

The States parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. [Emphasis added.]

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

Preamble, Constitution of the World Health Organization, 1948

INTRODUCTION

The sweeping definition of health contained in the Preamble to the Constitution of the World Health Organization (WHO), that was first signed in July 1946, then ratified and put into effect in 1948, has generated controversy ever since. It has been variously called masterful or dysfunctional, profound or meaningless; defended as indispensable in its present formulation or seen as needing revision; at times held to have opened the door to medicalization of most of human existence and to abuses of state power in the name of health promotion.¹

The first of nine principles listed in the Preamble defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” It is preceded by a declaration holding all nine principles (including this first one) to be “basic to the happiness, harmonious relations and security of all peoples.”² This assertion is on its face false, fortunately for humankind. For if the principles were thus basic, it is hard to see how the peoples of the world could ever have enjoyed such states even briefly. The fact that the principles were included in the Preamble generated an anomaly not present when they were stated as shared aims.

The second principle, declaring that “the enjoyment of the highest attainable standard of health is a fundamental right of human beings,” appears to temper somewhat the extravagance of the definition itself. But it leaves open the question of what such a standard might be, and how shortfalls from attaining it might be measured and compared.³ Between the opening declaration and the claim about the right to health, the mystifying definition of health lies coiled: coiled, to borrow Winston Churchill’s 1939 words about the action of Russia, like “a riddle wrapped in a mystery inside an enigma.”⁴

Does this definition convey a riddle we can solve or serve purposes we can no longer fully fathom? How viable is it at present? To what extent can it function as an operational definition for today’s practices of measurement, assessment, and policy-making? The scope for medical care and research has expanded beyond anything that those who wrote the WHO Constitution could have imagined in 1946. So have the ranks of health professionals: as one commentator points out, most of the professions we now find in hospitals, clinics, and health

centers did not exist before World War II.⁵ Controversies continue to mount over access to health care, priorities for resource allocation, and the responsibilities of richer societies with respect to populations beset by malnutrition, violence, and pandemics such as HIV/AIDS. At the same time, the advent of life-prolonging technologies and drugs, along with efforts at health enhancement through pharmaceuticals, surgery, and genetic engineering, raise new questions about how to interpret “the highest attainable standards of health” that the Preamble’s second principle sets forth as a fundamental right.

As the WHO prepares its 2006-2015 General Programme of Work (GPW), the time seems ripe for a rethinking of the definition of health that its founding delegates arrived at over half a century ago. Such a rethinking calls for bringing into the open underlying political and moral conflicts that the definition blurs, and to ask how best to deal with the resulting conceptual and practical problems. The present paper aims to contribute to this process by first re-envisioning the definition in its original context, then examining its most problematic terms in the light of critiques and suggested changes in its wording, and finally returning to the question of how viable it remains today.

THE HISTORICAL CONTEXT

The temptation to dismiss the WHO definition as bureaucratic clap-trap or as naïve but dangerous utopianism is strongest for those many commentators who simply examine it in the abstract without considering the circumstances under which it was debated and finally accepted as the first principle in the Preamble of the WHO Constitution. It is difficult to recapture the emotions and perspectives of the delegates to the Technical Preparatory Committee meeting in Paris, in March and April 1946. A month earlier, the United Nations Economic and Social Council had voted to establish a single international health organization of the United Nations. The Technical Preparatory Committee, with 22 members, alongside observers and advisors, had been asked to draft a Constitution to be considered by the International Health Conference that was to meet in New York that summer with the charge to adopt a final document.

