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## **YOUNG ADULTS' HEALTH BEHAVIOURS: AN ELEMENT OF HEALTH POLICY IN THE LIGHT OF THE "YOUTH OF WARSAW" STUDY**

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### **Abstract**

The aim of the study is to point to the essence and role of health policy in shaping health behaviours and then to present the study and its findings regarding knowledge about health and the ability to shape the behaviours of young adults in Warsaw. The description was taken, followed by an analysis of the field study on health behaviours of the adult youth of various types of secondary schools, i.e. vocational schools, technical schools and general secondary schools in Warsaw. The research hypothesis in this study says that there is a relationship between the type of school that young people attend and health knowledge and skills shaping their health behaviours.

In the light of the research, it turned out that the examined youth from vocational schools considerably less recognizes situations threatening to health in the form of a poorer nutrition (consuming insufficient amounts of dairy products, vegetables, or not eating a single warm meal during the day) or the frequency of contacts with psychoactive substances in comparison with young people from technical schools or college students.

**Keywords:** health behaviours, health policy, the study of adult youth in Warsaw

### **Introduction**

Social studies on health determinants in societies are multi-layered and complicated in nature, and therefore require a multidisciplinary approach.

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The specificity and unique characteristics of each of the disciplines, along with numerous determinants of human health, oftentimes unidentified, pose challenges to the studies.

Health policy is part of public policy, which according to WHO: '[...] refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society.'<sup>1</sup> The definition goes on to mention a vision for the future which helps to establish health targets. This, in turn, has an influence on outlining priorities and helps define the expected roles of different groups, which builds consensus.

Health behaviours are attitudes towards health, largely derived from one's value system. These also include all behaviours which yield positive or negative health effects. Health attitudes do not emerge by themselves – they are shaped during one's entire lifetime, mainly through health education, which is conceptually and practically related to health policy.<sup>2</sup>

The purpose of this article is first to indicate the essence and the role of health education in shaping health behaviours, and subsequently to present a study and its findings concerning health awareness and the ability to shape these behaviours among Warsaw's young adults.

## 1. Health policy

Health policy (healthcare policy) falls within '[...] the scope of social policy'<sup>3</sup> One may consider the legitimacy of separating healthcare policy from social policy. However, this would not be a valid approach, as health issues cannot be studied when detached from factors such as unemployment and its effects, social exclusion and living conditions. After all, health policy is not merely a scientific 'beneficiary' of social policy, although it utilizes its concepts, research tools and test methods. Social policy also adopts theoretical findings developed in the area of health policy.

Social policy and health policy are considered both scientific disciplines and practical activities. It is a simple and commonly understood division, considering its universal dimension. Health policy understood as a **scientific discipline** analyses and examines the principles which are prerequisites for achieving the assumed health goals. It also defines the actions undertaken for the purpose of health restoration or

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<sup>1</sup> [http://www.who.int/topics/health\\_policy/en/](http://www.who.int/topics/health_policy/en/) (retrieved: 14.05.2017).

<sup>2</sup> P. Zimbardo, *Psychologia i życie*, Wydawnictwo Naukowe PWN, Warszawa 2012, pp. 310–312.

<sup>3</sup> C.W. Włodarczyk, *Współczesna polityka zdrowotna*, Lex a Wolters Kluwer business, Warszawa 2014, p. 31.

health improvement by adopting medical regimens, disease treatment, health maintenance and enhancement (e.g. medical screening, vaccination), and injury treatment.<sup>4</sup>

Health policy objectives shall be determined taking into consideration health policy adequacy, concerned with the application of knowledge and skills corresponding to the merits of particular scientific disciplines and expert preparation of members of society for the fulfilment of the assumed tasks, or its universality, i.e. ensuring healthcare to all citizens.<sup>5</sup>

Health policy as the **practical activity** is concerned with the shape, scope and method of application of health policy theory in the social context. One of such theories says that health policy is created by social groups which exert influence on the condition of institutions within the healthcare system. Health policy understood in this way refers to activities undertaken in order to achieve the assumed healthcare goals.<sup>6</sup>

The applied aspect of health policy is realised in the following spheres: prevention, whose purpose is to limit the incidence of diseases and accidents, focused on risk groups; treatment of individuals affected by disease; physical therapy, which aims to help people regain mobility lost due to a condition or injury, as well as a sense of usefulness within the community; health promotion.<sup>7</sup> It is essential to promote healthy behaviours on each of these levels.

