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The social dimension of health and illness, care and social support for a sick person

Społeczny wymiar zdrowia i choroby, opieki oraz wsparcia opiekuńczo-pielęgnacyjnego osoby chorej

Abstract

Introduction. Health, illness, care and social support are phenomena that can be analysed in both medical and social contexts. Both perspectives are interrelated and interdependent.

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Aim. The aim of the study is to highlight the social context of health, illness, care and social support, which complement the already existing medical perspective that neglects the influence of factors not directly related to the biological human body.
Methods and materials. The study is based on the method of reviewing Polish and international literature on social factors influencing the definitions of health and disease, determining the social effects experienced by the elderly and chronically ill, as well as determining the scope of available care and support. An analysis of available statistical data from the Central Statistical Office was also performed.
Conclusion. The situation of an ageing population calls for reforms and changes in social policy to meet the growing needs for healthcare and care support that takes into account the needs of the elderly and chronically ill. It is necessary to develop and integrate a long-term care system that provides comprehensive medical, rehabilitive, and social support for the elderly and chronically ill. A major challenge is to prepare programmes to support active ageing. Through the integration of modern technology, the development of care systems and support for community initiatives, dignified and effective care can be provided for all those in need.

Keywords: social dimension of health, care, social support, older people, seniors, long-term care.

Abstrakt

Wprowadzenie. Zdrowie, choroba, opieka oraz wsparcie opiekuńczo-pielęgnacyjne to zjawiska, które mogą być analizowane zarówno w kontekście medycznym, jak i społecznym. Obie te perspektywy są wzajemnie ze sobą powiązane i współzależne.
Cel. Celem opracowania jest zwrócenie uwagi na społeczny kontekst zdrowia, choroby, opieki i wsparcia społecznego, które dopełniają już istniejącą perspektywę medyczną, pomijającą wpływ czynników niezwiązanych bezpośrednio z biologicznym ciałem człowieka.
Metody i materiały. W opracowaniu wykorzystano metodę przeglądu literatury polskiej i światowej na temat czynników społecznych mających wpływ na określenie zdrowia i choroby, skutków społecznych, jakich doświadcza osoba starsza i chora, a także wymiaru opieki i wsparcia. Dokonano również analizy dostępnych danych statystycznych GUS.
Wnioski. Sytuacja starzejącego się społeczeństwa wymaga reform i zmian w polityce społecznej, aby sprostać rosnącym potrzebom opieki zdrowotnej i wsparcia opiekuńczo-pielęgnacyjnego uwzględniającego potrzeby osób starszych i przewlekle chorych. Konieczne jest rozwinięcie i zintegrowanie systemu opieki długoterminowej, aby zapewnić kompleksowe wsparcie medyczne, rehabilitacyjne i społeczne dla osób starszych i przewlekle chorych. Poważnym wyzwaniem jest przygotowanie progra-

mów wspierających aktywne starzenie się. Dzięki wykorzystaniu nowoczesnych technologii, rozwoju systemów opieki oraz wsparcia dla inicjatyw społecznych można zapewnić godną i efektywną opiekę dla wszystkich potrzebujących.

Słowa kluczowe: społeczny wymiar zdrowia, opieka, wsparcie społeczne, osoby starsze, seniorzy, opieka długoterminowa.

Introduction

Health, illness, care, and care support are phenomena that can be analysed in both a medical and a social context. Both perspectives are interrelated and interdependent.

Health is a multidimensional concept, the definitions of which stem from various social, cultural and historical contexts. One contemporary sociologist even writes that “what is healthy and normal depends on culture” (Giddens, 2007, p. 176). Nowadays, according to the WHO, health is defined not only as the absence of disease but as a state of complete physical, mental, and social well-being (World Health Organization, 1948). The concept of health emphasises the importance of non-biological factors and shows that it is subject to sociocultural influences and varies depending on the historical, cultural and economic context. Disease is also not only a biological but also a social phenomenon, as its experience, understanding and treatment are shaped by the norms and values of a given society, which has a crucial role in establishing norms and values regarding health and disease. Changing health standards are the result of a process involving various social groups, institutions and value systems, as well as people’s experiences.

In this study, the authors will pay more attention to the elements of the social context of the indicated phenomena, which complement the already existing medical perspective that generally ignores the impact of factors not directly related to the human body. Factors that can negatively affect health and general well-being in a social context include economic situation (poverty), level of education or lower social class, access to medical care, place of residence, as well as gender (female) and age.

Historical overview of health and illness – theoretical context

Every historical era in Europe had its characteristic diseases that instilled fear and terror in societies and affected everyday life. The same factors shaped the understanding of health (Vigarello, 2011). In the Middle Ages, the belief that illness was God's punishment for sins was dominant. Health was perceived as a state of harmony with God's order, and disease was evidence of its violation. Treatment often consisted of religious practices: prayers, pilgrimages and penitential rituals. The most dangerous disease of the period was the plague, which decimated the population of Europe in the 14th century, claiming the lives of millions of people.

