International Journal of Innovative Research in Medical Science (IJIRMS)
Volume 09, Issue 11, November 2024,
https://doi.org/10.23958/ijirms/vol09-i11/2001

Review Article

Chasing the Mirage of Complete Health: Revisiting WHO's Definition of Health in Modern Health Paradigms

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Received 07 October 2024; Accepted 14 November 2024; Published 19 November 2024

Abstract

The World Health Organization's (WHO) in 1948 defined health as a "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" which had been influential yet controversial among public health scholars. This critical review examined the limitations of the WHO definition through an analysis of contemporary literature. Key limitations identified include its static and idealistic nature, inadequacy in accommodating the needs of individuals with chronic illnesses and aging populations, and as well the limited cultural and spiritual relevance and inclusivity. The findings of this review emphasized the need for a more adaptable, resilient, inclusive definition of health that reflects the dynamic and complex realities of health in the 21st century, with implications for policy, clinical and public health practices, and global health frameworks.

Keywords: ***WHO, Definition of Health, Complete Health, Absence of disease***

Introduction

In 1948, the World Health Organization (WHO) defined health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity," a concept that was revolutionary in moving beyond a strictly biomedical model of the definition of health (WHO, 1948). At a time when public health emphasized disease eradication and physiological normalcy, this definition introduced a holistic perspective on health that underscored the importance of mental and social dimensions. Over time, however, this idealistic definition has faced mounting critiques, particularly concerning its applicability within the context of modern health paradigms in the 21st century (Huber et al., 2011; Marielle J et al., 2015, Kutmec Y, et al., 2021).

This review examined the limitations of WHO's definition based on recent literature, highlighting its impracticality in addressing chronic illness, natural aging processes among elderly people, mental health, and cultural and spiritual determinants of health (Huber et al., 2011; Marielle J et al., 2015, Kutmec Y, et al., 2021). Moreover, this appraisal shed light on other health frameworks and models, including resilience-based and biopsychosocial models, which offer adaptable and inclusive perspectives. The findings of this review paper may support scholars' calls for a more flexible definition of health that can better guide public health policy, resource allocation, and culturally and spiritually sensitive interventions in contemporary health settings across the continent.

Critique of the WHO definition of health

1. The unrealistic notion of "complete" health

The concept of "complete" health embedded in the WHO definition has been criticized as unrealistic and unattainable for most individuals and communities in the contemporary era. This is especially true in developing countries, where violence, stress, poverty, lack of education, poor housing conditions, lack of governmental and social support, and infectious diseases are prevalent, also in developed countries, where chronic non-communicable diseases and aging populations are widespread (Huber et al., 2011; Marielle J et al., 2015, Larson, 2016). Huber et al. (2011) contended that such an ideal perspective disregards the lived realities of individuals with chronic conditions, or those getting older yet experience significant well-being and functional health despite persistent symptoms or limitations. Chronic diseases such as diabetes, rheumatoid arthritis, stroke, hypertension, and cardiovascular diseases require lifelong management rather than cure, rendering "complete" health an impractical and unrealistic standard of health and well-being (Wagner et al., 1996).

Moreover, with rising life expectancy, age-related health decline is a natural and often manageable process, one that current healthcare models emphasize through functional health rather than complete well-being (Marielle J et al., 2015, Larson, 2016). This critique is supported by evidence showing that health frameworks and models focusing on adaptability and self-management are more realistic and relevant for aging populations, where successful aging

is characterized by maintaining good quality of life rather than achieving complete state of health and well-being (Braveman & Gottlieb, 2014, Marielle J et al., 2015).

Furthermore, translating this ideal concept into practical, measurable, and actionable health indicators for policy and clinical applications proved challenging. Operationalizing "complete" health requires benchmarks for physical, mental, and social well-being that are not only difficult to set but are also inherently subjective and variable across population settings, which raises some issues, including:

Measurability and practicality: Defining and measuring "complete well-being" is inherently complex, as it involves subjective and multifaceted dimensions. Health assessments typically rely on quantifiable metrics (e.g., physical exams, mental health screenings, socioeconomic data), yet "complete well-being" lacks clear, universally accepted metrics. This complicates efforts to implement the WHO definition in public health policy or clinical settings, where measurable and actionable indicators are essential for planning and evaluation (Bice, 1976; Callahan, 1973).

