioeconomic circumstances in phases of the human life cycle from the earliest stages of ontogenesis [21, 22]. The growing amount of evidence pointing to early-childhood beginnings of chronic diseases (in particular, coronary artery disease) [23] justifies revision of the previously accepted views on the overcoming of social inequalities in health, for example, by supplementing them with actions oriented towards children and teenagers living in the areas of poverty and social deprivation, and towards their families.

The great importance of the problems of social inequalities in health is conclusively emphasized by the European studies data showing the scale of the phenomenon. The studies conducted under the *European Community Household Panel* (ECHP-UDB) in the European Union countries in 1994-2001 demonstrated that persons and groups of high socioeconomic status were in a privileged position regarding their health in each European society [24]. Likewise, the analyses by O. van dem Knesebeck et al., covering 22 countries and conducted under the *European Health Survey* of 2003, showed that the level of education was an important predictor of functional limitations and low self-assessment of health [25]. The problem in question is reflected in the official European Union documents. Take for example the record of the 4 March 2008 note of the EU Council for Employment, Social Policy, Health and Consumer Affairs which reported that:

'despite overall improvements in health there remain striking differences in health outcomes not only across Member States but also within each country between different sections of the population according to socioeconomic status, place of residence and ethnic group, and gender. On average, people with lower levels of education, wealth or occupational status have shorter lives and suffer more often from disease and illness than more well-off groups and these gaps are not declining. Income inequality, poverty, unemployment, stress, poor working conditions and housing are important determinants of health inequalities /.../' [26].

In the context of this necessarily limited and selective analysis of the state of sociological research on social inequalities in health we should note that students of the problem are now focusing less on documenting them (this issue has been exhaustively studied [see for example 27]), and their interests shift towards designing practical solutions to this principal problem of public health (especially in Poland). When discussing this question, A. Ostrowska, a leading representative of Polish medical sociology, observed that '*attempts to reduce social inequalities in health must first of all focus on the sources of social inequalities which consequently lead to health inequalities [...]*' [12]. Western scholars also agree that striving to reduce social inequalities in health is the duty of both scientists/academics, including sociologists (conducting research, expert analyses, reports for institutions that plan and implement social policies) and the principal task which society expects the government to implement [28]. Attempts to reduce social inequalities in health have become a priority in the activities of many EU governments, although coherent strategies for action in this area have not yet been developed. Observe that various European countries use different approaches in combating social inequalities in health: these are oriented, for example, towards occupational protection of the chronically ill (Sweden), access to healthy foods through mass catering in schools (Finland), combating

smoking among women of low socioeconomic status (UK), or towards improving the quality of medical care offered to persons with a low SES (Netherlands) [29]. It should be emphasized that these strategies are oriented towards different elements of the complex chain of psychosocial factors leading to health inequalities.

The phenomenon in question is also a priority in the work of a number of specialized international organization agencies such as the UN, UNESCO or WHO. For example, in 2004, the World Health Assembly appointed the *Commission on Social Determinants of Health*. The Commission started its operation in 2005, which consisted in documenting social inequalities in health and planning social policy actions oriented towards social determinants of health [27, 30].

The problems of social inequalities in health are currently at the top of the research priority list of the European sociology of health, illness and medicine. This was one of the main themes of scientific debates during four consecutive congresses of the European Society for Health and Medical Sociology (ESHMS) in Cracow (2006), Oslo (2008), Ghent (2010), and Hanover (2012). We should be reminded that social scientists' interest in these problems accelerated the publication of (making it more in-depth) the famous *Black Report* in the UK in 1980, which documented differences in the majority of health indicators between social classes in British society, having at the same time proposed a multi-aspectual interpretation the phenomenon, which then became the subject of many follow-up studies. The issue of social inequalities in health has also a long tradition in Polish medical sociology. The initiator of this research trend was the founder of medical sociology in Poland, Professor Magdalena Sokołowska who, shortly after the publication of *The Black Report*, gave high priority to research on social inequalities in health, in particular to studies on the search for sociobiological mechanisms responsible for the relationships between social structure and health [31]. This research subject, however, was not systematically continued in the studies by Polish sociology, for example, as long-term research programmes concerning social inequalities in health and illness, correlated with social status. Observe, nevertheless, the few Polish sociomedical analyses which were successfully carried out. The author of synthetic and comprehensive approaches to the problem in question is A. Ostrowska [32, 33, 34]. She has also conducted survey studies on the relationship between social stratification and health, recently in the Warsaw population [12]. The issues of social inequalities in health in Polish medical sociology were also the subject of interest on the part of, inter alia, Zofia Słońska [35] and, in the case of coronary artery disease, Michał Skrzypek [36, 37, 38]. Some conclusions about their studies are worth close attention. Their authors agree that within the research trend in question, sufficient empirical verification confirmed the hypothesis that wealth is conducive to health, while poverty is the correlate of diseases and premature deaths; it was also proved convincingly that medicine has a comparatively lower effect on human life expectancy than the factors in the material and social environment, in particular the individual's position in the social structure. The foregoing Polish studies emphasize that social structural factors, including socioeconomic status, impact the individual's agency regarding health and determine his/her health behaviours. These studies also point out that the modification of the 'principal cause of health' is

essentially beyond the individual's reach. This has a definite effect on directives on practical action that are oriented towards the equalization or elimination of social inequalities in health. What is necessary here are multisectoral actions in the area of social policy aimed at creating environmental circumstances conducive to healthy behaviours [see inter alia 33, 35]. These propositions underlie the sociological model of health promotion based on the achievements of social sciences. The focus of attention here are on distal, sociocultural health determinants which exert influence mainly through individual health behaviours. Within this model, an important role in reducing socially determined inequalities in health is attributed to the State's policy, which has a number of health-promoting 'instruments', including fiscal and legislative, etc., [35 and many other studies by Z. Słońska]. In Polish medical sociology, the problem of social inequalities in health was also analyzed on the example of coronary artery disease: it was pointed out that the consequence of the contribution of social – including structural – factors to the etiopathogenesis of this principal civilization disease is its specific social distribution in highly developed countries, which consists in that this disease is more widespread in social groups with a low socioeconomic status. It was also emphasized, on the basis of many Western studies, that there is a continuous inverse relationship between the socioeconomic status and the rate of coronary disease risk, which means that any higher income and education level has a protective effect on the human heart [36, 37, 38].