The Renaissance brought changes in the perception of health and disease, related to medical and scientific discoveries. Human anatomy began to be studied, which allowed for a better understanding of the functioning of the body. Health was perceived as the result of a balance between different fluids in the body (humoral theory), and disease as a result of an imbalance. Treatment included practices such as bloodletting, the use of herbs and diets. The disease that caused the greatest fear in society at the time was syphilis, which appeared in Europe at the end of the 15th century.

In the 17th and 18th centuries, under the influence of the Enlightenment scientific revolution, a mechanistic approach to the body developed, according to which it was perceived as a machine whose functioning could be understood by studying its parts and mechanisms. Health was defined as the proper functioning of this machine, and disease was the result of failure or dysfunction of its individual components. Treatment focused on repairing these mechanisms.

In the 19th century, clinical medicine was born, emphasising empirical research, and patient observation. Health could be measured and assessed using objective methods, and disease indicated a deviation from the norm. Treatment involved increasingly specialised medical and pharmacological procedures. In the 19th century, Europe experienced several cholera pandemics, and at the beginning of the 20th century, the influenza pandemic known as the Spanish flu killed around 50 million people. Partly as a consequence of these experiences, the 20th century saw the development of preventive and social medicine, which was associated with a greater understanding of the role of social and environmental factors. Public health programmes, vaccinations, hygiene and health education became key elements of health strategies. From then on, health began to be seen as the result not only of medical interventions but also of social and political measures aimed at improving living conditions.

In the 21st century, the SARS-CoV-2 pandemic dominated the world, causing a global health, social and economic crisis. For more than two years, societies struggled with the new virus, which caused serious health problems and forced the introduction of strict control measures such as lockdowns and quarantines.

Regardless of the experiences with infectious diseases, the real epidemic of the 20th century was cancer. It became the dominant health problem of the last century. Lifestyle changes, industrialisation and environmental factors, as well as diagnostic possibilities, contributed to an increase in the incidence of various types of cancer. They have become a cultural metaphor for modern diseases.

Now, in the post-industrial era, chronic diseases such as diabetes and heart disease are becoming increasingly prevalent, reflecting changes in lifestyle and the demographic structure of ageing societies. A new category of diseases has also emerged, which are no longer infections that are a metaphor for contact with social and biological "strangers" (with viruses and bacteria from outside the body, which the immune system has to fight, but also – in a social sense – migrants and refugees), but conditions called "excess positivity" diseases, which come from the neuronal system, i.e., from inside the body (from within society). These include depression, burnout and autoimmune diseases (Han, 2022).

Regardless of the historical evolution and cultural diversity of the understanding of health and disease, the modern approach to them is strongly rooted in the social context. Definitions of health and disease have evolved over the centuries, but they still depend on the social perception of these phenomena. Traditional medicine has focused on identifying and treating diseases, while health has often been defined negatively as the absence of disease symptoms. This approach, although useful in clinical practice, is insufficient to fully understand the complexity and diversity of the social determinants of health.

For many centuries, medicine focused on identifying physiological, biochemical or psychological abnormalities, and treated health as the default opposite of a disease state (Blaxter, 2009). The problem, however, was to define what exactly the norm means. Its idea was multifaceted and included variable reference points, for example, the average is understood as physiological values such as body mass index (BMI), which can be misleading, e.g., the BMI for bodybuilders exceeds the acceptable norms adopted for people who do not exercise regularly. Another proposal was to comply with the medically accepted body ideal, although this definition did not include people experiencing degenerative changes depending on age and lifestyle and the expected functionality of the body. Yet another idea was to set a range of normality for individual functional or even biochemical parameters of the body, which, however, varied depending on age, gender and race, as well as the hormonal cycle, co-occurring infections, and even the monthly (e.g., menstrual cycle) or daily (e.g., circadian) rhythm. The criteria for the norm itself were developed in medicine based on observations and examinations of patients from the 19th to the mid-20th century. Some of these criteria are already being questioned, e.g., the normal human body temperature is gradually decreasing (in the 19th century it was 37.0ºC, in the mid-20th century 36.6ºC, and today even lower values are increasingly indicated as the norm) (Protsiv, Ley, Lankester, Hastie, & Parsonnet, 2020).

In sociological and medical literature, there are many models for defining health. One of the most common is the perception of health as the absence of disease, which is understood here as a pathological condition of the body leading to a potential shortening of life or reduction in fertility. In this view, deviations from the norm that have no negative effects are not taken into account (Blaxter, 2009). A problem here is the failure to consider mental illnesses, which do not necessarily manifest themselves in an obvious way or have physical effects on the body (Giddens, 2007). Another way of perceiving health is based on the subjective perception of the symptoms of health and illness. Many people may experience various types of minor ailments (e.g., periodic headaches, numbness in the hands, etc.), which are not evidence of the body's health, but also do not constitute a serious health problem. Even the absence of symptoms can be an abnormality. In this context, it is difficult to determine what level of symptoms or discomfort is normal (Conrad, 2007).

