

# Distend Concept of Health

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**Abstract:** *The sense of health has advanced over time. In 1948, the World Health Organization (WHO) defined health linking fitness to well-being, in phases of physical, mental, and social well-being, and no longer the absence of disease and infirmity. The WHO definition has been criticized as-(i) static, (ii) morbidity's changing styles and (iii) definition's operationalization. This paper attempts to understand the enlarged concept of health through use of those words, objective and subjective related inter-objective and intersubjective. The understanding of health has changed substantially with reconceptualizing health on a continuum rather than as a static state, and adding existential health to physical, mental, and social well-being. Enlarged concept of disease and the binomial health-disease can be better understood under the distend concept of health.*

**Keywords:** health, definition, WHO, expanded concept

## 1. Introduction

Health is thought as the extent of practical or metabolic performance of a living organism. The sense of health has advanced over time. In line with the biomedical perspective, early definitions of health focused at the subject matter of the body's ability to function; health was seen as a state of normal function that could be disrupted from time to time by disease. An example of such a definition of health is: "a state characterized by anatomic, physiologic, and psychological integrity; ability to perform personally valued family, work, and community roles; ability to deal with physical, biological, psychological, and social stress" <sup>[1]</sup>. Then, in 1948, in an intensive departure from preceding definitions, the World Health Organization (WHO) proposed a definition that aimed higher, linking fitness to well-being, in phases of "physical, mental, and social well-being, and now no longer simply the absence of disease and infirmity" <sup>[2]</sup>. Although this definition got welcomed via way of means of few as being innovative, it got additionally criticized for being indistinct and excessively extensive and became now no longer construed as measurable. The WHO definition has been criticized with reference to: (i) the static nature of the definition, i. e. health as a state, (ii) the converting styles of morbidity and (iii) the operationalization of the definition. Operationalization of health as a state of 'entire physical, mental and social wellness' is arduous because it is hard as it is not always smooth either to define or measure 'complete'. Moreover, critics said, the requirement of entire wellness has contributed to the medicalization of society <sup>[3-6]</sup>. Patterns of populace morbidity got modified since 1948 and the number of humans living with one or greater persistent illness has aggrandized worldwide <sup>[7-9]</sup>. According to WHO's definition, these kinds of people are taken into consideration to be 'ill', without thinking about their degree of functioning or well-being. For many years, it was set apart as an impractical ideal, with maximum discussions of health returning to the practicality of the biomedical model <sup>[10]</sup>. Just as there has been a change in perspective of disease as a state to

considering it as a process, identical shift in outlook came about in definition of health.

### 1.1 Definition of health developed over the years

Observably, definition of health is evasive and methods of considering it have developed over the years. Three major propositions include the "medical model (dominant in North America throughout the 20<sup>th</sup> century)", the "holistic model (exemplified by the 1947 WHO definition)", and the "well-being model (WHO discussion document of 1984 health promotion initiative)". This evolution has been meditated in converting methods to measure health and WHO played a leading role when it fostered the development of the health promotion advertising motion in the 1980s. This delivered a brand-new concept of health, no longer as a state, however in dynamic phrases of resiliency, in alternate words, as "a resource for living". In 1984, WHO revised the definition of health defined it as "the extent to which an individual or group is able to realize aspirations and satisfy needs and to change or cope with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources, as well as physical capacities." <sup>[10]</sup> Thus, health is noted the capacity to hold homeostasis and get over unfavorable events. Mental, intellectual, emotional and social health cited to a person's capacity to address stress, to collect skills, to hold relationships, all of which shape assets for resiliency and independent living <sup>[11]</sup>. Health may be understood on biological approach, biomedical technique, behavioral outlook, spiritual point of view, health education perspective, public health viewpoint and many more. This divulge many opportunities for health to be taught, bolstered and learned. Following the WHO definition, it become determined that bodily well-being corresponds to an 'objective' process. Contrarily, mental well-being is associate to a 'subjective' process. It is imperative to recognize the use of these two words, 'objective' and 'subjective.' This paper attempts to understand the expanded concept of health through use of those words, objective and

subjective related inter-objective and intersubjective. Expansion or amplification can occur in vivo (in the living individual) or in vitro (in the laboratory).