When presenting the selected themes in the achievements of Polish medical sociology in our area of interest, we should not omit one of the latest research projects describing the social determinants of health inequalities in the population of Warsaw. It showed, inter alia, that persons living in poverty were characterized by worse indicators of subjectively assessed physical and mental health, worse indicators of declared disability, incidence of chronic diseases, living a healthy life style, and health culture [12]. These persons' relations with the medical system were also limited and disturbed. It was found that the medical needs of persons with the lowest incomes, below the objective poverty level, were satisfied to a far lesser degree than in the remaining population surveyed, while their contact with medicine 'was clearly reduced and less frequent'. Consequently, the author concluded that 'health, its accompanying behaviours and access to appropriate medical care are /.../ an element of social stratification in Poland' [12]. We will discuss in more detail the aforementioned subject of socioeconomically determined differences in the utilization of medical care services, also referring to other Polish sociomedical studies. However, we should first remember that this is one of hypotheses seeking to explain the causes of worse health in social groups of lower socioeconomic status. Analyses showed that one of more dramatic manifestations of social inequalities in health in Poland is worse access to oncological services for indigent people, which causes the period of waiting for diagnosis and therapy in this field to be literally 'deadly long'. In 2011, at the top of the waiting list for all kinds of medical procedures were patients waiting for oncological diagnostic procedures. The cause of this 'systemic' pathology is, inter alia, the fact that patients are placed on the waiting lists in general hospitals, which are not prepared to start procedures of fast oncological diagnosis. According to the Watch Health Care Foundation's

report, patients in Poland currently have difficulties with the availability of over 200 procedures formally guaranteed by the State. This leads to corrupt practices, yet the sick, and at the same time poor (and often elderly) persons, are not the giving (=bribing) side in corruption relations, because they simply 'have nothing to give' [39]. This suggestion has been confirmed by studies of medical sociologists associated with the Ministry of Health Centre for Healthcare Information Systems, who analyzed inequalities in access to medical provisions (especially those in short supply). They pointed out the corruption-generating character of waiting lists for medical procedures in short supply, and emphasized that the widespread 'queue or waiting-list system' in the Polish medical system is 'an opportunity to violate the rule of universal and equal access to healthcare' [40]. As a comment to these findings, observe that recently in the Polish realities, the State and its agencies are clearly reducing their role in the sphere which was traditionally treated as 'highly social', i.e. in healthcare: the State seems to hope to counterbalance this fact through citizens' initiative, resourcefulness and activity, and through the spontaneous action of the 'market's invisible hand'. The real goals of social policy (including health policy) in Poland are not, regrettably, consistent with the directive on reducing socioeconomic differences that hinder or prevent access to healthcare. Many things indicate that the principle of social solidarity, or even limited social justice, is no longer relevant.

We will now elaborate on the subject of healthcare disparities, being one of the adverse consequences of the Polish systemic transformation. This analysis draws attention to social factors (ethnic, socioeconomic etc.) that account for 'differences in access, healthcare quality or healthcare outcomes that are not due to clinical needs or the appropriateness of treatment' [41]. The issue is also analyzed in different contexts of highly developed countries, for example, in the USA under the research project SCF-HSD (The Socio-Cultural Framework for Health Services Disparities). For the sake of our analysis, we will look at the interpretation perspective proposed in the project. When analyzing the origin of healthcare utilization disparities, SCF-HSD investigators emphasize the intermingling of effects of lay social networks and systems of professional help in illness, and stress that both kinds of effects determine inequalities in health. Local communities are seen here as an important reservoir of health resources and, at the same time as the environment where processes occur which determine the presentation of the health problem (or not) in the context of formal medical care. The project showed that the local meanings of health and illness are 'introduced' into the field of healthcare both by its clients and formal representatives, inter alia, in such a way that the socioculturally specific modes of symptom presentation can affect the accuracy of medical diagnosis and, consequently, decide the efficacy of medical care, while the behavioural patterns in illness – learned in the socialization process – make the right interpretation of response to treatment difficult. The inadequacy of medical care resulting from these phenomena contributes to the generation and consolidation of health inequalities [41].

We will finish the survey of selected sociological research findings on health disparities with a short presentation of the investigation carried out as part of the international LEECH project covering selected EU countries (Poland, Slovenia, Latvia and Spain), which was coordinated by the



National Centre for Workplace Health Promotion in Łódź (Lodz), Poland. The part of the project titled 'Low-educated Workers and Health – A Challenge to Health Education' verified the hypothesis that a lower socioeconomic status is associated with adverse health behaviours, lower motivation for supportive health changes, and ultimately with poorer health condition [42]. The results of the Polish part of the project in question confirm again that a low educational and income level is an indicator of insufficient knowledge of health issues, improper care of one's health, and, as a result, of the worse health of persons belonging to the numerous category of low-educated and poorer workers [43]. At this point, we will proceed to the further stage of analysis in order to show the phenomenon of social inequalities in health from the perspective of 'ordinary people', based on qualitative sociological research methods

*Sociological Studies on Health and Illness
from the Perspective of 'Ordinary People'
– Specificity of Research Approach*

The analytical approach applied in this work is well-established in the tradition of non-medicocentric sociological studies, oriented towards lay people who, in the situation of living with illness based on the meanings given to it and linked with the culturally available interpretation resources, take active measures aimed at coping with illness and its multiple consequences. The beginnings of such an approach can be found in the American interactionist tradition of sociomedical studies, in which of central significance is the analytical category of work inspired by illness, realized by lay people, comprising work on the symptomatic and biomedical level of being ill, work on everyday life, as well as on one's personal biography (the two spheres being disturbed by illness) [for more, see 44]. Non-professional, lay interpretations of health and illness are of interest to the medical sociologist, first of all because they determine the subjective activities in health and illness implemented in the context of everyday life. The focus of the sociologist's attention in this approach is therefore the 'ordinary people' invested with the prerogative of agency in relation to problems of health and illness. The crucial role in the development of the sociological, lay people-oriented research approach was played by the American medical sociologist Eliot Freidson, who suggested that the problems of illness and being ill should be analyzed from a perspective independent of institutional medicine. His views became a significant inspiration and methodological directive and, at the same time, an important point of reference in studies on the ways of thinking and social activity of 'ordinary people'. A key role is played here by the early 1960s concept of the 'lay referral system', describing universal mechanisms that enable 'ordinary people' to cope comparatively effectively in illness, despite having no medical knowledge. Eliot Freidson tried to describe the processes of information exchange about health and illness, ways of mutual assistance, and utilization of lay support network (lay referral network) provided by family, neighbours, friends, colleagues, etc. The lay referral system concept allows one to understand how people agree on diagnosis, compare different items of advice on therapy, seek effective ways of maintaining health and avoiding typical diseases, and enables understanding of social mechanisms determining the patterns of utilization of professional referral networks. Freidson studied the behaviours of ordinary people