Health is also often treated statically – as a constant state of the human body, despite the dynamic conceptualisations of the labile state of self-regulation of internal systems that have existed throughout history, in which treatment consists of restoring balance, by traditional theories of the balance of the four elements (Hippocrates or Galen). According to this understanding, the pregnant woman's body has an internal imbalance, despite the physiological state of her body. It is also possible to feel healthy despite being diagnosed with a disease by modern medicine (e.g., the situation of a diabetic patient with regulated glucose levels). Furthermore, health can be perceived as the ability to adapt and function in society, and illness as an adaptation problem and a disturbance of functioning, e.g., the limitation of the ability to perform daily activities related to movement in the elderly or disabled (Blaxter, 2009).

Finally, illness in the sociological sense *stricto* can be conceptualised as a deviation, as a state that deviates from social normality, with negative connotations and social stigma. Sick people are perceived as unproductive, and their treatment is costly for society, requiring care or supervision from medical personnel and the wider social environment (Parsons, 1951). Health can be understood as a kind of individual capital, i.e., the body's ability to resist disease. This perception of health leads to the conclusion that health capital can be squandered or accumulated through lifestyle, or it can vary from the moment of birth (different genetic susceptibility to disease) (Blaxter, 2009).

Aim and method

The aim of the study is to emphasise the social context of health, illness, care, and social support, which complements the existing medical perspective that disregards the impact of factors not directly related to the human biological body.

The analysis was an attempt to answer the following research questions:

- What social factors influence health and illness?
- What are the social consequences of illness for people experiencing health deficits?
- What is the social dimension of health and illness?
- What is social support in health and illness?
- What types of care and nursing support are there?
- What role do non-governmental organisations have in providing social support?

To find answers to the research questions posed, a review and analysis of Polish and world literature was carried out, followed by a selection and reconstruction of the most relevant contemporary answers to the research questions given above. The conclusions from the available research were used to determine the theoretical context and outline the practical applications of care and social support for the elderly and sick. Among other things, statistical data from the Central Statistical Office (GUS) and the Report of the Supreme Audit Office (NIK) on the state of the healthcare system and the demand for care and nursing support were analysed.

Biomedical model of health and disease

Medicine aims to heal, which is why traditional medicine focuses more on explaining illness than defining health. The biomedical model of health and illness, based on the assumptions of biological and medical sciences, is extremely effective, but it is also criticised for its limitations.

The biomedical model requires a definition of disease and its causative factors. It assumes a specific aetiology of diseases and identifies the disease of the organism through factors such as viruses, bacteria or parasites, and ignores the influence of the host organism and its adaptive capacities (Conrad, 2007). The same model cannot be applied to metabolic, developmental or functional disorders. The causes of many diseases are interrelated and interact with each other. In addition to the pathogenic factor, the host organism and its ability to adapt to the environment, which can also be an active source of disease, are not recognised. The biomedical model is still unable to clearly explain why some people are more susceptible to infections of external origin and others are immune (as the recent SARS-CoV-2 pandemic has shown). Acute illnesses can be explained more easily with this model than chronic illnesses, and the causes of mental illnesses are not easily recognisable.

Another assumption of the biomedical model is that there are general illnesses that are universal to the species *homo sapiens* and can be catalogued, limited to a certain number of symptoms and causes (e.g., in the ICD model). The disease can therefore be treated if it has been diagnosed. The act of making a diagnosis is equivalent to the medical staff deciding on the appropriate treatment. Therefore, it is not the person who is the subject of the treatment, but the illness, because no one can be sick if they are not recognised as such by a doctor. A person's ailments that have not been diagnosed by medicine cannot be treated, nor are they defined as an illness. Medicine treats and therefore sometimes defines as diseases such ailments that are not diseases (e.g. erectile dysfunction), and until recently it treated "diseases" that are not (e.g., female hysteria, abnormal sexual orientation).

Medicine assumes the existence of a normal state, i.e., the internal homeostasis of the body functioning within the range of acceptable deviations from the norm. The adaptation of the body's structures and functions to the environment is often overlooked. For example, it is difficult to determine at what point hypertension becomes a disease, when it is just an abnormality, when low haemoglobin levels due to a long-term vegetarian diet is a disease, and when it is an acceptable adaptation of the body.