### 1.2 Objective and Subjective connotations to Health

In the last decennary of the 20 centuries, ‘objective’ became increasingly validated, and the opposite happened to ‘subjective’. The word objective is related to ‘object’ and subjective to ‘subject’. So, society turned pragmatic, and a kind of ‘objectification’ of individual befell collectively with dehumanization in medicine. Objectification is a notion central to feminist theory. It can be roughly defined as the seeing and/ or treating a person, usually a woman, as an object, with denial of subjectivity. Philosopher Nussbaum (1995, 1999) observed seven ways objectification occurs: ownership (the person can be possessed), instrumentality (the person can be used), denial of autonomy (the person lacks independence), denial of subjectivity (the person's feelings are not considered), inertness (the person lacks in agency) [12]. Similarly, dehumanization is endemic in practice and therefore the psychological science of dehumanization result from inherent options of medical settings, the doctor-patient relationship, and the readying of routine clinical practices. Six major causes of dehumanization in medical settings are deindividuation practices, impaired patient agency, dissimilarity, mechanization, sympathy reduction, and ethical disengagement [13]. So, this paper intends to use those words, objective and subjective related to inter-objective and intersubjective to better understand the enlarged concept of health. Conforming to the thought process, social well-being is correlated to an interjective process. Fifteen years ago, Kahneman, Diener and Schwartz [14] proposed a new science of wellbeing and two conceptual approaches to wellbeing research evolved. The objective approach defines wellbeing as a combination material resources (e. g. income, food, housing) and social characteristics (education, health, political voice, social networks and connections). The objective approach to wellbeing largely originates from Amartya Sen’s work in welfare economics [15, 16] about how to measure poverty and inequality, and its extension [17, 18] to the potential individuals should have to live fulfilling lives. When people were required to wear masks or be vaccinated during a pandemic, it became easier to comprehend the social state of health. The signs of traffic, for example, are required to promote inter-objective social wellbeing. As a result, social rules that condition mutual respect determine inter-objective wellbeing.

### 1.3 Cultural factors in Health promotion

In the WHO Ottawa Conference in 1986, it was proposed that health promotion could include cultural factors in that well-being. That Conference was held in response to growing global aspirations for a new public health movement [19]. The cultural and environmental aspects of the project were prioritized. As a result, it is thought that a fourth component of health, the cultural component, could be included. All variables that contribute to the culture of distinct individuals, such as aesthetic features, ludic factors, community customs, religiosity, and spirituality, could be included in this component. An instrumental notion for

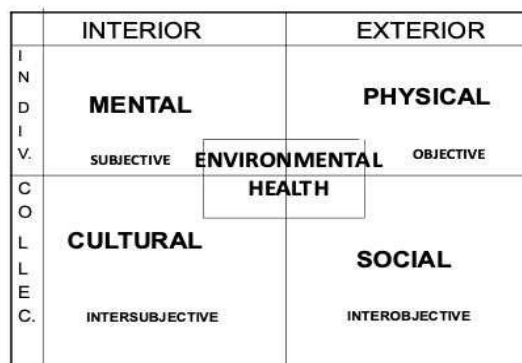
health professionals undertaking research or health intervention among rural or indigenous communities, as well as urban situations characterized by patients from various social classes, faiths, regions, or ethnic groups, is Culture-as defined by anthropology. These patients exhibit distinct actions and attitudes related to sickness, as well as specific belief about health and therapeutic techniques. These peculiarities are the result of social and cultural difference rather than biological variations. In a nutshell, our starting assumption is that everyone has culture, and that culture is what determines these particularities. Furthermore, concerns about health and illness processes should be evaluated in the context of specific socio-cultural environments in which they occur [20]. This idea regarding the significance of culture is not exclusive to anthropological knowledge; since the second half of the 1960s, thinkers, researchers, and practitioners in the health sciences-particularly those in medicine and nursing-have accepted it [21, 22]. All of these cultural elements can have a favorable or negative impact on physical, mental, and social well-being. Therefore, the cultural part of health can be characterized as an ‘intersubjective process’, as the conceptualized diagram below with these four components of health, and the table with two columns and two lines corresponding to ‘interior’ and ‘exterior’ aspects of the human being; and correlation to individual and collective aspects would describe-