Implementation of a health policy by a particular country, involving a whole spectrum of economic, political and demographic dependencies, entails the development and introduction of changes in health-related attitudes. This approach is based on the assumption that the process requires social approval and readiness to participate in the changes. The process is related to creating a strategy of health policy for a specific purpose.<sup>8</sup>

Understood as practical activity and including a purposeful collection of actions, healthcare policy affects the distribution of resources among conflicting social groups.<sup>9</sup> To add an economic perspective to the statement concerning health policy purposefulness, it should be emphasised that while the overall objective is health improvement, the costs necessary for its implementation need to be

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<sup>4</sup> V. Korporowicz, *Zdrowie i jego promocja. Kształtowanie przyszłości*, Oficyna Wydawnicza SGH, Warszawa 2008, p. 63.

<sup>5</sup> *Handbook of development economics*, Elsevier, North Holland, Oxford–Amsterdam 2010, p. 34.

<sup>6</sup> J.D. Sachs, *Commonwealth. Economics for a crowded planet*, Penguin Books, London 2008, p. 3.

<sup>7</sup> Frąckiewicz, *Polityka ochrony zdrowia. Synteza*, Wydawnictwo AE im. K. Adamieckiego, Katowice 1991, pp. 66–67.

<sup>8</sup> *Health policy*, [in:] *Health topics*, World Health Organization, <https://www.who.int/library/science-and-technology/health-and-medicine> [retrieved: 14.02.2017].

<sup>9</sup> D.L. Patrick, P. Ericson, *Health status and health policy*, Oxford University Press, Oxford–New York 1993, p. 419.

taken into account.<sup>10</sup> By all means, this type of activity focuses on the methods of distribution of various resources, whose allocation largely depends on financial resources.<sup>11</sup> However, this approach fails to indicate a beneficiary of health policy interpreted in this way, or on whose behalf it is implemented.

One cannot overlook the fact that health policy as a practical activity is a social process related to the design and implementation of activities which shape the healthcare system. This process may include decisions about taking or not taking particular actions, actions undertaken and completed, as well as actions not taken or abandoned. In addition, health policy understood in terms of a process should also contain a variable of time, in which health-related actions should be adjusted to social and economic conditions. The time frame determines the scope of activities within health care policy, as there might appear changes to the political system, population age structure, or the educational system.<sup>12</sup> In this approach to healthcare policy, possible changes should always be taken into account in the phase of planning and implementation of educational initiatives aimed at, among other things, promoting health behaviours.

## 2. Health behaviours

Health behaviours refer to activities related to health. These include human activities expressed by means of behavioural variables related to health and disease, including any health-oriented behaviours such as habits, attitudes, and values of individuals and entire social groups.<sup>13</sup> These behaviours go far beyond attitudes towards their own health, shaped from the early childhood, for example in the process of health education. The aforementioned education process takes place at home, at school or at a workplace.<sup>14</sup>

<sup>10</sup> *Economies of death, economic logics of killable life and grievable death*, J. Patricia et al., Routledge, London–New York 2015, p. 58.

<sup>11</sup> *Public management organizations governance and performance*, L.J. O'Tode, K.J. Meler, (Eds.), Cambridge University Press, Cambridge 2011, pp. 1–2.

<sup>12</sup> *Europejski model społeczny. Doświadczenia i przyszłość*, D.K. Rosati et al., PEW, Warszawa 2008, p. 62.

<sup>13</sup> Health attitudes are closely related to an individual's way of acting, along with the sense of responsibility for one's health, which is consistent with one's value system – a fundamental category of axiology. The WHO's 'Health for All by the year 2000' strategy emphasizes the fact that health is closely related to health attitudes, which enable individuals or groups to meet their goals, fulfil tasks and other needs.

<sup>14</sup> A. Rączaszek, *Demograficzne uwarunkowania rynków konsumpcji społecznej*, "Wokół polityki społecznej", K. Głąbicka, M. Grewiński et al., Polskie Towarzystwo Polityki Społecznej WSzP TWP w Warszawie, Instytut Polityki Społecznej, Warszawa 2008, p. 191.

Health behaviours are also defined as any behaviour patterns related to both personal health and the health of others (cigarette smoke is inhaled by both active and passive smokers). There are approaches that give the term 'health behaviour' a pedagogical interpretation. They include activities encouraging health behaviours, as well as health-promoting activities by health educators. It is believed that health behaviours may be a practical measure of the effectiveness of educational and health-related activities.<sup>15</sup> This aspect concerns the choice of attitudes towards health threats, and health protective behaviours, which requires familiarity with environmental hazards and the influence of these factors on health, and knowledge of desirable health behaviours. It is worth mentioning that all health behaviours depend on individual people, and the decisions taken are inseparable from each person's responsibility for their own health.