The biomedical model assumes the objective neutrality of the doctor who treats the biological human organism. In this way, it ignores many culturally defined diseases, such as the aforementioned 19th-century "female hysteria" or diseases with an aetiology related to the contemporary socio-cultural environment, such as anorexia, dysmorphophobia, neuroatypical disorders (dysgraphia, dyscalculia, autism spectrum, ADHD, etc., which are in sense diseases of maladjustment to the contemporary requirements of the social environment and culture or effects of social expectations) and a whole range of mental and psychosomatic illnesses. The stress experienced by many people is also not seen as a medical condition, but it can make people more susceptible to illnesses.

The biomedical model separates the sick from the healthy; there is no intermediate status. This leads to a greater focus of medical efforts on treating diseases rather than promoting health. Lack of salutogenic thinking Aaron Antonovsky summarises with the observation that doctors are "not interested in smokers who do not get lung cancer" (Antonovsky, 1979, p. 203).

The growing criticism of the dominant medical model has also been supported and promoted by the WHO through the inclusion of social and psychological aspects of health. Health is seen here as a state of complete physical, mental and social well-being, not just the absence of disease (World Health Organization, 1948). This model emphasises the importance of promoting health through lifestyle changes and environmental modifications. Since the second half of the 20th century, a holistic approach to health has become increasingly prevalent, taking into account physical, psychological, and social aspects. The social model of health and illness, which complements the biomedical perspective, considers three factors:

- illness – medically defined pathology (this area is part of biomedical thinking);
- affliction – the subjective experience of ill health by the patient;
- sickness – the social role of people defined as sick or suffering from illness.

The social dimension of health and illness

In some cases, the social model of health and illness draws attention to the negative aspects of medical practice that pose a risk to the patient (e.g., deficiencies in the organisation of healthcare resulting in hospital-acquired infections). Furthermore, the stressors and pathogens that co-occur in many disease states are not always negative but are part of the human condition and factors that also cause positive reactions in the body, so they should not be eliminated. Modern clinical medicine also relies heavily on medical technology that lacks a "human" touch. A patient lying alone in a hospital, connected to medical equipment, may experience loneliness and rejection because neither he nor his relatives receive emotional support. After all, the biomedical model pays little attention to social variables in the development of diseases, such as poverty or lifestyle, which have been proven to have a significant impact on the distribution of health and disease in society. Variables such as social class, gender, race, or place of residence influence the health status of individuals and populations (Link, Phelan, 1995). Other studies indicate that people from lower social classes have poorer health and a shorter life expectancy than people from higher social classes (Marmot, 2005). This is due to differences in access to health resources, education, working conditions and lifestyle. Social determinants of health, such as living conditions, level of education, economic status and access to medical care, also have a significant impact on the health of the population (Blaxter, 2009).

Furthermore, living conditions, including work and housing, access to clean water and sanitation, as well as environmental safety play a key role in maintaining health. People living in poor housing conditions are more exposed to infectious diseases, health problems related to air pollution and stress (Marmot, 2005). Education is also an important factor for health. A higher level of education is associated with a better understanding of health information, a greater awareness of the importance of prevention and the ability to make healthy lifestyle choices (Cutler, Lleras-Muney, 2006).

The fact of being ill in a social sense is often associated with stigmatisation, in which individuals suffering from certain illnesses are depreciated, discriminated against and isolated because of their health condition. This may be due to ignorance, fear, stereotypes and cultural norms prevailing in a given community. Erving Goffman (1963) defines stigmatisation as a process in which an individual with a certain characteristic that is considered negative is rejected by society. This can manifest itself in blaming the patient for the illness in the case of cancer (as a punishment for leading an unhealthy lifestyle) and depends on the visibility of the disease (especially in the case of physical disability). AIDS has been particularly stigmatised (and in developing countries still is). Since the discovery of HIV/AIDS in the 1980s, sufferers have been strongly stigmatised and often seen as carriers of "moral decay" due to the connection between the disease and risky behaviour such as drug use and homosexuality. This stigmatisation led to social exclusion, discrimination and difficulties in accessing healthcare.

Another example of stigmatisation is mental illness, which is often perceived as a sign of weakness or an inability to control one's emotions. People with mental health issues experience social exclusion, discrimination in the workplace and difficulties in establishing and maintaining social relationships due to fears related to the unpredictability of the patient's behaviour.

The COVID-19 pandemic has caused new forms of stigmatisation. People who have been infected were often perceived as potential sources of infection, which led to their social exclusion. In addition, people from the regions most affected by the virus, such as China at the beginning of the pandemic, were also stigmatised.

Isolation is also one of the most significant social effects of the disease. People who are ill often experience exclusion, both due to their fear of infecting others and due to the reactions of those around them. Social reactions to illness can include various "punishments" such as avoiding contact, suspicion or ostracism. Isolation can lead to a deterioration of mental health, including depression and anxiety.