The public health officials who met in Paris to plan for what would become the World Health Organization had lived with the devastations of the second World War. They knew, as few others, the calamitous health conditions around the world; the ravages of epidemics of flu, typhus, and cholera, the many millions who had died and the many others who lived at the edge of subsistence. They recognized the special predicament of children: UNESCO estimated that 13 million children were abandoned, without parents, after the war, in addition to all those who had died or been killed during the war years. And with Hiroshima and Nagasaki indelibly imprinted in

their memories, the delegates were passionate in warning against further uses of what we now call “weapons of mass destruction”: The atomic bomb and biological warfare, they wrote, “had become a fearful menace and unless doctors realize their responsibilities and act immediately, humanity runs the risk of total annihilation.”⁶

The delegates also shared the understanding of how war and insecurity and persecution affected survival and public health. The Preamble to the Charter of the United Nations, adopted at its San Francisco meeting in April 1945, had stressed the common ends of maintaining international peace and security and of promoting economic and social advancement of all peoples. Later in the Charter, Article 55 had stated that “conditions of stability and well-being [are] necessary for peaceful and friendly relations among nations”; and that nations should promote “solutions of international, economic, social, health and other problems.”⁷

Because the Cold War had not yet begun, it was still possible to hope for unprecedented global collaboration among governments of the world, enlisting health professionals everywhere: the kind of collaboration that had been derailed time and time again earlier in the century and finally collapsed as the Second World War broke out.⁸ In the face of vast, urgent health problems it now seemed more realistic to envisage great collective benefits from the “immense progress [that the war had brought] in the fields of science and technology as applied to medicine.”⁹

From the outset, delegates also expressed the aim to deal, not only with the most negative aspects of health, but also with all the factors that influence it, such as poverty, malnutrition, and war, in order to achieve positive good health. There was nothing new about linking the aim of combating disease and infirmity, on the one hand, and encouraging positive forms of well-being, on the other. In the fourth century B.C., Aristotle had spoken of health as a contributing factor to a state of thriving, flourishing, or well-being (*eudaemonia*). And in India, around the same period, the *Caraka Samhita*, containing the oldest known Auyrvedic writings, held that “Health is the supreme foundation of virtue, wealth, enjoyment, and salvation. Diseases are the destroyers of health, of the good of life, and even of life itself.”¹⁰ But in spite of underscoring such links, no earlier thinkers had claimed that complete health was indispensable to human thriving or well-being.

The delegates were in agreement that combating disease and infirmity while also seeking to achieve the highest attainable levels of positive health would require promoting higher standards of living, better nutrition, access to medical care for all, and universal health insurance. They agreed, too, that these tasks should be undertaken on a global scale never before envisaged, and that access to all needed measures should be considered a right for all men and women and children everywhere.

Among those meeting in Paris, five physicians took the lead in preparing drafts for the new organization's constitution, distributed to the group on March 19 and 20, 1946. The five were no faceless bureaucrats. Each had long experience with domestic and international public health. They were: France's foremost public health officials, André Cavaillon and Xavier Leclainche, Great Britain's Chief Medical Officer, Sir Wilson Jameson, called the "architect of national health," US Surgeon-General Thomas Parron, a specialist on rural sanitation and communicable disease, and Yugoslavia's Andrija Stampar, who had founded the School of Public Health in Zagreb before the War with a grant from the Rockefeller Foundation, spent the war years imprisoned by the Nazis, and was now Dean of its medical school.

The five drafters met in consultation with the other members of the Preparatory Committee. They devoted long sessions to set forth aims for the new organization and offer perspectives on health to be expressed in a Constitution. They meant for the Preamble to cast the widest possible role for the new health organization. To be politically independent in seeking to achieve its aims, it would have to be set up as an independent agency; but its work should relate to the central aims of the United Nations, and above all to peace and security, an aim specifically mentioned in the US, French, and Yugoslav drafts.

Dr. Stampar traced the historical background of international efforts leading up to the decision to form the WHO. Gradually, he pointed out, "the work was extended from the negative aspects of public health -- vaccination and other specific means of combating infection -- to positive aspects, i.e. the improvement of public health by better food, physical education, medical care, health insurance, etc."¹¹

Unlike the work done by previous international health organizations, each of the drafts stressed that the WHO should address mental health, not only physical health.^{12, 13, 14} Only the Yugoslav draft, however, written by Dr. Stampar, provided an explicit definition of health in its Preamble: "Health is not only the absence of infirmity and disease but also a state of physical and mental well-being and fitness resulting from positive factors, such as adequate feeding, housing, and training."¹⁵

By the time the subcommittee submitted a joint draft of the Preamble, on March 21, the Yugoslav formulation, including the definition, had been adopted and somewhat revised, and the word "social" had made its first appearance: "Health is not only the absence of infirmity or disease but also a state of physical fitness and mental and social well-being."¹⁶ Finally, when the Constitution as a whole was submitted, the same day, there had been further editing of the definition, coming close to the definition finally adopted. But the word "complete" was still

nowhere in sight: “Health is a state of physical fitness and of mental and social well-being, not only the absence of infirmity or disease.”