Health behaviours have been classified in various ways. One classification divides them into negative and positive ones. The **negative behaviours (health-impairing behaviours)** include smoking, excessive alcohol consumption, use of addictive substances, poor diet, a lack of exercise, excessive stress, or risky sexual practices. It should be added that promoting health requires knowledge of the negative behaviours, with their social and individual foundations, in order to correct them.<sup>16</sup> The **positive (desirable) health behaviours** include: physical activity, healthy nutrition, limiting excessive fat consumption, smoking reduction, good stress management, maintaining personal hygiene or house cleanliness. Behaviours within this definition also include maintaining proper interpersonal relations.

The factors which underlie the formation of health behaviours are:

- 1) knowledge of health determinants among individuals, their parents, family, teachers and peers;<sup>17</sup>
- 2) patterns of behaviour as influenced by family, tradition, culture and politics;
- 3) socio-economic conditions of a given country, which determine the possibilities of practising health-related behaviours;
- 4) skills and capabilities of individuals and healthcare institutions.<sup>18</sup>

The basic classification of the factors affecting health behaviours is not exhaustive or complete. It provides neither the description nor the rank of the significance

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<sup>15</sup> *The Cambridge handbook of consumer psychology*, I.M. Norton, D. Rucker (Eds.), Cambridge University Press, New York 2015, p. 542.

<sup>16</sup> *Mental illness. Invisible but devastating*, "Africa Renewal" December 2016/ March 2017.

<sup>17</sup> M. Rymsza, *Polityka rodzinna. Cele, wartość, rozwiązania – w poszukiwaniu konsensualnego programu, Polityka wobec rodziny w Polsce*, "Studia BAS" 1, 2016.

<sup>18</sup> M. Grewiński, *Modele wielosektorowości w pluralizmie polityki społecznej*, [in:] *Wokół polityki społecznej*, K. Głabicka, M. Grewiński, (Eds.), Polskie Towarzystwo Polityki Społecznej WSzP TWP w Warszawie, Instytut Polityki Społecznej, Warszawa 2008.

or weight of each of the factors. This means that they are attributed the same significance, while in reality, factors such as the level of each person's knowledge and skills are determined by socio-economic conditions. Another essential observation is that health behaviours include activities related to aspects on an individual's life which one cannot influence, such as unemployment or economic crises, which determine the socioeconomic status and ultimately one's sense of purpose in life.

It is assumed that there are three major trends impacting health behaviours: habits, views and attitudes. The influences determining behaviour change outcomes relate to all these elements. Changes in health behaviours occur mainly as a result of educational activities through increased awareness. The process involves constructing the perceptions of reality and the world within a society, accounting for various aspects of health. Ultimately, the process should also involve revision of health knowledge, which determines attitudes through which health-enhancing behaviours are adopted.<sup>19</sup> They consist not only in acquiring health-related knowledge through an increased understanding of new distinctions and meanings concerning reality, but also in engagement in shared activities, and making informed choices.<sup>20</sup>

The purpose of promoting health attitudes is to indicate the benefits of good health. Individuals can learn, work effectively, and enjoy life, as long as their health permits it. The changes to one's health behaviour should contribute to living an independent, creative life. At the same time, health behaviour awareness should underlie the process of devising health education programmes.<sup>21</sup>

Currently, it is believed that health behaviours are essentially shaped by the attitudes and beliefs which are self-developed and subject to self-evaluation.<sup>22</sup> This, in turn, makes them more acceptable than those that would be imposed or irrelevant to those involved.

The individual has a decisive impact on his or her health, and their behaviour may account for the mechanisms necessary for undertaking any health-oriented activities. This is exactly the embodiment of the 'Your Health in Your Hands' motto.<sup>23</sup>

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<sup>19</sup> *Health and inequality*, Vol. 2: *Health inequalities, causes and pathways*, K.E. Pickett et al., Routledge, London–New York 2009, p. 154.

<sup>20</sup> J.B. Karski, *Praktyka i teoria promocji zdrowia. Wybrane zagadnienia*, CeDeWu, Warszawa 2003, p. 16.

<sup>21</sup> Health education should include specific social initiatives, aimed primarily at children and adolescents, although the importance of adult education is increasingly emphasized – relative to the social concepts and objectives functioning in a given society in the form of health, intervention or popularized programmes. The effects of such a programme may essentially be ambiguous, or even counter-intentional. This occurs due to the fact that regardless of the merits of a social change programme, it is still not possible to design the changes so as to avoid the impact of other activities or existing patterns. The activities may be addressed to the entire society or its part.