Being ill also results in the individual's dependence on others, both physically (the need to provide medication, care for the sick person, replacing them in everyday activities), as well as psychologically (the need to provide emotional support, burdening loved ones with anxiety about their health, disorganising the lives of family and loved ones by having to reorganise the daily duties of carers). Sometimes, the sick person can also pose a threat to their environment, especially in the case of infectious diseases. This can result in ostracism and a complete breakdown of social bonds, as we experienced as a society a few years ago during the SARS-CoV-2 pandemic. Illness can lead to a change in social roles. People in certain professional, family or social roles may be forced to give them up or change the way they fulfil them. A chronic illness often requires long-term treatment and care, which can limit the ability to work and participate in social life.

In an existential sense, illness is always a kind of mystery, hence the social and cultural attempts to narratively tame this state in the form of various types of metaphors, which is especially true for cancer (Sontag, 1999). Hence the emergence of military metaphors such as “cancer cell invasion,” “mobilisation and fight against an insidious enemy” or “cancer is the enemy” (Tobiasz-Adamczyk, 2012).

The role of the healthcare system in the social dimension of health and disease

Nowadays, the healthcare system is a very important element of the social dimension of health and illness. Healthcare is one of the main pillars of support for sick people, but its effectiveness largely depends on the social context in which it is provided. As Avedis Donabedian (1988) notes, the quality of healthcare is determined by three main factors: structure, process and outcome. Structure refers to the resources and organisation of the healthcare system, process refers to the interaction between the patient and healthcare professionals, and outcome refers to the health effects for patients. All these elements are derived from the social context.

The healthcare system can be defined as a group of people and institutions whose task is to provide healthcare to the public. The healthcare system consists of many different, interrelated elements, the main purpose of which is to carry out activities related to health. Another definition says that it is an organised and coordinated set of activities aimed at providing preventive, therapeutic and rehabilitative services and care to protect and improve the health of individuals and society (Nojszewska, 2011). The primary goal of the system should be to achieve the maximum health effect with the effective use of available resources, which will translate into a longer life in good health (Supreme Audit Office, 2019).

The most important links in the healthcare system in Poland include the practices of doctors, nurses and midwives, clinics and hospitals. The first level of healthcare is primary healthcare (POZ), where in case of illness, a general practitioner provides advice, refers to examinations, and, in justified cases, to a specialist clinic (the second level of healthcare within outpatient specialist care) for further diagnostics. The GP and specialist can refer the patient to the hospital. In a life-threatening situation, accident, poisoning or childbirth, the patient can go to the hospital on their own, without a doctor’s referral (see *Poznaj system…*[Get to know the system...]).

Pharmaceutical care is an important element of healthcare, i.e., the provision of healthcare services by a pharmacist who, in cooperation with the patient and the treating physician, ensures the proper course of pharmacotherapy. Their role includes conducting pharmaceutical consultations on the selection of medicinal products and medical devices, carrying out medication reviews including pharmacotherapy assessments, and developing individual pharmaceutical care plans that consider the patient’s medication problems (see *Poznaj system...*).

In Poland and worldwide, there is a trend towards an ageing society. According to data from the Central Statistical Office (GUS), in 2030 the number of people over 65 in Poland will reach 8.5 million, and around 4 million over 75 (Gałuszka, 2013). Demographic changes in Polish society are forcing decision-makers to introduce changes in healthcare, taking into account the group of elderly patients at different stages of the ageing process. Due to the ageing of the population, the number of people with chronic diseases such as diabetes, hypertension, coronary heart disease and asthma, as well as cancer, Alzheimer's disease, dementia and mental illnesses, will increase (Gałuszka, 2013). Therefore, geriatric patients should receive holistic healthcare, including nursing and long-term care, from specialists – doctors and nursing staff (Gałuszka, 2013).

In reality, the development of geriatric medicine is only theoretical due to the lack of geriatricians (there are 120 geriatricians in Poland, which is one doctor for every 50,000 patients), as well as the lack of geriatric wards focused on the health problems of the elderly. Therefore, a change in health and social policy is urgently needed to adapt healthcare conditions to the needs of the elderly. Long-term care is a response to the needs of the elderly and the chronically ill. According to the definition of the Ministry of Health, it is long-term, professional care and rehabilitation as well as the continuation of pharmacological treatment and dietary management at home (*Rozporządzenie…*[Regulation…], 2013). Long-term nursing care is provided at home or in a long-term care facility, based on an assessment of the patient's health and care needs. To receive this type of assistance under the National Health Fund (NFZ), a referral from a general practitioner or other specialist and a qualification procedure are required.