Coming back to Churchill’s metaphor, the hyperbole in the Preamble’s initial statement is enigmatic, not so much because of the high hopes it conveys but because they are stated as claims rather than as aims or hopes. It was surely important for states to express the sense of a new beginning for humankind and to link the pursuit of health to that of peace, happiness, and security, in accordance with the United Nations Charter. But where the Preamble to the UN Charter speaks of ends, or aims, the WHO Preamble introduces a seemingly empirical (and, on its face, counterintuitive) claim about the nine principles, including the first, defining health as complete well-being, as *basic* to the happiness, harmonious relations, and security of all peoples. Bringing all nine principles held to constitute such a basis into the WHO Preamble intensifies the oddity of the claims it makes. Why go against the normal function of a Preamble, which, as the name suggests, is to come before, to introduce, the document to follow, with the principles or articles that it contains? This function is eloquently served in Preambles such as that of the UN Charter.

The most puzzling among the nine principles included in the WHO Preamble has surely been the first one, defining health. And within that definition, it is the term “complete” that constitutes the central riddle. How did those taking part in the International Health Conference, in July 1946, come to adopt that term? It is nowhere to be found among the drafts that had been offered by the Preparatory Committee members in March and is utterly counterintuitive to ordinary understandings of health, whether of any one individual or of a population. The oddity is more striking still if one considers the constitutions for other U.N. organizations. What if the Preamble to the Constitution of the Food and Agriculture Organization had somehow defined the term “food” as a state of complete nourishment, whatever that might be? Or if UNESCO’s Preamble had defined “educational” or “cultural” in terms of some complete form of education or culture – again, whatever those forms might be?

By 1948, when WHO was established as a specialized UN agency after member states ratified its constitution, the underlying tensions between East and West had intensified. Cooperation turned out to be much more difficult than anticipated at first. It was clearer than ever that the costs of prevention, research, and curative health care would often have to be weighed against one another; and that societies could allocate greater resources to health only by making sacrifices elsewhere, say with respect to education, housing, or defense.

In examining the terms of the definition, I shall consider, first, the challenges in defining highly abstract terms such as “health” and “well-being”; second, the added complications arising

from qualifying them by the term "complete"; third, how inserting these terms into the definition complicates the traditional and relatively unproblematic understanding of health as encompassing both physical and mental well-being; and, fourth, how adding the term "social" further affects this heady brew.

EXAMINING THE DEFINITION'S TERMS

The delegates to the July Conference in New York specified that they aimed to define health positively and broadly, not negatively or narrowly as the absence of disease or infirmity. In so doing, they could draw on long-standing understandings of health as thus positive and broad. Beginning with the most ancient traditions of medicine, it has been known that thriving is more than not suffering from identifiable ailments; and that the positive side is harder to describe, put in words, than the negative one. As the Swedish poet Erik Gustaf Geijer wrote with respect to health: "Each misery has its own cry, but health remains silent. "Var plåga har sitt skri för sig, men hälsan tiger still."¹⁷

Even envisioning health as a state of *complete* well-being has long antecedents. It posits as possible in the here-and-now a state similar to that of the golden age familiar from many ancient civilizations: a period in which individuals were free from illness, death, and all other evils. One of the earliest Greek poets, Hesiod, spoke of a time when men had lived on earth "without evils, hard toil, and grievous disease." But then Pandora's curiosity and greed had led her to raise the lid of a box out of which flew "thousand of miseries [that now] roam among men; the land is full of evils and full is the sea."¹⁸ The historian of medicine Owsei Temkin points to the story of Pandora as reflecting views that were common among archaic cultures and still to be found today: that disease was imposed on human beings by gods or other supernatural forces as punishment for some trespass or sin or wrong-doing; or else as resulting from malevolent spirits or sorcerers aiming to inflict suffering.¹⁹