<sup>22</sup> A. Ostrowska, *Zróżnicowanie społeczne a zdrowie. Wyniki badań warszawskich*, Instytut Pracy i Spraw Socjalnych, Warszawa 2009, p. 16.

<sup>23</sup> <http://www.who.int/healthpromotion/about/en/> [retrieved: 10.05.2017].



### 3. The 'Youth of Warsaw' study

The purpose of the 'Youth of Warsaw' study is to diagnose the health attitudes of adult Warsaw youth exhibited in the changing social reality. The method employed in the study involves conducting a field study concerning health awareness and the ability to shape health behaviours among young adults in Warsaw's secondary schools in the school year 2016/2017. A parallel purpose of the study is to find an answer to the question regarding the social and economic problems, which need to be addressed in order to improve the health condition of the Polish youth. Despite the relatively abundant Polish literature on the subject of health expenditure, there has so far been no study to assess which factors are decisive in shaping health resources.

Field studies regarding health awareness are key to identifying the prevalent health threats. The data obtained should be the basis for the development and updating of health policy in a complex socioeconomic situation. At the same time, knowledge of health behaviours is the starting point for developing health education assumptions.

The study's thesis is the statement that the type of education pursued by the subjects, and the level of parents' education are the main predictors of health behaviours, including health perception. Therefore, the groups of schools were selected purposefully, as representative groups, including general high schools, technical schools and vocational schools, to represent the multitude of entanglements and health determinants, which generates a multitude of issues. This explains the variety of problems raised in questions addressed to students of randomly selected schools.

The research tool adopted here is a questionnaire specifically constructed for the purpose of conducting the survey by means of central location interviews.<sup>24</sup> It enabled the collection of data regarding declared behaviours directly from the respondents participating in the study. The principal advantage of this method is a high response rate, the possibility of encouraging response, and the possibility of explaining inaccuracies. However, there are several shortcomings to this method, including disproportions between the declared and the actual behaviours, a high dependence of the reliability of response on the sense of complete anonymity while completing the survey, extended duration of response, and the influence of the interviewer on the response.<sup>25</sup>

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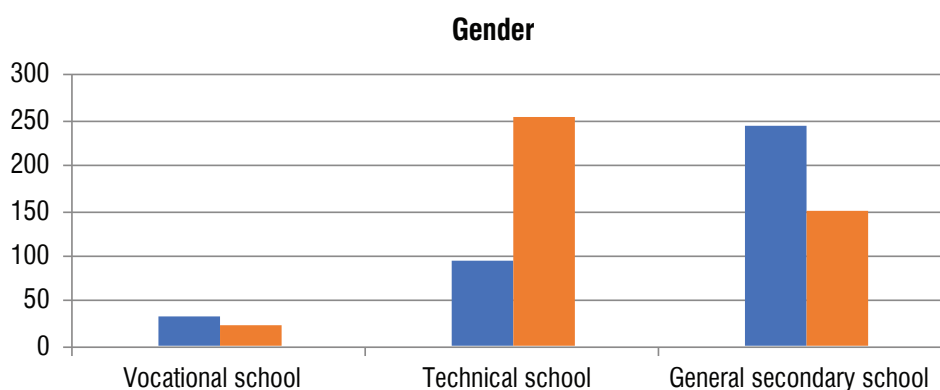
<sup>24</sup> Central location interview is a type of a written interview, where the form or questionnaire is filled out by the respondent. The method involves the respondent or group of respondents to complete the questionnaire unassisted. The surveyor does not conduct an interview in person, and their role is usually limited to informing the respondents about the study's purpose and method of survey completion. The advantage of central location interviews is a considerably high response rate, i.e. the survey completion rate expressed in the form of a percentage and a relatively low cost of the survey.

<sup>25</sup> J. Apanowicz, *Metodologia nauk*, TNOiK "Dom Organizatora", Toruń 2003, p. 104.

The survey questionnaire contains 34 closed-ended study questions, including many general questions supplemented with detailed questions, and 16 questions concerning the respondents' particulars. All the questions include the division into the different types of schools. While selecting the schools, a comprehensive database of upper-secondary schools was used, including general secondary schools, technical and vocational schools within the city of Warsaw, extracted from the nationwide database, available on the website of the Education Information Centre: <http://www.cie.men.gov.pl/index.php/sio-wykaz-szkol-i-placowek/26-wykaz-wg-wojewodztw.html>. The selection was made with the use of a programme with a built-in random function in order to select a specified number of schools.