According to a 2019 report by the Supreme Audit Office on the situation of the healthcare system in Poland, patients do not have access to the same range of treatment options as people in Western Europe. Compared to other EU countries, Poland is lagging in the introduction of new technologies for the treatment of diseases, including oncological treatment. The scale of healthcare financing is also low compared to other European countries, which results, among other things, in a reduced supply of healthcare services in response to the justified needs of the population. Increasingly, access to medical services depends on the patient's financial situation in the private healthcare sector. Poor organisation of the system, staff shortages and, as a result, lack of implementation of preventive programmes result in spending on so-called remedial medicine rather than disease prevention. The adopted system of financing services for the service, and not for the quality and effect of treatment, is the reason for the subjective treatment of patients and the generation of queues while waiting for health services. The poor situation of the healthcare system is also favoured by the inadequate distribution of healthcare resources, i.e., medical staff and equipment (Supreme Audit Office, 2019). According to many international rankings, the Polish healthcare system is one of the worst in the EU, and according to surveys, the healthcare system is perceived negatively by the public (Supreme Audit Office, 2019).

To properly assess the healthcare system worldwide, several indicators affecting the quality of services provided must be analysed. In its 2023 report on health and sustainable development, the World Health Organization defines more than 50 health indicators that also affect social well-being (World Health Organization, 2023). The analysis takes into account variables such as availability (e.g., number of doctors per 1,000 inhabitants), quality (technologies, staff training), outcomes (life expectancy, infant mortality) and efficiency (costs incurred by the healthcare system compared to the results achieved) (World Health Organization, 2023). In the ranking of countries with the best healthcare systems, Canada came first, Iceland second and South Korea third. The healthcare systems in Western European countries such as Switzerland, Germany and Sweden were also rated very highly. The German healthcare system is rated very highly, among other things, due to the short waiting times for qualified specialists, as well as the high level of treatment for cancer and neurological diseases. Poland was ranked 31st.

Social support in sickness and in health

There are many definitions of social support. It is generally accepted that it is “help available to an individual in difficult, stressful situations,” “help commonly expected in situations that the individual is unable to cope with on their own,” “a certain system of social relationships and bonds that have a positive direct or indirect effect on the individual” (Kózka, 2010, p. 46). It is widely believed that social support can affect the onset of illness or the lack thereof. An individual who does not experience support from their environment is more susceptible to diseases such as heart attacks, stomach ulcers, and cancer, as well as depression, schizophrenia and other mental illnesses (Kózka, 2010).

Social support can take place on several levels:

- emotional support – exchanging emotions, providing encouragement in difficult situations, showing a sense of understanding, empathy and care, and being ready to help;
- informational support – consists of giving advice, medical advice or information about the causes of the disease and the therapeutic approach;

- material support – consists of providing material resources (funds, clothing, furniture, or other goods) to support the individual in undertaking activities for further development;
- instrumental support – assistance to a sick or disabled person in undertaking activities outside the home or in performing daily household activities (Kózka, 2010).

Concerning a sick or disabled person, social support can also be understood as helping the individual and their family to strive for independence.

Care support for elderly or sick people

The need for care and nursing support for the elderly is a result of their dependence due to illness or age. According to data from the Central Statistical Office (GUS), over 2.6 million adults have problems performing basic, everyday activities, with over 470,000 of them having serious limitations. These problems increase with age and are often the result of neglect caused by poor lifestyle choices, lack of prevention or lack of adequate care. This, in turn, generates increased demand for care and nursing services and constant care, including long-term care (Błędowski, Maciejasz, 2013).

Undoubtedly, the family plays the most important role in caring for the elderly, and only under specific circumstances do healthcare and social institutions take over these tasks. Currently, the activities of non-governmental organisations and the private sector in the provision of care and nursing services are also developing more and more (Błędowski, Maciejasz, 2013).

The services provided by the healthcare system are either inpatient or outpatient (home-based), and the costs are covered by the National Health Fund (NFZ) as part of health insurance. Inpatient care is provided around the clock in nursing care facilities (ZOL) and is intended for patients requiring 24-hour nursing care. Long-term care services are financed by the National Health Fund (NFZ), while the patient bears the costs of food and accommodation (Błędowski, Maciejasz, 2013).

The second form of service is home care, which is provided by a nurse or long-term care team. These services include care, rehabilitation and assistance in meeting basic biopsychosocial needs (Błędowski, Maciejasz, 2013). An elderly person who requires care and nursing support can also count on social welfare assistance in the form of cash benefits (periodic sickness benefits, specific benefits intended to meet a particular need or nursing benefits granted to partially cover the costs of care) and in the form of non-monetary benefits such as care services (Błędowski, Maciejasz, 2013).

Care services at home provide assistance in meeting the basic needs of everyday life, including hygiene, care and rehabilitation, as well as assistance in dealing with official matters and ensuring contact with the environment. Such care can significantly improve the quality of life of the elderly and infirm and their families, but the scale of need far exceeds the number of service providers, so not everyone in need can receive assistance (Błędowski, Maciejasz, 2013).

The role of the family in caring for the elderly or sick person

As mentioned above, the family has the most important role in caring for a sick person, although in most cases, taking responsibility for a sick person is a necessity. The family, but also people close to the patient, such as friends, neighbours or acquaintances, are considered the primary source of support in a crisis and illness (Kózka, 2010). Caring for a sick person changes the family's previous functioning, professional and financial situation, and also affects the deterioration of relations with the environment and the health and well-being of the carer (Błędowski, Maciejasz, 2013).