Resource allocation: The pursuit of "complete" health as an operational goal may lead to inefficient resource allocation, as health systems may overextend efforts to address an ideal that is unattainable for many individuals and communities, especially those with chronic or lifelong conditions. Prioritizing complete well-being risks diverting resources from achievable goals, such as managing chronic disease or enhancing quality of life, toward unrealistic standards that may not be feasible within the constraints of available resources (Downie, 1990).

Adaptability and responsiveness: The ever-changing, dynamic health needs, are widely vary across different population groups, nations, and contexts. Operationalizing a "complete" health model restricts the ability of healthcare systems to adapt to changing health needs and prioritize preventive, rehabilitative, or palliative care as needed. Instead, models that focus on resilience, adaptability, and functionality allow health policies and programs to respond effectively and more flexibly to the diverse and evolving needs of individuals and communities (Huber et al., 2011; Ryff & Keyes, 1995). These limitations suggest that an operationally feasible health model would benefit from an adaptable framework focused on attainable, measurable health outcomes.

2. Inadequate accommodation of chronic diseases

The WHO's emphasis on the "absence of disease" in defining health is increasingly misaligned with the global health burden of chronic and non-communicable diseases (Murray & Lopez, 2013, Marielle J et al., 2015). Chronic illnesses, which require long-term, sustained, adaptive management approaches, highlight the inadequacy of a disease-free standard of health and well-being. For instance, individuals living with HIV, chronic pain conditions, or cardiovascular disease often report elevated levels of satisfaction and decent quality of life through effective disease management (King et al., 2016). This indicates that health cannot merely be defined by the absence of disease but must take into consideration individuals' functional capacities, elevated level of satisfaction, and overall well-being in the presence of illness and infirmity.

Huber et al. (2011) advocated for a health paradigm centered on the "ability to adapt and self-manage," which emphasizes resilience and capacity for management over complete health and well-being. Such a functional perspective aligns with the practical needs of chronic illness provided healthcare services, as well as the aging population's needs, where health interventions focus on enhancing the quality of life, self-efficacy, adaptivity, and resilience rather than cure (Tulip C, et al, 2020).

3. Interrelation between mental health and social well-being

Although WHO's definition incorporates mental and social well-being, recent literature suggested that it inadequately captures the complexities of these domains in contemporary contexts. Social determinants of health, including income, education, residence whether urban or rural, housing condition, cultural adaptation, and social support, significantly influence mental health outcomes (Marmot et al., 2012; Braveman & Gottlieb, 2014). This socio-environmental influence on health underscores a critical gap in the WHO's definition, which lacks the depth to address these systemic and external factors.

The biopsychosocial model, introduced by Engel (1977) and expanded later by Borrell-Carrio et al. (2004), provided a comprehensive understanding of health by integrating biological, psychological, and social dimensions. Such a model is particularly valuable in addressing mental health, as it recognizes the dynamic interplay between individual, social, and environmental factors that shape well-being (Solar & Irwin, 2010). Studies demonstrated that mental health and social well-being are not purely individual concerns but are profoundly affected by larger socio-economic forces, a consideration that the WHO definition insufficiently addresses (Solar & Irwin, 2010; Kirmayer, 2012).

4. Overemphasis on disease-free state as health

The WHO's implied equating of health with a disease-free state has been a point of debate among scholars advocating for positive health frameworks and models (Kickbusch, 2007). This disease-centered perspective aligns more closely with early biomedical models and can inadvertently overlook preventive health and wellness measures. Sisto, A., et al (2019) emphasized that health should not solely be defined by the absence of pathology but by the capacity to adapt, recover, and maintain resilience in the face of challenges.

Resilience-based models redefined health as a resource for coping with life's stresses, emphasizing the importance of well-being, functionality, and resilience over mere disease absence (Ryff & Keyes, 1995). Aging studies underscored the relevance of this approach, as functional health is increasingly valued over traditional markers of "complete" health, reflecting an adaptive model that prioritizes individuals' capacities to thrive despite chronic conditions or age-related changes (Larson, 2016).