– workers employed in the Bronx area of New York – focusing attention on their subjective, private beliefs motivating their conduct in illness. Freidson's key category is the 'anatomy of decision-making': who should be entrusted with the care of my own illness (a medical professional or a lay healer?), can nothing be done while waiting for the illness to pass, or whether to treat oneself? The tendency to yield to the power and care of medicine is the higher, Freidson believes, the more the patient is identified with the doctor's professional culture. Analysis of stereotypes, emotional judgments, irrational decisions, simplified opinions and intuitive behaviours – it is this world of meanings, symbols and specific 'cultural codes' that makes up the area of 'ordinary people's' daily experiences related to health and illness. Eliot Freidson's conceptions, presented in detail in his books *Patients' Views of Medical Practice* (1961) [45] and *Profession of Medicine* (1970) [46], have inspired a number of studies in social health sciences that showed that most lay people use informal health care, and it is in this sense that the statement 'we are all health workers' is true. Eliot Freidson's theses are an original and also fundamental contribution to sociology for building a social model of being ill, pointing out that this process is largely shaped by lay influences. It is common knowledge that the symptoms of most illnesses, both in Western and non-Western societies, are not referred to professional consultants, but are consulted with other lay people who function in the role of diagnosticians and symptom interpreters as well as treatment providers. Help-seeking processes in illness are a result of a number of effects, linked with society and occurring at the micro- and microstructural levels, as well as with the cultural context of the sick person [47]. The aforementioned problems are covered by the sociomedical concept of the 'social construction of illness', the development of which was initiated and dynamized by Eliot Freidson.

In summing up the foregoing introductory remarks, we should state that the authors of the present study combine two leading trends in sociomedical research: 1) concerning the relationships between social structure and health, practiced by medical sociologists termed 'structure seekers' by L. Pearlin, and 2) focused on sociological descriptions of problems of health and illness from the non-professional perspective of 'ordinary people' and developed by 'meaning seekers' [11]. Our project is an attempt to cross the 'demarcation line' dividing the two sociomedical research groups. We are convinced that achieving the research goals of meaning-seeking sociology, i.e., in Pearlin's interpretation, getting to know the relationships between life circumstances and human agency regarding the issues of health and coping with illness, in particular the reflection on whether they strengthen or weaken this agency [11], constitutes an important, original contribution of medical sociology to health sciences, especially to the problems concerning social determinants of health. We propose that this question be analyzed using the sociological method of qualitative studies (which comprises, inter alia, analysis of personal documents, including letters). The method enables the exploration of social consequences of the Polish systemic transformation from the perspective of persons of low socioeconomic status, who were affected by its adverse effects to the highest extent. The investigation of social inequalities in health by means of qualitative research methods is also justified by the fact that subjective health indicators are increasingly often used in this research [e.g. 25]. When initiating the analyses of social

health determinants within the new section of the journal *Annals of Agricultural and Environmental Health (AAEM)*, we are also answering the suggestion of the journal's Editor-in-Chief, A. Wojtyła, who pointed out that '*social aspects of health problems have become of crucial importance*', and also observed that '*the political system in which the population lives /.../ exerts a great effect on the occurrence of differences in health*' [48].

RESEARCH OBJECTIVES

The presented study is a part of a broader empirical research project conducted in 1990-2011, aimed at building the methodological, theoretical and taxonomic foundations of 'the sociology of non-medical healing'. The main reason why the project was launched was the observation that the widespread and growing phenomenon, which is the mass utilization by Poles of therapies and techniques not accepted by academic medicine and offered by persons without formal medical training, has not yet been scientifically described or socially interpreted. Additionally, it was assumed that new phenomena and social processes connected with the systemic transformation in Poland, are a specific kind of accelerator and catalyst which increase the range of health needs realized outside the system of health services. The aim of the studies in question was to conduct a detailed and systematic analysis and interpretation of social phenomena concerning unconventional healing, and to describe it in terms of sociology of health and illness.

An integral part of this research project was its empirical section consisting in sociological qualitative and quantitative analyses of over 3,500 letters sent by viewers who systematically watched the TV sessions hosted by the unconventional therapist A.M. Kashpirovsky. The results obtained in this way enabled us to answer the question about the main reasons why the Poles utilize the offers of unconventional healers, and what are the social consequences of practicing this type of treatment (the analysis also covered potential and genuine dangers arising from the use of healing methods not recognized and criticized by academic medicine); the range of this phenomenon was also analyzed. Also laid out were the theoretical and methodological framework of future investigations [49, 50]. The results obtained constitute a sociological description of Polish society during the systemic transformation.

In the present text, the authors present a part of the above-described research project which concerns the adverse social consequences of the systemic transformation in the sphere of health and illness. The results of transformation in this area were noticed fairly early by social students of the 'great change'. In this study, we therefore focus on the negative aspects of the systemic transformation and its adverse effect on attitudes, needs, and behaviours in health and illness. We suggest that one of its adverse consequences is the growing utilization of non-medical healing methods caused by the fact that many ordinary people's health needs were not met within institutional medicine. Implementing these treatment methods may be also interpreted as a way of coping with sociopsychological costs of the Polish systemic transformation, used by people of low socioeconomic status whose range of choices regarding health behaviours is severely limited. We suggest that such a situation results in

a deepening of social inequalities in health. These problems will be shown from a 'post-Freidsonian' perspective. The adoption of this analytical perspective is necessary if we want to realize the sociological postulate of 'understanding' the views, attitudes and behaviours of a large (and growing) group of people in Polish society who, as a rule, have a low socioeconomic status, poor education and low income. This category constitutes about one quarter of the Poles. The group is often characterized by an irrational attitude towards health and illness (as documented by the aforementioned studies conducted as part of the LEECH project). The subject of analysis will therefore be the subjective view of health and illness from the perspective of lay people – medical non-professionals. The application of sociological qualitative research method enables the description of the specific 'non-presented' world, understanding of experiences, beliefs, and emotions that accompany illness and the process of being ill. Conducting social studies oriented towards understanding the phenomenon of social inequalities in health in the context of Polish socioeconomic transformation, is also important because Poland is one of those European countries characterized by a comparatively higher socioeconomic health gradient [51].