A total of 820 students participated in the representative survey.<sup>26</sup> Of these, 422 were boys and 382 were girls, and 16 students did not indicate their gender. As can be seen from Figure 1, there are more males than females in technical schools, and there are more females in general secondary schools. In vocational schools, the number of girls and boys does not vary significantly.

**Figure 1. Number and gender of respondents including the division into school types**



Source: the author's own calculations based on the field data.

An analysis of the responses in the area of subjective health self-assessment shows that in all three types of schools, i.e. vocational schools, technical schools and general secondary schools, the students described their health status as "very good", in similar proportions. They amounted to 32%, 32% and 37%, respectively. Similarly, the responses to the question to which they answered 'good' amounted to 32%, 43%, and 46%. This shows that in their self-assessment of health, the young people

<sup>26</sup> (The chi-square goodness of fit test was used (also known as the Pearson's test, which is applied to compare an observed distribution of variables with their theoretical distribution. If the test fails to show any significant differences, then the observed results for each group are statistically the same. The result turned out to be statistically insignificant ( $p > 0.05$ )).



attending general secondary schools and technical schools slightly more often than the students of vocational schools declare 'very good' and 'good' well-being, which may indicate a relatively good health condition of the youth attending these types of schools (Table 1).

As to the self-assessment in terms of physical fitness, it is noticeable that the responses of the students from various types of schools are similar to the previous category, i.e. health assessment.

**Table 1. Self-assessment of health according to the type of school (%)**

How do you assess your health?	Upper-secondary school		
	Vocational school	Technical school	General secondary school
Very good	32	32	37
Good	32	43	46
Average	32	21	14
Bad	2	1	3
I have serious health issues	2	3	0

Source: the author's own calculations based on the field data.

In terms of physical fitness, 25% of the general secondary school students rated themselves as 'very fit'. For the vocational school students, the percentages drop to 19%, and 22% in technical schools, which shows that the secondary school students rated their 'physical fitness' higher than the students of other schools (Table 2). All other responses in the three types of schools are also statistically similar, with the exception of the 'I have serious health problems' question, indicated primarily by the youth from vocational schools. A high percentage of the students of vocational schools who suffer from health issues compared to the students of other schools may result from the fact that these issues were a hindrance to their education in primary school and junior high school, which, in turn, could affect their ability to get into e.g. a technical school.

**Table 2. Self-assessment regarding physical fitness according to the type of school (%)**

How do you assess your physical fitness?	Upper-secondary school		
	Vocational school	Technical school	General secondary school
Very good	19	22	25
Good	35	40	42
Average	35	32	28
Bad	1	4	3
I have serious health issues	10	2	2

Source: as in Table 1.

An analysis of the general knowledge about the ‘impact of human behaviour on health’, shows a significant advantage in the level of awareness among the youth attending general secondary schools, indicated by 40.0% positive responses, compared to the young people attending vocational schools who provided positive responses to the same question in merely 22.0% of all the pupils, while in technical schools the responses amount to 27%. Therefore, the level of knowledge about shaping health through appropriate behaviours appears to be higher among high school students than in vocational school students (Table 3).

**Table 3. Assessment of the impact of student behaviour on health (%)**

To what extent does your behaviour affect your health?	Upper-secondary school		
	Vocational school	Technical school	General secondary school
Yes, to a large extent	22	27	40
Yes, to some extent	32	37	33
Yes, to a small extent	11	13	8
It does not matter at all	16	9	6
It is hard to say	19	13	11
No data	0	1	2

Source: as in Table 1.

A large proportion of the students attending general secondary schools share a belief that a person can potentially shape their health and influence its condition. Similar conclusions arise from the responses that individuals may only have little or no influence on their own health. In comparison, the students of general secondary schools responded to these questions in 8% and 6%, respectively. On the other hand, the vocational school and technical school students demonstrated a considerably lower level of belief in the value of one’s impact on their health – 27.0% and 22.0%, respectively. This may indicate that the general secondary school youth have much greater awareness of the impact of their behaviours on their own health, compared to the youth attending vocational and technical schools.

One of the questions verifying the level of awareness of the impact of one’s own behaviour on health is, for example, the one regarding PE lessons attendance: 89.0% of the general and technical secondary school students responded that they attended PE lessons, while in vocational schools significantly less – 75.0% of all the respondents. Interestingly, the lower level of physical fitness of the vocational school youth is also confirmed by the number of temporary and permanent exemptions from PE lessons, which are more prevalent among vocational school students compared to technical and secondary schools (Table 4).