5. Limited cultural relevance and inclusivity

Another major critique concerns the WHO definition's limited cultural adaptability. Health is conceptualized differently across cultures and nations, and for many Indigenous and non-Western communities, health includes aspects like spiritual and communal well-being, which were not reflected in the WHO's framework (Waldram, 1990; Stephens et al., 2005). Kirmayer (2012) argued that a universal health definition rooted in Western health norms may marginalize non-Western health practices and norms, suggesting that culturally adaptable frameworks are necessary to accommodate diverse understandings of health. This limitation becomes especially evident when examining health beliefs, norms, and practices in populous countries like China and India, which together account for nearly half of the world's population. These countries have rich, longstanding cultural traditions that offer different understandings of health, many of which conflict with or extend beyond the WHO's framework.

In China, health is deeply influenced by Traditional Chinese Medicine (TCM), which has a comprehensive approach emphasizing balance, particularly the balance between the opposing

forces (Bhasin, 2007). For many Chinese, health is understood as harmony between the body, mind, and environment, achieved through the regulation of life energies and maintaining equilibrium among different body elements. This perspective differs from the WHO's definition, which is centered on an idealized, static state of "complete well-being" rather than a dynamic process of achieving and maintaining balance (Amzat, J., et al O., 2014; Jegede, 2005).

Similarly, in India, traditional health practices are rooted in an ancient system that views health as a balance between mind, body, and spirit (Omonzejele, 2008). Health is thus not solely about the absence of disease but about aligning one's physical, mental, and spiritual dimensions with the natural order (Garro, 2000; Jegede, 2002). In this cultural context, health is viewed as a lifelong journey of self-discovery, spiritual growth, and harmony with one's environment, rather than the attainment of an absolute, disease-free state (Kirmayer, 2012; Bhasin, 2007). The WHO's definition, with its static and idealized concept of health, did not sufficiently account for these holistic and spiritual elements central to Indian perspectives on health.

This limitation hinders the potential for culturally sensitive health policies that incorporate health practices in non-Western societies. Consequently, the definition's limited cultural adaptability may restrict its effectiveness in guiding global health policies and might fail to accommodate the diverse ways in which health is understood and maintained by nearly half of the world's population (Prince et al., 2007; Jegede, 2005).

For global health efforts to be inclusive and effective, there is a pressing need to redefine health in a way that takes into consideration the spiritual and cultural diversity of the different nations. A revised definition might incorporate the principles of the ability to adapt, harmony, and cultural and spiritual integration, allowing for a broader and more inclusive understanding that resonates with both Western and non-Western health practices and norms. By integrating cultural and spiritual dimensions of health in current healthcare practices, public health frameworks and models can better meet the needs of diverse populations, making health intervention policies more effective, relevant, inclusive, and equitable across both sides of the ocean (Kickbusch, 2007; Marmot et al., 2012).

Models of health that can be utilized to enhance the WHO definition of "health"

Resilience and adaptability as health

Huber et al. (2011) proposed redefining health as "the ability to adapt and self-manage in the face of social, physical, and emotional challenges." This resilience-based model addresses the limitations in chronic disease contexts, where health is better viewed as a dynamic process of adaptation. However, critiques of resilience models suggest they may inadequately capture broader social determinants, highlighting a need to integrate resilience with socio-ecological perspectives (Braveman & Gottlieb, 2014).

Biopsychosocial and social-ecological models

The biopsychosocial model, originally proposed by Engel (1977), offered an integrated approach to health that encompasses biological, psychological, and social factors. This model addressed mental health and chronic illness, where social determinants and environmental factors play a critical role (Borrell-Carrio et al., 2004). Social-ecological models extended this approach by incorporating community and environmental dimensions, providing a more comprehensive framework for understanding health disparities and promoting health equity (Solar & Irwin, 2010; Marmot et al., 2012).

Positive health frameworks and models

Frameworks and models emphasizing positive health, such as those proposed by Ryff and Keyes (1995), redefined health as a subjective state of well-being that encompasses resilience, life satisfaction, adaptability, and social integration. These models allowed health to be viewed as a subjective experience, which may be relevant in contexts of chronic illness and aging, where well-being is often defined by functional status rather than disease absence (Larson, 2016). This model, when viewed from an operationalized perspective, reveals significant limitations due to its embedded subjectivity.