MATERIAL AND METHODS

Below are described the selected results of the content analysis of 1,311 letters received by the editorial section of Polish Television's Channel Two in 1991, following the appeal of the commentators of the unconventional therapist Anatoly M. Kashpirovsky's programme (henceforward referred to as 'teletherapy') shown in 1990-1992, and watched by an average audience of 8-9 million per session. The material obtained in 1991 was first analyzed in 2008-2009. It was characterized by similar socio-demographic features as the collection of personal documents which was the framework of the first stage of the above-described research project, the stage having culminated in a book in 1993 [49]. Among the authors of personal documents (letters) examined at that stage of the project, women were by far the predominant group, most authors being over the age of 50. The examined group of teletherapy viewers also consisted predominantly of persons with primary, basic vocational, and secondary education.

The subject of sociological analysis was excerpts from typical personal documents. Units of analysis were coherent parts of letters with dominant, clearly distinct themes. The material presented and commented on below consists of a collection of teletherapy participants' statements about assessments of the social transformation and its effects in health and illness, taking into account the issues of social inequalities in health. In accordance with the directive of qualitative sociology, the examined personal documents were treated as a '*valuable source of data about society*' [52]. A detailed description of the methodology of the research project presented here in fragmentary parts has been given elsewhere [50].



RESULTS OF STUDIES: EFFECTS OF THE SOCIOECONOMIC TRANSFORMATION FROM 'ORDINARY PEOPLE'S' PERSPECTIVE, TAKING INTO ACCOUNT INEQUALITIES IN HEALTH

From the above-mentioned collection of letters written by participants in the teletherapy conducted by A. M. Kashpirovsky, a portion was selected for presentation below. We were especially interested in three main categories of problems:

- a) financial difficulties felt by the participants in the first stage of the transformation
- b) feeling the 'trauma' of the great change (uncertainty, anxiety, threat, a sense of lack of prospects);
- c) manifestations of new thinking about socioeconomic matters (self-creative, civic, innovative, and pro-reform attitudes).

Below are presented the excerpts from the letters grouped according to the foregoing classification in their original, unchanged language with a concise sociological comment.

a) Financial Difficulties

"I the undersigned am writing to you as an old and sick woman [to ask]: are we, the sick, going to watch it or not [will the programme continue]? It is very important for us the sick because not all can go for treatment to our doctors because we don't have money to pay them all because the pension is small" (Code 112)

"We are asking you politely to broadcast TV session with Dr Kashpirovsky. We are asking you to show the programmes alive. We are waiting for such programmes for us, poor and ailing people – old age pensioners and on disability pay, living in the polluted environment." (Code 763)

"We are waiting for doctor Kashpirovsky's shows. I'm writing we are waiting because like me, many people would like to watch this. I'm a disability pensioner, a group II invalid, have the lowest disability pension, and medicines have to be paid for now. I don't have enough to pay the rent and other bills, and what about food?" (Code 101)

"I live with my family in a small town in the Zielona Góra province. People do not write much to you about Kashpirovsky and his TV sessions because they can't afford to buy stamps, they count every penny twice. We are pensioners and our pensions are very low. All our family has to live on these pensions. There are many people like us." (Code 1041)

"Now on TV they are only speaking of politics but special-care children do not have decent treatment conditions. Not every child can take advantage of Minister Jacek Kuroń's offer. Perhaps many people would give up the soup for a [Kashpirovsky] session. Money is coming to so many [charity] accounts that you can hardly count them, for example The Helping Hand. It that us, the disadvantaged families, living in poverty, usually unemployed mothers, in which the other person has been the bread-winner for

years, who should pay to the SOS account? Excuse me, but I don't understand this general mess and I don't know whom to support and what we can count on." (Code 450).

"One more sad thing, probably TV licenses fees have gone up again, for what reason, how long will that go on? Price rises from quarter to quarter year, city transport has gone up, and electricity, and insurance and so on. What should a farmer do if everything is getting cheaper [in agricultural production], we are in fear. What will happen next? We sell one liter milk at 350-599 zloty, depending on the region. And a small bottle of lemonade costs 500 – 600 zloty. My God, what times are these? And this is supposed to be Poland governed by the Solidarity – one kilogram of eggs at 3,000 zloty. And you can buy one kilo and a half of salt for it, more than a decade ago – it was 20 kilos, horror of horrors, what's going on? After all, the farmers are not to blame that the country is in crisis, those who are to blame still live in prosperity." (Code 321).

These statements show one of the typical themes which appear in the letters examined: they indicate growing financial difficulties, a growing sense of helplessness, desolation, and frustration. Most of those who wrote the letters are old people (including old-age and disability pensioners), for whom even a partial payment for medicines (as a result of the reform of the healthcare system), and the abrupt rise of their prices were the cause of real drama in their lives. During the period of high unemployment in the early 1990s, in many families, old-age and disability pensions became the only predictable source of income, even though at a low level. It should be remembered that this was the time of the Tadeusz Mazowiecki government, which tried to introduce some kind of cushion measures to ease the economic effects of Leszek Balcerowicz's 'shock therapy'. High inflation, the trauma of fast-rising unemployment, and lack of prospects prompted people to seek consolation, support and optimism in A.M. Kashpirovsky's teletherapy sessions.

b) Feeling the 'Trauma' of the Great Change

"I went down an illness when my married life broke up; I've been alone for thirteen years, bringing up my 13-year-old son. Because I have been on a sick pension for ten years on account of my condition, I and my son are in a very difficult economic situation, which has recently made me depressed and sad. I worked part-time but have just lost my job because the firm closed down. I was on the brink of complete breakdown – my ailments have become more acute and my ulcer started to give me trouble." (Code 23)