**Table 4. Percentages of respondents regarding PE attendance (%)**

Do you attend PE lessons?	Upper-secondary school		
	Vocational school	Technical school	General secondary school
Yes	75	89	89
No, I am temporarily exempt from PE	8	3	2
No, I am permanently exempt from PE	14	3	6
No, my parents excuse me from PE	0	2	1
No data	3	2	2

Source: as in Table 1.

In addition, as presented in Table 4, the adult students of Warsaw vocational schools are more often permanently and temporarily exempted from PE by a doctor than the general and technical secondary school students altogether. The figures amount to 22%, 6% and 8%, respectively. On the one hand, these figures may be indicative of a weaker health condition of the vocational school youth compared to young people from other types of schools, while on the other hand, they may be evidence of the increased reluctance of this group to improve their physical fitness level. Similar conclusions arise from Kalupa's study of the lifestyle of Poles. They show that merely 30% of the respondents spent their free time actively. Sports were mostly performed by males with higher education.<sup>27</sup>

Similar data demonstrating low physical activity of Poles is presented by the Statistical Research Department of the Central Statistical Office (Główny Urząd Statystyczny) in Poland: as many as 31% of adult Poles spend their free time exclusively in a passive way, watching TV, sitting in front of the computer, or reading newspapers; 35–39% combine passive leisure activity with moderately active leisure time with little active leisure, e.g. walking, and only 15–16% do sports during most of their free time, e.g. ride a bicycle, do jogging or work in the garden.<sup>28</sup>

The subsequent question regarding declared behaviours and their impact on one's health concerned the respondents' opinions about proper nutrition. 56% of the young adults attending Warsaw's general secondary schools responded 'yes' to the question: 'Do you eat healthy?', compared to 33.0% and 38.0% of the students of vocational and technical schools, respectively (Table 5). Therefore, the vocational and technical school youth declared healthy eating habits less often than the students of general secondary schools.

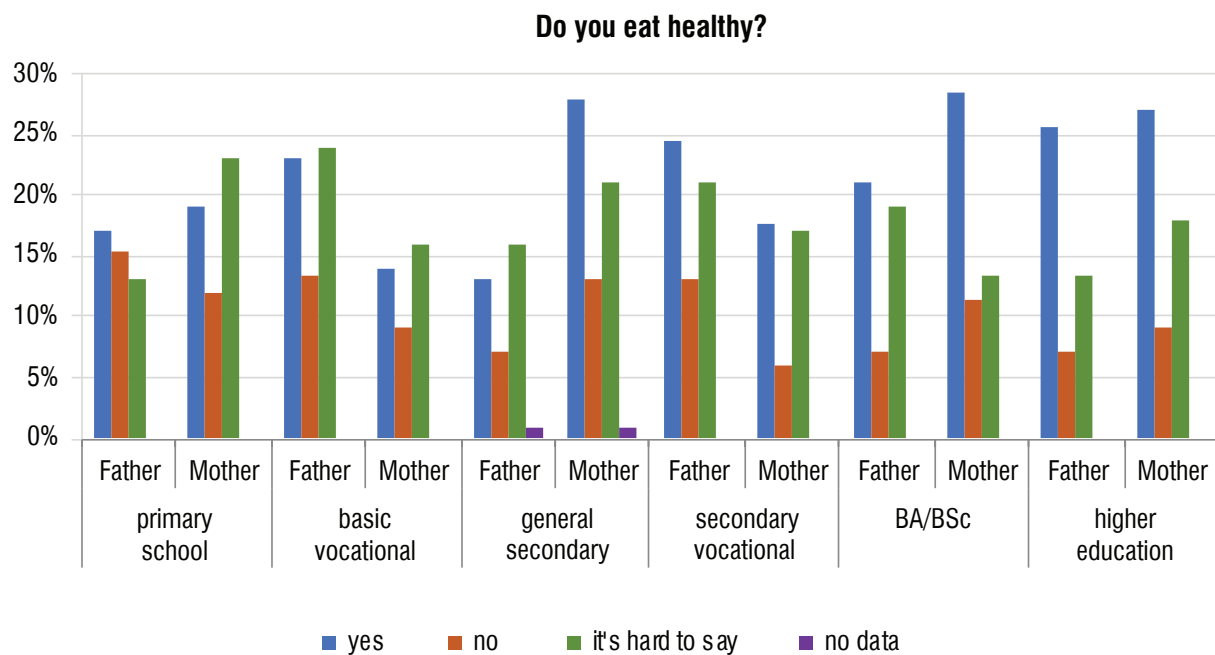
<sup>27</sup> W. Kalupa, *Zachowania prozdrowotne w badaniach elementów stylu życia*, "Badanie stanu zdrowia populacji i funkcjonowanie opieki zdrowotnej. Zagadnienia wybrane", T. Maksymiuk, L. Bartkowiak et al., Wydawnictwo AM im. K. Marcinkowskiego in Poznań, Poznań 2002.