Conclusion

The WHO's 1948 definition of health, while groundbreaking in its time, is limited in addressing the complexities of modern healthcare system challenges. This review identified key limitations of the definition including its static, idealistic nature, inadequate accommodation of chronic illness, insufficient mental and social health integration, and limited spiritual and cultural applicability. Contemporary models and frameworks such as resilience-based, biopsychosocial, and social-ecological models offer approaches that reflect the dynamic and culturally diverse nature of health and can be utilized to enhance the WHO 1948 definition of health. By emphasizing functionality, resilience, and adaptability rather than an idealized state of complete well-being, healthcare systems can allocate resources more efficiently, set realistic goals, and address population health needs more responsively. Incorporating resilience, functionality, and inclusiveness in the WHO definition could significantly improve public health policies and practices, enhancing its relevance in a world increasingly hit by chronic illness, mental health concerns, aging populations, and health disparities. Future research should focus on validating these models in diverse settings to evaluate their effectiveness and applicability across diverse cultural and socioeconomic contexts.

List of Abbreviations

WHO: World Health Organization
TCM: Traditional Chinese Medicine
HIV: Human Immunodeficiency Virus

Declarations

Ethics approval and consent to participate

Not Applicable

Data Availability

This review relies on previously published studies; no original data was generated. Interested readers can access data through the cited sources.

Conflicts of Interest

The author declares no conflicts of interest. This review was conducted independently, without external influence.

Funding Statement

This study received no specific grant from any funding agency.

Acknowledgments

Not Applicable

References

[1] Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. Annals of Family Medicine, 2(6), 576-582. https://doi.org/10.1370/afm.245

[2] Braveman, P., & Gottlieb, L. (2014). The social determinants of health: it is time to consider the causes of the causes. Public Health Reports (Washington, D.C.: 1974), 129 Suppl 2(Suppl 2), 19-31. https://doi.org/10.1177/00333549141291S206

[3] Bury M. (1982). Chronic illness as biographical disruption. Sociology of health & illness, 4(2), 167-182. https://doi.org/10.1111/1467-9566.ep11339939

[4] Sisto, A., Vicinanza, F., Campanozzi, L. L., Ricci, G., Tartaglini, D., & Tambone, V. (2019). Towards a Transversal Definition of Psychological Resilience: A Literature Review. Medicina (Kaunas, Lithuania), 55(11), 745. https://doi.org/10.3390/medicina55110745.

[5] Engel G. L. (1977). The need for a new medical model: a challenge for biomedicine. Science (New York, N.Y.), 196(4286), 129-136. https://doi.org/10.1126/science.847460

[6] Huber M, Knottnerus JA, Green L, et al. (2011). How should we define health? BMJ, 343, d4163.

[7] Marielle Jambroes, et al, (2015) Implications of health as 'the ability to adapt and self-manage' for public health policy: a qualitative study. European Journal of Public Health. Oxford University Press.

[8] Kickbusch, I. (2007). Health Governance: The Health Society. In: Health and Modernity. Springer, New York, NY. https://doi.org/10.1007/978-0-387-37759-9_9

[9] King, D. E., et al, (2013). The status of baby boomers' health in the United States: the healthiest generation? JAMA Internal Medicine, 173(5), 385-386. https://doi.org/10.1001/jamainternmed.2013.2006

[10] Kirmayer L. J. (2012). Rethinking cultural competence. Transcultural psychiatry, 49(2), 149-164. https://doi.org/10.1177/1363461512444673

[11] Larson J. S. (1999). The conceptualization of health. Medical care research and review: MCRR, 56(2), 123-136. https://doi.org/10.1177/107755879905600201

[12] Marmot, M., Allen, J., Bell, R., Bloomer, E., Goldblatt, P., (2012). WHO European review of social determinants of health and the health divide. Lancet, 380(9846), 1011-1029. https://doi.org/10.1016/S0140-6736(12)61228-8.