Alongside the view of a past golden age have been conceptions of a future period devoid of suffering, including illness – either in heaven or paradise after death for those deserving such felicity or in some earthly utopia. Sir Thomas More wrote, in his *Utopia*, about the pleasure of "lively" or "perfect" health, entirely free from all admixture of pain: "almost all the Utopians reckon it the foundation and basis of all other joys of life; since this alone makes the state of life easy and desirable; and when this is wanting, a man is really capable of no other pleasure."²⁰

Golden ages and utopias apart, however, identifying well-being as the enjoyment of such complete or perfect health clashes with what most people ordinarily think of as health. As with efforts to define many other abstract terms such as "happiness," "suffering," "love," or

“violence,” there are no agreed-upon rules for defining any of them; no established criteria for when they do and do not apply to particular circumstances.²¹ The same is true of “health” and of “well-being.” Such abstract terms of universal scope provide ideal vessels into which people can place quite different, sometimes clashing, sorts of content.

It is no wonder, given the vast consequences that adopting one definition of health or well-being rather than another can have for individual lives and for institutions, that some should wish to single out what alone constitutes its “perfect” or “complete” or “true” form. In so doing, they redefine the term at issue as different from how it is ordinarily understood. The same is true when it comes to, for example, true, complete or perfect happiness (or love, courage, and other valued states).²²

Because people over the millennia have had so many clashing views about just what constitutes well-being, qualifying the term by the adjective “complete” serves to multiply the occasions for confusion and misunderstanding, the more so as “complete” can be understood in two incompatible senses: an all-or nothing sense and one which admits of degrees. Most meanings of “complete” that dictionaries specify are of the first kind: something either is or is not complete, entire, concluded, ended, or thorough, consummate, perfect. There are no degrees, no levels of completeness in this sense of the word. We speak of complete disarmament, for example, of the complete works of an author, or of a plant with complete parts.*

To redefine “health” as “complete well-being” in that sense of the term would not only be unsuitable for the purposes of measuring and comparing states of health; it would also leave us with a “null set” of persons as actually possessing health. Most people who take themselves to be healthy are surely aware of a variety of minor allergies, aches and pains, mood swings, digestive ups and downs. They would not qualify as exhibiting complete well-being in this sense. Not even seemingly thriving persons without any diseases or impairments could be known to possess complete physical well-being in this sense, much less mental or social well-being. Even if someone did achieve such a state of complete health, it would be short-lived; and there would be no chance of finding members of any group, let alone inhabitants of a society or a region, enjoying such a felicitous state simultaneously.

* The second sense of “complete” does admit of qualification by terms such as “more” or “most,” and thus also of comparisons, perhaps measurements. It specifies comprehensiveness of scope or thoroughness of treatment, as in the claim that a book is the “most complete” treatment of a topic, or that one health insurance scheme offers “more complete” coverage than another. It is a sense rarely referred to by linguists and frowned upon by some; and the WHO definition makes no mention of more or less complete states of health. Even if it did, efforts to compare or measure greater or lesser degrees of health or well-being would fail in the absence of some agreed-upon conception of what complete well-being itself might be.

Aristotle spoke of completeness in this first, all-or-nothing sense, when he held that we can only evaluate a life from the point of view of well-being or happiness after it is over: "Therefore, the human good turns out to be the soul's activity that expresses virtue. / . . . / Moreover, it will be in a complete life. For one swallow does not make a spring, nor does one day; nor, similarly, does one day or a short time make us blessed and happy."²³

The completeness of a life, in this sense, had nothing to do with its length. A life either was or was not complete, regardless of how long or short it had been. Aristotle referred to Solon's reputed reply to King Croesus boasting of his wealth and asking whether he was not the happiest among men: "Until he is dead, do not yet call a man happy but only lucky." Nor did Aristotle claim that well-being or happiness in its own right could somehow be characterized as complete. On the contrary, he listed a number of factors, such as good health, income, friendship, that could contribute to the likelihood of achieving or enhancing the "soul's activity that expresses virtue."