<sup>28</sup> <http://statystyka.org.pl/> [retrieved: 21.05.2017].

**Table 5. Respondents' assessment regarding proper nutrition (%)**

Do you eat healthy?	Upper-secondary school		
	Vocational school	Technical school	General secondary school
Yes	33	38	56
No	17	24	13
It is hard to say	49	38	30
No data	0	0	1
Total	1	1	1

Source: as in Table 1.

**Figure 2. Student assessment regarding proper nutrition including their parents' education level (%)**

Source: as in Figure 1.

A more detailed analysis of the question regarding the declared quality of nutrition, combined with the parents' education level, shows that proper nutrition is declared by the surveyed youth of all upper secondary schools in Warsaw whose parents have general secondary education, Bachelor's level education or higher. This applies particularly to females. On the other hand, the young people whose parents have primary or vocational education declare proper nutrition relatively less often. This confirms the assumption that mothers and their education level have a decisive influence on the transfer of health-enhancing behaviours.

**Table 6. Students' opinion regarding the consumption of fruit and vegetables (in %)**

How often do you consume vegetables and fruit?	Upper-secondary school		
	Vocational school	Technical school	General secondary school
Every day	32	40	67
A few times a week	40	45	27
A few times in a month	13	7	4
Rarely	16	4	1
Never	0	2	1
No data	0	2	1

Source: as in Table 1.

When combined with the responses regarding the actual eating habits, the information provided shows that the students of general secondary schools declared daily consumption of fruit and vegetables (67%) much more frequently than the students of vocational schools (32%). Predictably, however, the 'rarely' response to the question regarding the consumption of fruit and vegetables was provided by 16% of the vocational school students, and merely 1% of the general secondary school students (Table 6). Similar responses are observed regarding the consumption of milk and other dairy products: 50% of the general secondary school students declare that they consume these products daily, compared to only 27% of the vocational school students, which is indicative of a difference of over 20% to the disadvantage of vocational school students with regard to the consumption of the products mentioned (Table 7). The aforementioned Kalupa's study showed that as many as 36% of the respondents eat unhealthily and irregularly.

**Table 7. Respondents' opinion regarding the consumption of milk and other dairy products (in %)**

How often do you drink milk and milk products?	Upper-secondary School		
	Vocational school	Technical school	General secondary school
Every day	27	40	50
A few times a week	41	42	35
A few times a month	11	7	5
Rarely	17	8	6
Never	3	2	4
No data	0	1	1

Source: as in Table 1.

The results of the self-assessment of proper nutrition among Warsaw's adult youth are partially compatible with actual behaviours in this respect. The general secondary school youth and technical school youth in Warsaw more often declare proper nutrition, and indeed consume vegetables and fruit more often, as well as drink milk and milk products more often than the students of vocational schools. As for the consumption of sweets – the responses to subsequent questions indicate that young people attending Warsaw schools frequently consume sweets and the responses are similar in all types of schools.

On the other hand, in terms of declared health-impairing behaviours, the survey contains a question regarding cigarette smoking (Table 8). Here, the responses indicate that smoking is much more common among vocational school students than among young people attending technical and general secondary schools. In vocational schools, 49% of the respondents declare that they smoke cigarettes daily, without a single 'once a few days' response, which confirms the reliability of the responses. Since they admit to smoking, they smoke consistently. However, 11% of the youth state: 'I tried once and that's it' and 21%: 'I have never tried'. Interestingly, Warsaw's young adults attending general and technical secondary schools provided similar responses, i.e. in the general secondary schools, they declared that they smoke 'daily' – 11%, 'once every few days' – 2%, 'I tried once and that's it' – 16%, 'I have never tried' – 49%, and in the technical schools: 20%, 2%, 15%, and 41%, respectively. These results support the statement that the general and technical secondary school youth surveyed have significantly less contact with nicotine than the vocational school students (Table 8).

**Table 8. Responses regarding smoking cigarettes (%)**

Do you smoke cigarettes?	Upper-secondary school		
	vocational	technical	high school
Yes, every day – how much ...	49	20	11
Yes, every few days– how much ...	0	2	2
Yes, occasionally (one/two)	19	19	20
I tried once and gave up	11	15	16
No, never	21	41	49
No data	0	2	2

Source: as in Table 1.