According to data from the international EUROFAMCARE project, which was also carried out in Poland in 2003–2004, the number of informal carers for the elderly and disabled was around 2 million (Perek-Białas, Stypińska, 2010). This form of caregiving mainly affects women, disrupts their professional lives and, consequently, causes financial problems. In a study conducted by Magdalena Durda, Maria Kaczmarek, Magdalena Skrzypczak, and Anita Szwed (2010) on the assessment of the quality of life of carers of people with Alzheimer's disease, the respondents indicated that the greatest costs were incurred in the purchase of medicines for the sick person and the employment of an additional carer at certain times. The results also showed that the extended time spent caring for the patient correlated with a reduction in the time spent working (Durda, Kaczmarek, Skrzypczak, & Szwed, 2010).

In the same study, respondents also indicated that caring for a person with Alzheimer's disease has a negative impact on family functioning and the relationship between the carer and their partner (71% of respondents gave this answer) (Durda, Kaczmarek, Skrzypczak, & Szwed, 2010).

Research also suggests that the lower quality of life of carers who have no support from family or institutions is associated with a feeling of burden, longer time spent on care, lower education and financial disadvantage (Rachel, Jabłoński, Datka, & Zięba, 2014). Caregivers of the sick are more likely to suffer from diseases such as hypertension, immunodeficiency, respiratory diseases and obesity, experience stress and neglect their health, which puts them at a higher risk of death (Rachel, Jabłoński, Datka, & Zięba, 2014; Basińska, Lewandowska, & Kasprzak, 2013). Carers of people with Alzheimer's disease are at high risk of depression and anxiety (Basińska, Lewandowska, & Kasprzak, 2013).

It is still mainly women who take care of sick family members, although there is an increase in the number of men in this area. Researchers also observe a lower quality of life among women caring for a sick person compared to male carers (Rachel, Jabłoński, Datka, & Zięba, 2014). Men more often decide to provide institutional care for the sick person, and if they provide care themselves, it is task-oriented, and less emotional. Women are more often emotionally involved in caring for a loved one, which is also due to cultural factors (Rachel, Jabłoński, Datka, & Zięba, 2014).

In the context of the financial, emotional and health costs incurred by people providing care and nursing for a sick loved one, support must be provided by public and private institutions to both the sick person and the family. Professional help and support from other family members have a positive effect on the carer's mental state and reduce the fatigue and stress associated with caregiving (Basińska, Lewandowska, & Kasprzak, 2013).

According to a study conducted by Krystyna Kurowska and Marzenna Frąckowiak on social support and stress management styles in chronic illness in the example of type 2 diabetes (Kurowska, Frąckowiak, 2010), the respondents indicated that they receive the least support in the emotional sphere, while the most in the instrumental sphere. The respondents showed an emotional style of coping with stress, i.e., focusing on their experiences (Kurowska, Frąckowiak, 2010). This is also an important aspect to consider when caring for a sick person, especially when it comes to illnesses related to emotional instability or perceived stress. This is a challenge for both families in care and professionals.

Non-governmental activities: the role of foundations, associations and volunteering as social support for the elderly and sick people

The deficits of the healthcare system and the social difficulties in caring for the sick by families and relatives are recognised and supplemented by government programmes and the activities of non-governmental organisations. Many non-governmental organisations and institutions in Poland support the sick and their families. A few of them are mentioned here, for example:

- Rak'n'Roll Foundation – this foundation supports people with cancer, offers psychological, financial, and material assistance programmes, organises awareness campaigns, raises funds for treatment and conducts educational activities in the field of cancer prevention;

- Amazonka Association – this organisation brings together women who have had a mastectomy, offering them emotional and psychological support, running support groups, organising rehabilitation and working to raise public awareness of breast cancer;
- AIDS Community Committee – this organisation supports people living with HIV/AIDS, offers psychological support and legal assistance, and runs educational campaigns aimed at reducing the stigmatisation of infected people.

The most important government programmes currently in place include:

- The "Za Życiem" programme is a comprehensive government programme aimed at families with children with disabilities and adults requiring constant care. The programme offers financial support, medical care, rehabilitation and assistance in social and professional integration.
- National Mental Health Programme – this initiative aims to improve the availability and quality of healthcare for people with mental disorders. The programme includes measures for early diagnosis, treatment, rehabilitation and social support.
- Care 75+ programme – this programme is aimed at elderly people who require care support. The activities include financial support for carers, access to care services in the place of residence and the development of a social support network for seniors.
- National Cancer Control Programme – the programme aims to improve cancer diagnosis, treatment and prevention. The programme includes educational activities, awareness campaigns, financial support for patients and the development of medical infrastructure.