"Our society is after all so very sick and stressed. Nowadays, when there aren't enough drugs and with high prices, just let people take advantage of this opportunity and this free treatment. This won't do any harm, and may help in many cases. Let as many persons use it as they can; soon the choice of therapy will depend on people and their own will can be fulfilled." (Code 791)

"Think, though, about the vast masses of people with limited means – the young and the elderly, the suffering children! In Poland, where help is so difficult to get in all



kinds of illnesses. If this program causes just one thing – that broken-down people, depressed in our hard situation, will feel cheered up and others will feel like fighting with their addictions, it may be well worth continuing.” (Code 114)

“Well, postal charges in Poland have gone up so much over the year that not all the elderly, especially old-age pensioners and disability pensioners can afford to correspond anymore. In Russia, postal charges for a letter are negligible and it’s enough only to want and have someone to write to. We are living in the period of uncertainty of the future, everything is getting more and more expensive, inexpensive food is in short supply, we are afraid of losing our jobs.” (Code 96)

“It should be said that these TV sessions were extremely relaxing, with a positive, soothing effect on man’s mind. Our life is getting harder and harder, dull, full of stresses. An hour of relaxation once a week is a great benefit, we would be grateful for noticing these matters and meeting the needs of ordinary people.” (Code 1053)

“We are asking you kindly to resume A.M. Kashpirovsky therapy sessions, this is also my friends’ request. We would like to show great gratitude to Mr. Kashpirovsky for everything he can do for others. Thanks to him many people regained self-confidence, energy. In these hard, so stressful times we believe that a half-hour session is indispensable to maintain the right health of all of us.” (Code 1096).

Low wages, pensions and welfare benefits are not enough to ‘make ends meet’, the shortage and high prices of drugs, rising costs of energy and rents are a typical set of factors producing chronic, acute and progressive social stress, accounts of which can be found in the documents investigated. Contacts with the therapist are experienced by the audience as ‘warm, relaxing and unwinding’. They treat these sessions as a kind of remedy for everyday troubles and sorrows. Music and Kashpirovsky’s words and his timbre of voice, the TV-viewers believe, have a soothing and relaxing effect. They expect the management of Polish TV’s Channel Two to ensure the regularity of sessions, greater access to them (moving the programme to Channel One which can be received all over Poland), and above all, the viewers want to be assured that the series ‘Meetings with Dr Kashpirovsky’ will not disappear from the screens as it is the best way of coping with everyday stress, and the best method of support in these hard times.

c) Manifestations of New Thinking of Socioeconomic Issues

“If Mr. Kashpirovsky accepts the invitation, then the Polish TV should inform us about the account to which we could pay the money as his royalties, and I believe that everyone would send something, because we buy so expensive drugs, they hardly help in treatment, and for such sessions everyone would pay to a greater or lesser degree and many millions would surely be collected, from which even some small profit would be obtained.” (Code 211)

“For Chissake, do not stop broadcasting these sessions. We are waiting for them with great impatience, they cause the Polish nation to be healed, so help in this. The nation’s health is an imperative matter, and it means lower spending and costs in the budget, all this improves the present economy of our country.” (Code 395)

“If Television is unable to fund [the programme], an appeal on the screen is enough. Big money is sure to be paid into the accounts you will open.” (Code 494)

“The average Poles watch these programs, mostly the elderly, the sick, the pensioners, we have old television sets; we are happy to have some contact with the world. Many people would pay for a special service to watch Kashpirovsky’s programs. Announce it on television that those who want to watch a programme with Kashpirovsky should pay money into some account or donations, then you’d have additional benefits.” (Code 654)

“I am aware that this session programme for the Poles is expensive, but then there is nothing else but to determine at what time the sessions are effective and how many sessions will be highly effective. It would be enough to appoint a committee or for example an editor in charge to open a bank account to pay specified sums into it. If we make payments for other purposes, and also in this case subsidies for such a session will surely come in.” (Code 585)

“Dear Sirs, I am cordially asking you to introduce Kashpirovsky’s programme as a permanent item on Channel Two. Today, when treatment is accessible to the rich people exclusively, Dr Kashpirovsky is a blessing. When Balcerowicz is murdering the Polish nation, there is hope in Kashpirovsky.” (Code 34)

The authors of the letters are trying to find solutions to the daily problems in the new, formerly unknown reality, with which they cannot cope. We can observe the first manifestations of thinking in terms of capitalist economy: people start using such terms as deficit, profit, income, profitability etc. Seeing that the ‘poor’ State Television does not have funds to buy a new series of Kashpirovsky’s sessions, people suggest, for example, that a foundation, society or social organizations be set up which would collect money for funding the new therapy series. TV-viewers believe that the expenses of conducting successive sessions of unconventional psychotherapy are far lower than ‘doing nothing’, or the funding of therapies by the State for the growing numbers of people suffering from civilization diseases. The authors of the letters believe that despite the fact that television is still public, under the new system it can take its own financial initiatives (opening bank accounts, appeals for financial help, intermediation in transmission of socially important information). All these are meant to collect money to fund further sessions with the healer. Dr Kashpirovsky’s activity is treated by many authors as a widely available and effective form of therapy during hard times. One can also observe a high level of identification with the therapist and his methods. The viewers want to actively support the State Television (TVP) to be eventually rewarded by having a good, private doctor, and an effective method of treatment for ‘all diseases’ and health support.



DISCUSSION

The investigated phenomenon of the popularity of health services offered to the sick (and healthy) persons by non-physicians (non-professionals) appears to be directly or indirectly connected with the politico-economic transformation taking place in Poland. This relation has been pointed out by Antonina Ostrowska, in whose opinion *'since the 1990s, the market of services [in Poland] [...] offered by unconventional healing systems has expanded'*. She attributes the causes of this phenomenon to the growing pluralism of Polish society, which has grown more open to new options for health choices. Ostrowska also emphasizes that a major cause of the growing popularity of healers was the limited availability of conventional medical services offered under the national health insurance, which could not, for economic reasons, be fully compensated for by the utilization of private medical care, especially by people of low socioeconomic status. She is convinced that this situation has widened social inequalities in health in Poland [53].