Today, psychologists, economists, and sociologists explore the degree to which factors such as health, income, employment, and marital status contribute to people's "subjective well-being." No more than Aristotle, however, do they inquire about a state of complete well-being, much less define health in terms of any amount of well-being, complete or not. Instead, surveys ask individuals how happy or satisfied they are with their lives, their work, their health, and other factors, often using qualifying expressions such as "on the whole" or "in most ways." For instance, one frequently-used measure in current research is that of the "Satisfaction with Life Scale" used by psychologist Ed Diener and colleagues. It asks individuals to indicate whether they strongly agree, agree, slightly agree, neither agree nor disagree, slightly disagree, or strongly disagree with the following statements: "In most ways my life is close to ideal." "The conditions of my life are excellent." "I am satisfied with my life." "So far, I have gotten the important things I want in life." "If I could live my life over, I would change almost nothing."²⁴

Other researchers investigate criteria they take to provide objective evaluations of well-being – again, without attempting to measure complete well-being. It is the more difficult to arrive at agreement about such evaluations, however, because the term "well-being" is differently used in different disciplines. Whereas economists often address well-being in terms of preference satisfaction, philosophers inquire into its relationship to happiness and, with psychologists, ask how it may be enhanced or diminished by factors such as wealth, friendship, and health. In medicine, many take well-being – or being well -- to refer primarily to health; but it is also the focus of controversies regarding health promotion.²⁵

The inclusion of the term “complete” to qualify “well-being” in the WHO definition of health complicates, in turn, efforts to understand the three different forms of well-being included in the WHO definition – physical, mental, and social,. How are these to be specified, compared, measured?

To begin with, it is hardly problematic to link *physical and mental well-being* apart from the question of completeness. And to speak generally of estimating degrees to which both forms of well-being obtain, in individuals as in populations, is surely commonplace. Nevertheless, controversies continue about how to measure different aspects of physical and mental health; how to compare them, among individuals, groups, and societies; and about whether the measurements and comparisons can be formulated in any useful way in terms of well-being. The occasions for misunderstanding arising from these controversies, and for errors and abuses in health care as a result, are multiplied to the extent that the term “complete” is taken seriously in the context of physical and mental health. Without being clear about such a distinction, the notion of “complete physical and mental well-being” raises legitimate concerns about medicalizing all of human experience.

All these problems are greater still when it comes to the complete *social well-being* envisaged, first in the Yugoslav draft of the WHO definition, then adopted as part of the Constitution in July 1946. Warning signals should have been flashing as soon as the term “social” was introduced. We need only look at totalitarian societies, or at any society in which members of one gender, religious orientation, party, or ethnic background lay down the rules for what is and is not social well-being, to see the risks involved – as in the Soviet mental hospitals in which dissidents were imprisoned, classified as “mentally ill.”

Regardless of such extreme abuses, we have learned how common it is to look at individuals as maladjusted or less than fully adjusted from a social point of view -- otherwise bright and healthy school children, say, that teachers view as unwilling to learn, uncooperative, loners; or recalcitrant employees, perhaps labor organizers, or persons with unusual dietary or other preferences. And what about individuals who prefer solitude to socializing, or non-voters, uninterested in political and social issues?

Those who prepared the drafts for the WHO Constitution, and especially Andrija Stampar, the Yugoslav delegate, drew on the views of Henry Sigerist, a Johns Hopkins historian of medicine and close friend of Stampar's.²⁶ Sigerist had long stressed the social, as well as the physical and mental dimensions of health, the priority that should be given to preventive health measures, and the controlling role of the state in enforcing these.²⁷ A healthy individual, he had written, is a man who is well balanced bodily and mentally, and well-adjusted to his physical and

social environment. He is in full control of his physical and mental faculties. / . . . / [and] contributes to the welfare of society according to his ability. Health is therefore not simply the absence of disease; it is something positive, a joyful attitude towards life, and a cheerful acceptance of the responsibilities that life puts on the individual²⁸

Again the skeptic has to ask, with respect both to Sigerist's claims about the healthy individual and to the echoes of these claims in the WHO definition: are persons who are not well-adjusted to their physical and social environment or who do not contribute to the welfare of society somehow to be thought of as less *healthy*? What of social environments in which "social drinking" to the point of inebriation is the norm, and seen as healthy? Or in which provisions for reproductive health, seen as necessary in many other societies, are outlawed on social and religious grounds as *unhealthy*? And what about individuals who claim to prefer conditions, such as deafness, that others view as infirmities? Or, on the contrary, people who demand that conditions others take to be normal be reclassified as diseases?