Volunteers have an additional supporting role. They offer their time, skills, and emotional support, which is of great importance for the quality of life of patients and for relieving the burden on the healthcare system. In many hospices in Poland, volunteers support the medical staff by helping with the daily care of patients. Their presence and commitment are very well received by patients, especially in palliative care when people need not only medical help but also emotional support. Social solidarity is also demonstrated in local initiatives such as organising support groups, fundraising for medical treatment or neighbourly help. Volunteers often organise help for the elderly, sick and disabled, offering support in everyday activities, transport to the doctor or delivering meals. Volunteering and social solidarity are the foundations of support for the sick, bringing people together in activities to improve the quality of life for patients and their families. By involving local communities, NGOs and government institutions, it is possible to effectively support people in need and create a more inclusive and empathetic society.

Challenges in healthcare and social support

Healthcare and care services in Poland are facing many challenges that will shape their future. One of the most important trends is the ageing of the population. According to forecasts by the Central Statistical Office (GUS, 2022), the number of people over the age of 65 is expected to double by 2050. This demographic change requires the healthcare system to be adapted to the growing needs of the elderly, which entails an increased demand for care, rehabilitation and geriatric services.

Another challenge is the increasing number of people suffering from chronic diseases such as diabetes, heart disease and cancer. Medical advances are enabling people to live longer with these diseases, which increases the demand for long-term care. Healthcare systems must develop the scope of integrated care services that combine various forms of medical and social support.

In addition, the COVID-19 pandemic has exposed weaknesses and gaps in the healthcare system that require urgent intervention. The pandemic has increased the pressure on these systems and demonstrated the need for better preparedness for future health crises. It is essential to improve health infrastructure, increase the number of medical personnel and implement effective crisis management systems.

Technology can be an important factor in improving the quality of care and is becoming increasingly important in healthcare and care support. It offers new possibilities for improving the quality of life of patients and the efficiency of the care system. The most important opportunities associated with its application include:

- Telemedicine – the development of telemedicine enables remote medical consultations, health monitoring and remote treatment management. Telemedicine increases access to medical care, especially for people with reduced mobility and those living in rural areas. In Poland, during the COVID-19 pandemic, telemedicine became an indispensable tool for the continuation of healthcare, which demonstrated its enormous potential and the need for further development.
- Technologies supporting home care – smart homes, health monitoring devices and robots supporting home care allow the elderly and sick to live safely and independently in their own homes. In Poland, projects such as *Teleopieka dla seniora* [Telecare for seniors] offer health monitoring ser-

vices and support in emergencies, which contributes to improving the safety and quality of life of seniors.

- *Big data* and artificial intelligence – the use of big data and artificial intelligence can enable more precise diagnostics, disease prognosis and personalised treatment. In Poland, initiatives such as the Polish Medical Platform integrate health data from various sources, which supports scientific research and the development of innovative medical solutions.
- Mobile apps and health platforms – more and more people are using mobile apps and health platforms to manage their health. Such tools support patients in self-managing their health, remind them of doctor's appointments and medication intake, and enable communication with doctors. In Poland, applications such as *mojeIKP* (*Internetowe Konto Pacjenta* or Internet Patient Account) facilitate access to medical records and health services.

Summary and conclusion

The situation of an ageing society continues to require reforms and changes in social policy to meet the growing need for healthcare and support services that take into account the needs of the elderly and the chronically ill.

It is necessary to develop and integrate a long-term care system that will provide comprehensive medical, rehabilitation and social services. Funding for these services should be increased and mechanisms introduced for family caregivers to relieve their burden and ensure better quality of care. Programmes such as "Care 75+" offer financial and care support in the place of residence, enabling senior citizens to stay in their homes for longer. However, these initiatives are still insufficient.

A major challenge is the development of programmes to support active ageing. These should promote a healthy and active lifestyle among older people, which can contribute to a later onset of chronic diseases and a reduced need for long-term care. Investments in health promotion programmes, health education and infrastructure to support physical activity are crucial. Initiatives such as "Senior+" offer financial support to municipalities for the creation and maintenance of day centres and senior clubs that provide care, and social and cultural activities for the elderly.

The healthcare system itself needs to be prepared for the change associated with the growing demand for services resulting from an ageing population. Investments should be made in the development of medical staff, modernisation of healthcare infrastructure and the introduction of innovative technological solutions that will improve the efficiency and quality of care. In Poland, projects such as "Healthy

Future" focus on the modernisation of hospitals and health centres and the training of medical personnel.

Volunteering and social initiatives are also worth considering. Voluntary activities should be promoted and supported by offering training, organisational assistance and facilitating cooperation between the public and private sectors and NGOs. Due to the ageing population, comprehensive reforms and innovative approaches are necessary to meet the growing need for healthcare and care services. By integrating modern technologies, developing care systems and supporting social initiatives, dignified and effective care can be provided to all those in need.

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