The beginning of the operation of market economy, privatization processes, the increased economic activity of citizens, reduction of services formerly provided by State institutions exclusively (including the breaking of the monopoly of the State health service) are only some of the characteristics of the first transformation stage. The old rules, previously respected values, the well-known principles of social life have been questioned or challenged, while the new ones have not yet emerged. The phenomena of decentralization, demonopolization and deinstitutionalization have overlapped with legislative, technological and morals changes. Poland has also 'opened to the world', the Western world (it was then that the first wave of foreign tourism and economic emigration took place); on the other hand, contacts with the former Soviet Union countries (Belarus and Ukraine) have increased. Many healers and folk therapists and quacks started coming to Poland. The best-known representative of this group of migrants was the unconventional therapist A. M. Kashpirovsky.

One of the features of the Polish model of transformation, especially at its first stage, in which we are particularly interested, is the rapidly growing range of social inequalities in the principal spheres of public life, including health inequalities which became more pronounced and took hold. The so-called 'ordinary people' felt acutely and painfully that the rich and well-off had easier and speedier access to health services (especially non-standard ones) than they had. Initial hopes aroused by a market economy and democracy were unfulfilled when confronted with reality. It was also soon found that the difficulties were not temporary, but permanent. The elements of inequality and dysfunction intermingled not only with poverty, unemployment, and inefficiency of health services, but also with the feeling that the Welfare State had definitely ceased to exist. The foregoing factors may have caused, inter alia, mental disorders (due to social stress) and behaviour disorders [54]. During that period, psychologists pointed out the possibility of decline in the Poles' mental health potential as a result of the accumulating threats arising from macrostructures. It should be remembered that the psychological discomfort felt by the citizens reached the highest level in 1990-1992, i.e. during the period in which the aforementioned letters were written [55]. Disillusionment resulted not only in frustration, discouragement and apathy,

but also the will 'to take matter's into one's own hands' by confronting the difficult reality and seeking ways of solving new problems. This determined the social context of the growing popularity of non-medical healing systems in Poland in the early 1990s. In the complex socioeconomic conditions, people began to seek an inexpensive, widely available alternative to malfunctioning medicine. Under such circumstances, the offer of the public, widely available and inexpensive State Television broadcasting the sessions with the unconventional therapist, met with a favourable response. This special kind of 'psychotherapy' reached practically everyone who wished to watch it; it also coincided with social demand for convenient and practically free home therapies. The founder assured people that the teletherapy method worked fast, radically, painlessly, without risk of complications, and that in this way practically all diseases and ailments could be treated. It is therefore not surprising that according to the OBOP [Public Opinion Research Centre] survey, Kashpirovsky's sessions were watched by about 59% of adult Poles [56]. The 'A.M. Kashpirovsky phenomenon' is therefore an example of the offer type of 'the right man, in the right place, and in the right time'.

To sum it up, observe that in light of the accounts presented in the personal documents analyzed, the unconventional therapist A.M. Kashpirovsky has achieved the best results in treating sociopsychosomatic conditions (pain-related ailments, neuroses, circulatory diseases etc.) [49]. This fact points to the potential significance, in medical practice, of behavioural competences based on the knowledge of social sciences, enabling medical professionals to adequately respond to patients' non-medical problems related both to emotional and social consequences of falling ill (fear, depression, feeling under threat), and to psychosocial factors that play a role in the etiopathogenesis of health disorders, especially civilizational ones. The *American Psychosomatic Association* experts point out (as do medical sociologists) that the omission of non-medical aspects of being ill by academic medicine leads to patients choosing 'complementary and alternative medicine'. According to APA, this is a major argument for the broader incorporation of a biopsychosocial approach (which takes into consideration the social model of illness) into the curriculum of medical schools [57, see also 58]. Referring to the principal theme of our analysis, i.e. the widening social inequalities in health owing to the adverse effects of the Polish systemic transformation, it should be stressed that the psychosocial consequences of the systemic transformation manifested in the aforementioned growing psychological discomfort in Polish society in 1990-1992 [54], which we treat as the acceleration factor for using the offer of non-medical healing systems, can be also seen in terms of the mechanism intermediating between the worsened, transformation-related socioeconomic status of the Poles, and poor health. Psychosocial consequences of living in the conditions of comparative poverty (including chronic psychosocial stress), combined with financial deprivation and high health risk behaviours, are therefore perceived as significant causes of the deteriorating health condition of persons with a low socioeconomic status, and thereby as the causes of the widening social inequalities in health.



CONCLUSIONS

- The socioeconomic transformation – the most thoroughgoing and radical social change in post-war Poland – has produced a series of phenomena and processes, both positive and negative. The latter include the widening social inequalities in health.
- The negative effects of the systemic transformation in Poland have affected in particular Anatoly M. Kashpirovsky's typical 'clients': poorly educated, indigent residents of villages and small towns – losers in the process of transformation.
- The A. M. Kashpirovsky phenomenon, it appears, can be interpreted in terms of categories proposed by Eliot Freidson as an element of the lay referral system.
- The use of the methods of non-medical healing by the persons surveyed was the result of patients' unfulfilled needs (mainly sociopsychological) within institutional medicine during the period of transformation which, it appears, was one of the negative consequences of Polish transformation after 1989.