PROPOSED ALTERNATIVE DEFINITIONS

The process of reconsidering the WHO definition began early and has continued to this day. In 1973, Daniel Callahan surveyed the many existing critiques of the definition, and concluded that while some minimal level of health is required if there is to be any chance of human happiness, "one can be healthy without being in a state of "complete physical, mental, and social well-being." What would his own definition of health be? Having submitted the WHO definition to ruthless pruning, he retained only the terse statement that "Health is a state of physical well-being."²⁹

It matters, in this regard, to distinguish between defining and contributing factors in any definition. A variety of factors, including hereditary and environmental ones, contribute to health. This should not be thought to mean that they define health; Callahan's objection rightly cautions against such a leap. For instance, most critics who agree with him that "social well-being" does not belong in an acceptable definition of health, would nevertheless acknowledge that factors such as supportive family, community, and work-related social networks contribute strongly to individual as well as to population health.

Christopher Boorse, a few years later, took further distance from the WHO definition. He eliminated the term "well-being" and rejected the view that a definition of health should include positive health. Instead, he used a biomedical definition of health as "the absence of disease," Stressing the importance of defining health in non-normative terms, he saw it as "normal functioning, where the normality is statistical and the functions biological."³⁰

Leon Kass, in 1981, was equally dismissive of the WHO definition. “For complete mental well-being -- not to speak of the more ambiguous social well-being, which will certainly mean different things to Pope Paul, President Ford, and Chairman Mao – goes well beyond the province of sanity, depending as it does on the successful and satisfying exercise of intelligence, awareness, imagination, prudence, good sense, and fellow feeling, for whose cultivation medicine can do little.”³¹ Kass suggested three alternative definitions of health:

Health . . . is a state of being that reveals itself in activity as a standard of bodily excellence or fitness, relative to each species and to some extent to individuals, recognizable if not definable and to some extent attainable. If you prefer a more simple formulation, I would say that health is ‘the well-working of the organism as a whole’ or again ‘an activity of the living organism in accordance with its specific excellences.’³²

Norman Daniels, in 1985, adopted Boorse’s “narrow, if not uncontroversial biomedical model,” modifying it somewhat: “health is the absence of disease, and diseases (I include deformities and disabilities that result from trauma) are deviations from the natural functional organization of a typical member of a species.”³³ He rejected the WHO definition, viewing health as an idealized level of well-being, as over-medicalizing social philosophy.

In 2001, Lennart Nordenfelt, while arguing that the WHO definition had gone too far in specifying “optimal physical, mental, and social well-being,” proposed an alternative definition of “complete health” that leaves out the terms “social” and “well-being,” even as it provides a more flexible but correspondingly more diffuse context for the term “complete”: “A person is in a state of complete health, if and only if this person is in a physical and mental state such that he or she is able to realize all his or her vital goals, given a set of accepted circumstances.”³⁴

Callahan, three decades after his first article on the WHO definition, reiterated his critique of it as having opened the way to turning all human problems into medical problems by encompassing “social well-being.” His new definition expanded on his earlier one in several ways. It brought back an echo of the WHO reference to reference to mental as well as physical well-being, even as it left out the term “complete.” Like Nordenfelt’s definition, it included a mention of “vital goals”: “By health I mean a person’s experience of well-being and an integrity of body and mind, the capacity to pursue his or her vital goals, and to function in ordinary social and work contexts. / . . . / Health is no less characterized by the absence of significant pain, suffering, and harmful disease.”³⁵

Yet Callahan’s new definition raises new questions. Is it not vulnerable to his own previous objection to the all-inclusive WHO definition? Can one not be healthy without

possessing integrity of body and mind"? Such integrity is something most of us would surely prize, but rarely feel we attain. Should that really mean that we are less healthy? The same goes for being able to pursue one's vital goals. Depending on what those goals are, many may be constrained, by age, temperament, finances or family circumstances from pursuing their vital goals even though their health remains robust. In reply, Callahan might suggest that this all depends on how one defines "integrity of body and mind" or "vital goals." The debate over such terms is definitely worth pursuing; but it is not clear that it will be of practical use in defining health.