[13] Murray, C. J., & Lopez, A. D. (2013). Measuring the global burden of disease. The New England journal of medicine, 369(5), 448-457. https://doi.org/10.1056/NEJMra1201534

[14] Nordenfelt L. (2007). The concepts of health and illness revisited. Medicine, health care, and philosophy, 10(1), 5-10. https://doi.org/10.1007/s11019-006-9017-3

[15] Ryff, C. D., & Keyes, C. L. (1995). The structure of psychological well-being revisited. Journal of personality and social psychology, 69(4), 719-727. https://doi.org/10.1037//0022-3514.69.4.719

[16] Tulip C, et al, (2020) Building Wellbeing in People with Chronic Conditions: A Qualitative Evaluation of an 8-Week Positive Psychotherapy Intervention for People Living with an Acquired Brain Injury. Front. Psychol. 11:66. doi: 10.3389/fpsyg.2020.00066

[17] Solar, O., & Irwin, A. (2010). A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice), WHO. Accessed on: November 5, 2024. https://iris.who.int/bitstream/handle/10665/44489/9789241500852_eng.pdf?sequence=1

[18] Stephens, C., Nettleton, C., Porter, J., Willis, R., & Clark, S. (2005). Indigenous peoples' health--why are they behind everyone, everywhere? Lancet (London, England), 366(9479), 10-13. https://doi.org/10.1016/S0140-6736(05)66801-8

[19] Waldram J. B. (1990). The persistence of traditional medicine in urban areas: the case of Canada's Indians. American Indian and Alaska native mental health research: journal of the National Center, 4(1), 9-29. https://doi.org/10.5820/aian.0401.1990.9

[20] Wagner, E. H., Austin, B. T., & Von Korff, M. (1996). Organizing care for patients with chronic illnesses. The Milbank quarterly, 74(4), 511-544.

[21] World Health Organization. (1948). Preamble to the constitution of the World Health Organization as adopted by the International Health Conference. Official Records of the World Health Organization, 1-18. Accessed on: November 1, 2024. https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1

[22] World Health Organization. (2015). World report on ageing and health. World Health Organization. Accessed on: November 3, 2024. https://www.who.int/publications/i/item/9789241565042

[23] Yang, Y. C., McClintock, M. K., Kozloski, M., & Li, T. (2013). Social isolation and adult mortality: the role of chronic inflammation and sex differences. Journal of health and social behavior, 54(2), 183-203. https://doi.org/10.1177/0022146513485244

[24] Zola I. K. (1972). Medicine as an institution of social control. The Sociological review, 20(4), 487-504. https://doi.org/10.1111/j.1467-954x.1972.tb00220.x

[25] Zulu, J.M., Kinsman, J., Michelo, C. et al. (2014). Hope and despair: community health assistants' experiences of working in a rural district in Zambia. Hum Resour Health 12, 30. https://doi.org/10.1186/1478-4491-12-30

[26] Kutmeç Yilmaz, C., & Kara, F. Ş. (2021). The effect of spiritual well-being on adaptation to chronic illness among people with chronic illnesses. Perspectives in psychiatric care, 57(1), 318-325. https://doi.org/10.1111/ppc.12566

[27] Bhasin, V. (2007). Medical anthropology: A review. EthnoMed, 1(1), 1-20.

[28] Jegede, A. S. (2005). The notion of 'were' in Yoruba conception of mental illness. Nordic Journal of African Studies, 14(1), 117-126.

[29] Jegede, A. S. (2002). The Yoruba Cultural Construction of Health and Illness. Nordic Journal of African Studies, 11(3), 14. https://doi.org/10.53228/njas.v11i3.345

[30] Amzat, J., & Razum, O. (2014). Health, Disease, and Illness as Conceptual Tools. Medical Sociology in Africa, 21-37. https://doi.org/10.1007/978-3-319-03986-2_2

[31] Omonzejele, P. F. (2008). African concepts of health, disease, and treatment: An ethical inquiry. Explore: The Journal of Science and Healing, 4(2), 120-126. doi:10.1016/j.explore.2007.12.001

[32] Garro, L. C. (2000). Cultural meaning, explanations of illness, and the development of comparative frameworks. Ethnology, 39(4), 305-334.

[33] Bice T. W. (1976). Comments on health indicators: methodological perspectives. International journal of health services: planning, administration, evaluation, 6(3), 509-520. https://doi.org/10.2190/1A2A-5JNB-DB35-VWX7

[34] Callahan D. (1973). The WHO definition of 'health'. Studies - Hastings Center, 1(3), 77-88.

[35] Downie, R., Tannahill, C., & Tannahill, A. (1990). Health Promotion: Models and Values.