REFERENCES

1. Staniszkis J. W poszukiwaniu paradygmatu transformacji (In search of the paradigm of transformation). Warszawa: Wyd. ISP PAN, 1994 (in Polish).
2. Sztompka P. Trauma wielkiej zmiany (The trauma of great change). Warszawa: Wyd. ISP PAN, 2000 (in Polish).
3. Domański H., Rycharz A. Elementy nowego ładu (Elements of the new order). Warszawa: Wyd. IFiS PAN, 1997 (in Polish).
4. Wnuk-Lipiński E. Rozpad połowiczny. Szkice z socjologii transformacji ustrojowej (Partial disintegration. Essays in the sociology of politico-economic transformation). Warszawa: Wyd. ISP PAN, 1991 (in Polish).
5. Gumuła W. Transformacja ustrojowa (Politico-economic transformation). In: Bokszański Z. et al. (eds.). Encyklopedia socjologii (Encyclopedia of sociology). Vol. 4. Warszawa: Oficyna Naukowa, 2002: 259-267 (in Polish).
6. Shaw M, Dorling D, Smith GD. Poverty, social exclusion, and minorities. In: Marmot M, Wilkinson RG (eds.). Social determinants of health. Oxford: University Press, 2003: 211-239.
7. Kolasa-Nowak A. Zmiana systemowa w Polsce w interpretacjach socjologicznych (The systemic change in Poland in sociological interpretations). Lublin: Wyd. UMCS, 2010: 75-78 (in Polish).
8. Marody M. Między realnym socjalizmem a realną demokracją (Between real socialism and real democracy). In: Marody M (ed.). Oswajanie rzeczywistości. Między realnym socjalizmem a realną demokracją (Domestication of reality. Between real socialism and real democracy). Warszawa: ISS UW, 1996 (in Polish).
9. Warzywoda-Kruszyńska W, Grotowska-Leder J. Wielkomijska bieda w okresie transformacji (Urban poverty during the transformation). Łódź: Wyd. Inst. Socjologii UŁ, 1996 (in Polish).
10. Blaxter M. Medical sociology at the start of the new millennium. Soc Sci Med. 2000; 51: 1139-1142.
11. Pearlin L. Structure and meaning in medical sociology. J Health Soc Beh. 1992; 33: 1-9.
12. Ostrowska A. Zróżnicowanie społeczne a zdrowie. Wyniki badań warszawskich (Social stratification and health. Results of Warsaw research). Warszawa: Wyd. IPSS, Warszawa 2009 (in Polish).
13. Link BG, Phelan J. Social conditions as fundamental causes of disease. J Health Soc Beh. 1995; Extra Issue: 80-94.
14. Oakes JM, Rossi PH. The measurement of SES in health research: current practice and steps toward a new approach. Soc Sci Med. 2003; 56: 769-784.
15. Cockerham WC. Medical sociology. New Jersey: Upper Saddle River, 2004; 61-70.
16. Kaplan GA, Keil JE. Special report: socioeconomic factors and cardiovascular disease: a review of the literature. AHA Medical/Scientific Statement. Special report. Circulation 1993; 88(4): 1973-1998.
17. Wilkinson R, Marmot M (eds.). Social determinants of health. The solid facts. 2nd Edition. Centre for Urban Health, WHO Regional Office for Europe, 2008.
18. Siegrist J, Marmot M. Health inequalities and the psychosocial environment – two scientific challenges. Soc Sci Med. 2004; 58: 1463-1473.
19. Phelan J, Link BG, Diez-Roux A, Kawachi I, Levin B. "Fundamental causes" of social inequalities in mortality: a test of the theory. J Health Soc Beh. 2004; 45(3): 265-285.
20. Phelan JC, Link BG, Tehranifar P. Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. J Health Soc Beh. 2010; 51(S): S28-S40.
21. Siegrist J. Social differentials in chronic disease: what can sociological knowledge offer to explain and possibly reduce them? Soc Sci Med. 1995; 41(12): 1603-1605.
22. Adler NE, Ostrove JM. Socioeconomic status and health: what we know and what we don't. Ann N Y Acad Sci. 1999; 896: 3-15.
23. Bengtsson T, Mineau GP. Early-life effects on socioeconomic performance and mortality in later life: A full life-course approach using contemporary and historical sources. Soc Sci Med. 2009; 68: 1561-1564.
24. Hernandez-Quevedo C, Jones AM, Lopez-Nicolas A, Rice N. Socioeconomic inequalities in health: a comparative longitudinal analysis using the European Community Household Panel. Soc Sci Med. 2006; 63: 1246-1261.
25. von dem Knesebeck O, Verde PE, Dragano N. Education and health in 22 European countries. Soc Sci Med. 2006; 63: 1344-1351.
26. Joint Report on Social Protection and Social Inclusion, Council on Employment, Social Policy, Health and Consumer Affairs; Council of the European Union, Brussels, 4 March 2008; No 7274/08: 11.
27. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.
28. Robert S, House JP. Socioeconomic inequalities in health: an enduring sociological problem. In: Bird Ch, Conrad P, Fremont AM (eds.). Handbook of medical sociology. Upper Saddle River: Prentice Hall, 2000: 79-97.
29. Mackenbach JP, Bakker MJ. Tackling socioeconomic inequalities in health: analysis of European experiences. Lancet 2003; 362: 1409-1414.
30. Kelly MP, Morgan A, Bonnefoy J. et al. The social determinants of health: Developing an evidence base for political action. Final report to WHO Commission on the Social Determinants of Health, Measurement and Evidence Knowledge Network, Chile-United Kingdom, October 2007.
31. Sokołowska M. Socjologia medycyny (Medical sociology). Warszawa: PZWL, 1986 (in Polish).
32. Ostrowska A. Nierówności w sferze zdrowia (Inequalities in health). Kultura i Społeczeństwo 1998; XLII, 2: 149-162 (in Polish).
33. Ostrowska A. Styl życia a zdrowie. Z zagadnień promocji zdrowia (Lifestyle and health. Problems of health promotion). Warszawa: Wyd. IFiS PAN, 1999 (in Polish).
34. Ostrowska A. Zróżnicowanie społeczne i nierówności w zdrowiu (Social stratification and health inequalities). In: Piątkowski W (ed.). Socjologia z medycyną. W kręgu myśli naukowej Magdaleny Sokołowskiej (Sociology with medicine. In the circle of Magdalena Sokołowska's scientific thought). Warszawa: Wyd. IFiS PAN, 2010: 23-47 (in Polish).
35. Słońska Z. Rozwój i stan pojęcia „promocja zdrowia” w perspektywie socjologicznej (The development and state of the concept of 'health promotion' in the sociological perspective). In: Popielski K, Skrzypek M, Albińska E (eds.). Zdrowie i choroba w kontekście psychospołecznym (Health and illness in the psychosocial context). Lublin: Wyd. KUL, 2010: 213-225.
36. Skrzypek M. Niski status socjoekonomiczny jako społeczny czynnik ryzyka wieńcowego u progu XXI wieku (Low socioeconomic status as the social risk factor of coronary heart disease at the threshold of the 21st century). Polish J Cardiol. 2004; 6(4): 439-444 (in Polish).
37. Skrzypek M. Kardiologia behawioralna – zarys stanu wiedzy i aplikacje kliniczne w obszarze badań nad chorobą wieńcową (Behavioral cardiology – the knowledge advances outline and clinical applications in the study of the coronary artery disease). Polish J Cardiol. 2008; 10(2): 144-149 (in Polish).
38. Skrzypek M. Geneza społecznych nierówności w zdrowiu w perspektywie cyklu życia człowieka na przykładzie choroby niedokrwiennej serca (The origin of social health inequalities from the life-cycle perspective as exemplified by coronary artery disease). In: K. Popielski, M. Skrzypek, E. Albińska (eds.). Zdrowie i choroba w kontekście psychospołecznym (Health and illness in the psychosocial context), Lublin: Wyd. KUL, 2010: 245-267 (in Polish).
39. Szparkowska P. Fikcje leczenia za darmo (Illusions of free treatment). Rzeczpospolita 2011; 106 (8922): 1 (in Polish).