Article 12.1 of the International Covenant on Economic, Social, and Cultural Rights, adopted in 1966 and entering into force in 1976, clearly draws on the WHO definition, but departs from it in important ways. It offers no explicit definition of health; and in speaking of a right to health, does not bring in the terms "complete," "well-being" or "social." The Article holds that "The States Parties to the present Covenant recognize the right of everyone to the highest attainable standards of physical and mental health."³⁶ The General Comment on the implementation of Article 12, in 2000, specified that the committee drafting Part 12.1 did not adopt the WHO definition of health. The Comment goes on to point out, however, that the express wording of 12.2 "acknowledges that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life . . ." It then elaborates the role that availability, accessibility, and other factors should play in determining how to conceive of the highest attainable standard.³⁷

In a recent survey of the literature on definitions of health, Joshua Salomon and colleagues have pointed to the considerable consensus on several matters: that health is a separate concept from well-being; that any attempts to measure health must include measures of body and mind function; and that health is an "attribute of an individual person although aggregate measures of health may be used to describe populations." If health were defined broadly as well-being, they suggest, the health system, including health ministries would have to be seen as responsible for all areas of human activity.³⁸

Apart from critiques of the WHO definition and proposals for alternative definitions, there have been many attempts within WHO to revise the Organization's definition. As late as 1998, an effort was made to modify the rigidity of the notion of health as a state of well-being in that definition, by inserting the word "dynamic." It was also suggested that, instead of the three domains of health, a fourth should be added -- "spiritual." The definition thus altered was to read: "Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease and infirmity."³⁹

The proposed changes were at first adopted by the Executive Board. But in May 1999, a committee of the World Health Assembly wisely decided, after lengthy discussion, not to consider any proposed amendments to the WHO Constitution, including the above changes. Adding the two terms “dynamic” and “spiritual” only augmented the existing problems of interpreting the controversial terms contained in the definition. While changes have been made elsewhere in the WHO Constitution, no suggestions for altering the definition itself have been accepted, and in 1999, all further changes were tabled, pending continued discussion.⁴⁰

CONCLUSION

I asked, in the Introduction how viable the WHO definition is at present, and to what extent it can function as an operational definition for practices of measurement, assessment, and policy-making. My answers to the two questions are a qualified yes and No. Yes I think that the definition, as part of the entire Preamble, is viable, but only so long as it is regarded strictly as a historical document and seen as illustrating both the aspirations for world health expressed in 1946 and the as yet unanticipated obstacles to making it possible. No, however, the definition cannot serve operational purposes for measurement, assessment, and policy-making purposes.

If looked at strictly as a historical document, the definition can function both as inspiration and as cautionary example. It can offer an inspiring and much-needed reminder of the hopes present at the founding of WHO for all that nations could do together to improve health around the world; but can remind us, too, of the shortfalls in practice, given such aspirations, and the abuses that can slip in, sometimes disguised by innocuous-sounding terms such as “social,” when associated with the inspirational aspects of the terms “complete” and “well-being.” For these reasons, I believe it is a mistake to re-introduce the definition, as it now stands, without qualifications, into WHO and other resolutions as if it served more practical purposes. Ringing endorsements, as when delegates to the 1978 Declaration of Alma-Ata “strongly reaffirmed” the definition in its entirety as a fundamental human right, only serve to prolong the confusions and conflicts the definition has generated,⁴¹

Instead, vigilance is needed with respect to each of the terms, and above all with respect to “complete.” That term represents the riddle at the definition’s center – one that affects every other term and facilitates misjudgments and abuses. It is equally important to be wary of health measures to implement “social well-being.” True, a benevolent social system, fully respectful of human rights, might encourage such well-being without coercion and misjudgment, but experience offers too many examples of abuses even in democratic states and well-run health care systems.