**Table 9. Students' response regarding beer consumption (%)**

Do you drink beer?	Upper-secondary school		
	Vocational school	Technical school	General secondary school
Yes, every day – how much ...	13	2	2
Yes, every few days – how much ...	13	16	13
Yes, occasionally (one/two)	57	63	59
I tried once and gave up.	5	2	5
No, never.	2	6	11
I don't drink.	11	9	8
No data	0	1	1

Source: as in Table 1.

Similarly to smoking, declarations regarding health-impairing behaviours are demonstrated in the responses regarding the consumption of beer. In terms of these questions, the students of Warsaw's general and technical secondary schools declared more favourable behaviours than the students of vocational schools. 2% of the youth attending general and technical secondary schools declared daily consumption of beer, compared to 13% of the students of vocational schools. On the other hand, the 'I have never tried' responses in the schools surveyed amounted to 11%, 6% and 2%, respectively. This shows a considerable difference of over 5 percentage points in favour of general secondary schools compared to vocational schools (Table 9).

**Table 10. Response regarding drug use (%)**

Do you take drugs?	Upper-secondary School		
	Vocational school	Technical school	General secondary school
Yes, every day – how much and what...	11	10	1
Yes, once in a few days – how much...	7	7	2
Yes, occasionally	21	20	14
I tried once and gave up	29	20	18
No, never	32	43	65

Source: as in Table 1.

The results showing the scale of drug use among the adult students surveyed in upper-secondary schools in Warsaw are alarming. This is another question which belongs to the group of health-impairing behaviours declared by students. Similarly to smoking cigarettes and drinking various types of alcohol, the youth attending vocational schools declare more frequent contact with drugs in comparison to their technical and general secondary school peers. In terms of drug use in the surveyed

vocational schools, 7% of the students declare taking drugs once in a few days, 'occasionally, e.g. at parties' – 21%, 'I tried once and gave up' – 29%. In comparison, the responses to the same question in the technical schools amounted to: 7%, 20%, and 20%, respectively. The general secondary schools compare most favourably in this regard, i.e. 2%, 14% and 18%, respectively. The 'I have never tried' response was provided by 32% of the students, and in the technical schools – 43% of all the respondents, which is of particular interest in the case of contact with psychoactive substances. The general secondary schools score most favourably in this regard, where 65% of the respondents declared that they had so far had no contact with drugs.

Another increasing health problem is youth addiction to computers, mobile phones, tablets, and TV. Modern technologies create a virtual reality which is often detached from the real world. This results in decreased interest in all aspects of life, neglecting school and family duties, and isolation from others.

## Conclusion

Experiences related to shaping health behaviours are applied through health policy as an active and conscious process, the purpose of which is to maintain and increase one's health potential, considering the psychophysical and social development, as well as environmental conditions. This approach sees behaviour as a derivative of education, understood as a series of activities involving many problems, such as those of a psychological or social nature, and not as a spectacular, one-off activity. Activities aimed at recognizing a specific health problem are crucial for the health of not only one, but also future generations.

This approach is reflected also in the description and the subsequent analysis of the field study concerning health behaviours of young adults attending various types of secondary schools, including vocational schools, technical schools and general secondary schools in Warsaw. The research hypothesis of this study says that there is a positive correlation between the type of school that young people attend, and their knowledge about health and the abilities to shape health-enhancing behaviours.

The study shows that the youth surveyed in vocational schools do not recognize health-impairing situations easily and report poorer nutrition (eat fewer dairy products and vegetables, do not eat a warm meal during the day) and more contact with psychoactive substances compared to young people attending technical schools, and particularly general secondary schools. Therefore, it is important to:

- 1) Direct special attention of health educators to educational gaps, especially in vocational schools.
- 2) Reduce infrastructural disproportions between schools and school types.
- 3) Subsidize schools, especially vocational ones, within the scope of educational health programmes as well as sports and catering facilities.
- 4) Implement (select) educational health programmes which maintain the balance between the educational content and declarations with actual activities, not only in the school environment, but also in the family. This concerns particularly those activities which form the foundation of change and behaviour modification, ways of acting, teaching or school management.

Therefore, the overall conclusion of the study may be the observation that it is key to promote and shape knowledge about health through healthy lifestyle education, with a strong emphasis on students of vocational schools as those in need of the strongest substantive and infrastructural support. Such a lifestyle should determine specific behaviours and health-related habits of the individual and build awareness that our health depends also on ourselves, and that it is imperative to actively shape and increase health resources through, for example, physical exercise, diet and overcoming our weaknesses.

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