40. Halik J, Górecki W, Maciąg R. Problemy organizacji kolejek oczekujących na deficytowe zabiegi medyczne w Polsce i innych krajach Europy (Problems of organization of waiting lists for medical procedures in short supply in Poland and other European countries). In: Piątkowski W, Brodński A (eds.). *Zdrowie i choroba. Perspektywa socjologiczna (Health and illness. A sociological perspective)*. Tyczyn: WSSG, 2005: 255-256 (in Polish).
41. Alegria M, Pescosolido BA, Williams S, Canino G. Culture, Race/ethnicity and disparities: fleshing out the socio-cultural framework for health services disparities. In: Pescosolido BA, Martin JK, McLeod JD, Rogers A. *Handbook of the sociology of health, illness, and healing. A blueprint for the 21st century*. New York: Springer, 2011: 363-382.
42. Korzeniowska E, Puchalski K (eds.). *Nisko wykształceni pracownicy a zdrowie – wyzwania dla edukacji zdrowotnej (Low-educated employees and health – a challenge to health education)*. Łódź: Wyd. Instytutu Medycyny Pracy im. Prof. J. Nofera, 2010: 5 (in Polish).
43. Korzeniowska E. Nisko wykształceni pracownicy a zdrowie – przykład Polski (Low-educated employees and health – the example of Poland). In: Korzeniowska E, Puchalski K (eds.). *Nisko wykształceni pracownicy a zdrowie – wyzwanie dla edukacji zdrowotnej (Low-educated employees and health – a challenge to health education)*. Łódź: Wyd. Inst. Med. Pracy im. Prof. J. Nofera, 2010: 116-117 (in Polish).
44. Skrzypek M. Perspektywa chorego w socjologii choroby przewlekłej. Ujęcia teoretyczne, ich ewolucja i recepcja (The sick person's perspective in the sociology of chronic illness. Theoretical perspectives, their evolution and reception). Lublin: Wyd. KUL 2011.
45. Freidson E. Patients' views of medical practice. A study of subscribers to a prepaid medical plan in the Bronx. New York: Russel Sage Foundation 1961.
46. Freidson E. *Profession of medicine. A study of sociology of applied knowledge*. New York: Dodd, Mead Publ. 1970.
47. Sussman LK. The role of culture in definitions, interpretations, and management of illness. In: Gielen UP, Fish JM, Draguns JG (eds.). *Handbook of culture, therapy, and healing*. Mahwah, New Jersey, London: Lawrence Erlbaum Associates, 2004: 37-65.
48. Wojtyła A. Differences in health – a global problem and its various aspects. *Ann Agric Environ Med*. 2011; 18(2): 191-192.
49. Piątkowski W, Jezior J, Ohme R. Listy do Kaszpirowskiego. Spojrzenie socjologiczne (Letters to Kashpirovsky. A sociological view), Lublin: Wyd. M. Łoś, 1993: 43-52 (in Polish).
50. Piątkowski W. Lecznictwo niemedyczne w Polsce – tradycja i współczesność. Analiza zjawiska z perspektywy socjologii zdrowia i choroby (Non-medical healing systems in Poland – tradition and the present day. An analysis of the phenomenon from the perspective of health and illness). Lublin: Wyd. UMCS, 2008: 332-334 (in Polish).
51. Mackenbach JP, Stirbu I, Roskam AJR et al. Socioeconomic inequalities in health in 22 European countries. *NEJM* 2008; 358: 2468-2481.
52. Bowling A. *Research methods in health. Investigating health and health services*. 3rd edition. Open University Press, Mc Graw Hill, 2009: 447-461.
53. Ostrowska A. Zdrowie i zachowania zdrowotne Polaków na początku XXI wieku (Health and health behaviors of the Poles in the early 21st century). In: Frysztacki K, Sztompka P (eds.). *Polska początku XXI wieku: przemiany kulturowe i cywilizacyjne. (Poland in the early 21st century: cultural and civilizational transformations)* Wyd. Polska Akademia Nauk, Komitet Socjologii, Warszawa 2012: 355-366 (in Polish).
54. Brodński W. Ocena rozpowszechnienia zaburzeń psychicznych w perspektywie przemian społeczno-ekonomicznych w Polsce w latach 1990-2002 (An assessment of the spread of mental disorders in the perspective of socioeconomic changes in Poland in 1990-2002). In: Piątkowski W, Brodński W (eds.). *Zdrowie i choroba. Perspektywa socjologiczna (Health and illness. A sociological perspective)*. Tyczyn: WSSG, 2005: 185-201 (in Polish).
55. Ostrowska A. Samopoczucie psychiczne Polaków na tle Europejczyków (The Poles' subjective mental health as compared with the Europeans). In: Piątkowski W, Brodński W (eds.). *Zdrowie i choroba. Perspektywa socjologiczna (Health and illness. A sociological perspective)*, Tyczyn: WSSG, 2005: 167-183 (in Polish).
56. Komunikat z badań: "Telewizyjne spotkania z A. Kaszpirowskim" (An announcement on research of "Television meetings with Kashpirovsky"), OBOP, 03.1990 (in Polish).
57. Novack DH, Waldstein SR, Drossman DA et al. for the Professional Education Committee, American Psychosomatic Society. Designing and implementing a comprehensive, integrated, longitudinal curriculum in biopsychosocial medicine, www.psychosomatic.org
58. Piątkowski W. *Beyond medicine. Non-medical methods of treatment in Poland*. Frankfurt am Main, Berlin, New York: Peter Lang Verlag, 2012: 15-18.