	INTERIOR	EXTERIOR
I N D I V. C O L L. L. T R A D I T I O N S	<p><b>MENTAL</b></p> <p>SUBJECTIVE</p>	<p><b>PHYSICAL</b></p> <p>OBJECTIVE</p>
	<p><b>CULTURAL</b></p> <p>ARTS - LUDIC</p> <p>RELIGIOSITY</p> <p>SPIRITUALITY</p> <p>INTERSUBJECTIVE</p>	<p><b>SOCIAL</b></p> <p>INTEROBJECTIVE</p>

The cultural factor’s intersubjectivity is related to a community’s collective unconsciousness’s values, symbols, and other features. Intersubjective perceptions refer to common perceptions of psychological traits prevalent across cultures. Culture is a loosely organized pattern of ideas and behaviors that are shared (though imperfectly) across a group of interdependent individuals and passed down through generations in order to coordinate individual goal pursuits in collective existence. Culture change relies heavily on intersubjective perceptions [23]. Humans, like all other animals, must eat, drink, sleep, and reproduce. However, each of these characteristics must be associated to cultural conditions for the human person. And, depending on the cultural context, it may even be necessary to refuse some practices. The human person is the only animal species that can consciously refuse to act even when compelled by instinct till we know otherwise.

In the text ‘Incorporating “Culture” within a Culture of Health, the authors Ruiz and Devine explained that “the pathway to greater equity and better health outcomes for individuals in America of all cultures starts with recognizing that people from every background have contributions to

make”. So, when people are linked to the cultural values of their communities, individuals and community are in better conditions of health. So, we can say that this is a kind of ‘Culture of Health’, and now a days it must be built on that Culture. Today there is a growing part of the non white population in America with its own cultural characteristics that can enrich their health. It can be seen, for example, in the Indian or Hispanic population [24]. Various studies have found that cultural patterns and economic conditions have an impact on health perception in Latin America. An examination of this data suggests that health satisfaction is directly connected to country’s per capita income, albeit weakly, and is lower in nations with more recent economic growth. Objective health indices may be at conflict with cross-national assessments of health satisfaction. Within each country, disparities are intimately linked to people’s economic and health situations. Lower income people are more aware of health issues, but they are less tolerant of some of the health issues than the wealthy. Significantly varied reaction styles from one country to the next, possibly reflecting cultural variances in health ideals and customs [25]. Again, Chinese Medicine and India’s Ayurveda are Asia’s two major systems of traditional health knowledge. Understanding that people have varied metabolic types is central to these Asian wellness traditions, and a tailored and balanced approach to nutrition based on body type and cultural food traditions is paramount in Asian wellness theories and practices. Evidence supports Asian wellness traditions in lowering non-communicable disease (NCD) risk, reducing stress and mental health difficulties, and improving quality of life (QOL) and lifespan. The World Health Organization (WHO) recognizes that changing one’s lifestyle is the only method to stop the rising trend of NCDs [26]. So, as the title of that text says, incorporating Culture can be a step ahead in an expanded or amplified Concept of Health. With the word ‘enlarged or amplified’, it is meant health beyond the WHO concept or even the interesting biopsychosocial concept proposed by George Engel [27]. He proposed a biopsychosocial model that provides a blueprint for research, a framework for teaching, and a design for action in the real world of health care. This is because the dominant model of disease today is biomedical, with molecular biology its basic scientific discipline, and it leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. Following these ideas, one must be careful not to have a reductionist attitude and reduce each different condition to the objective physical well-being and disease. In that way, one could think that every adverse condition, mental, social, cultural, could be solved with pills as the physical problems of health, although sometimes it can be useful for several conditions. It is possible to add a fifth factor, ‘environmental well-being’, as an intersection of all the other factors, as conceptualized diagram illustrates.



It is possible to insert here categories related to the natural environment or the environmental conditions constructed by people. This fifth condition is nowadays growing in importance in front of the global environmental situation. For example, we can see growing dramatic conditions in the opposite side of well-being from ecological damage that can compromise each aspect of health. One thing that has been a focus of critical comments about the WHO concept of health is the word “complete” because it seems utopic and unattainable. However, it is possible to see that affirmation by the meaning that it can be an aim to be achieved. So, all the effort can have a proper direction, over which people can build roads to better well-being. We must see that all that concept is about health and not about disease or in firmity. It can be useful to insert a discussion about ‘disease’ as some counterpart to health as follows.

Other aspects of adding to this discussion are the words disease, illness, and sickness. There are different meanings for three words that are sometimes used as synonyms: disease, illness, and sickness. Concepts such as disease and health can be difficult to define precisely. Part of the reason for this is that they embody value judgments and are rooted in metaphor. The precise meaning of terms like health, healing and wholeness is likely to remain elusive, because the disconcerting openness of the outlook gained from experience alone resists the reduction of first-person judgments (including those of religion) to third-person explanations (including those of science). Professor Marshall Marinker, a general practitioner, suggested over twenty years ago a helpful way of distinguishing between disease, illness and sickness. He characterizes these “three modes of unhealth” as follows.

“*Disease* is a pathological process and the quality that identifies disease is some deviation from a biological norm. There is an objectivity about disease which doctors are able to see, touch, measure, smell. Diseases are valued as the central facts in the medical view.

“*Illness* is a feeling, an experience of unhealth which is entirely personal, interior to the person of the patient. Sometimes illness exists where no disease can be found. The patient can offer the doctor nothing to satisfy his senses.

“*Sickness* is the external and public mode of unhealth. Sickness is a social role, a status, a negotiated position in the world, a bargain struck between the person hence forward called ‘sick’, and a society which is prepared to recognize and sustain him. Sickness based on illness alone is a most

uncertain status. But even the possession of disease does not guarantee equity in sickness.

Disease then, is the pathological process, deviation from a biological norm. Illness is the patient's experience of ill health, sometimes when no disease can be found. Sickness is the role negotiated with society<sup>[28]</sup>. We can observe such peculiarities, for example, in indigenous communities and their traditional practices about health and infirmities. As we can see by those conceptions, illness and sickness are more appropriately related to subjective or inter-subjective aspects of health<sup>[29]</sup>. Together with all those ideas, the 'patient-centered medicine' in Canada was established where an amplified concept of health is applied<sup>[30]</sup>. In an on exclusive way of thinking, patient-centered medicine can work together with disease-centered medicine. Similarly, Narrative Based Medicine and Evidence-Based Medicine can complement each other. Evidence-Based medicine has an interesting rule sometimes not remembered by professionals: 'to respect the values and cultural aspects of patients'. This condition is where Narrative Medicine can combine with Evidence-Based Medicine. We can say that Narrative Medicine can be situated in the winter-subjective cultural component of health. It is also situated in a space between patient life stories and the conventional clinical history, or anamnesis.

## 2. Conclusion

The broad and idealistic WHO definition, describing health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, with its high idealism and acknowledgement of the social aspects, was groundbreaking when it was adopted. Even though an idealistic definition, but 95% of care remains focused on repair, recovery or prevention of disease and infirmity. Demographic developments also played a role, with more illness and more chronically diseased people as a result of ageing populations. To what extent the definition is realistic these days required review. Technological developments have also expanded the concept of disease, as more diagnostic techniques and treatments have become available. In other words, the current definition allows no room for a dynamic approach to health or for ability to adapt. The understanding of health has changed substantially. These changes include reconceptualizing health on a continuum rather than as a static state, and adding existential health to physical, mental, and social well-being. Further, good health requires adaptation in coping with stress and is influenced by social, personal and environmental factors. By all those considerations, the binomial health-disease can be better understood under the enlarged concept of health. As examples of those conditions, authors referred to cases that could be framed in that 'extended' model, as we have also seen similar situations in our own experience.

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