Once the definition is seen as a strictly historical document, it can be left intact even as the practical work of the WHO can continue to rely on more down-to-earth and broadly shared understandings of basic health needs; and to carry out measurements and assessments for policy-making purposes. It is not possible to measure anything, in practice, as a shortfall from complete well-being of any kind; and special dangers in attempting to do so with respect to complete social well-being. At the same time, it has long been evident that there is no need for any inspirational definition of health in order to measure, for instance, infant mortality or to project life expectancies.

Once it is clear that the WHO definition should be seen as a historical document and respected as such, but not be made to serve operational purposes, it will be possible to learn from the debates that it has engendered. Doing so permits us to see how individuals from antiquity on have reflected on life and death, illness and health, thriving and failing to thrive, what enhances and diminishes human well-being; and how they, very much including those first drafters of the WHO Constitution, have struggled to formulate what they see as most important. In turn, we can then see more clearly how the WHO definition, and the Constitution, can provide historical background against which to examine conflicts that have become more evident in recent centuries: conflicts, for example, having to do the role of the pharmaceutical industry and other vested interests, medicalization, health "enhancement," allocation for prevention, therapy, research and palliative care, and global, societal, and inter-group health inequities.

Notes

- ¹ Callahan D. The WHO Definition of 'Health.' *Hastings Center Studies* 1973;1:3:77--87.
Callahan D. *What Price Better Health? Hazards of the Research Imperative*. Berkeley: California University Press; 2003: 87; Caplan AL. The Concepts of Health, Illness, and Disease. In Veatch RM. Editor. *Medical Ethics*, Second Edition. Washington D.C.: Georgetown University Press; 1997:57; Downie MS, Fyfe C. *Health Promotion: Models and Values*. Oxford: Oxford University Press; 1990; Grad F. The Preamble of the Constitution of the World Health Organization. *Bulletin of the World Health Organization* 2002; 80:12: 981--2; Garcia D. What Kind of Values? A Historical perspective on the Ends of Medicine. In Hanson MJ, Callahan D, Kaebnick GE, editors. *The Goals of Medicine: The Forgotten Issue in Health Care Reform*. Washington D.C.: Georgetown University Press; 2001; Kass L. Regarding the End of Medicine and the Pursuit of Health. In Caplan AL, Engelhart HT, Jr., McCartney JJ, editors. *Concepts of Health and Disease: Interdisciplinary Perspectives*. Reading, Massachusetts: Addison-Wesley Publishing Company; 1981:3--33; Jonas S. *Talking About Health and Wellness with Patients*. New York: Springer Publishing Company, Inc; 2000: Ch. 2; Mann J. The World Health Organization and Global Health: Toward a New World order? The Frank A. Calderone lecture, October 25, 1994; Salomon JA *et al*. Quantifying Individual Levels of Health: Definitions, Concepts, and Measurement Issues. In Murray CJL, Evans DB, editors. *Health Systems Performance Assessment*. Geneva: World Health Organization; 2003:301-318. Nordenfelt L. On Medicine and Other Means of Health Enhancement: Toward a Conceptual Framework. In Hanson, Callahan, Kaebnick. *Goals of Medicine:69-87*; Seedhouse D. Well-Being: Health Promotion's Red Herring. *Health Promotion International* 1995;10 (1).
- ² The third principle's claim that "The health of all peoples is fundamental to the attainment of peace and security . . ." offers a partial overlap with the initial declaration, leaving "security" in the text but dropping "happiness" and "harmonious relations" while adding "peace."
- ³ The French version refers to the highest standard of health "réalisable": "L'accès à la plus haute norme de santé réalisable est l'un des droits fondamentaux de l'être humain."
- ⁴ Winston Churchill, October 1939, commenting on Russia's entering into a pact with Nazi Germany.
- ⁵ Nordenfelt L. On the Nature of Health: An Action-Theoretic Approach.
- ⁶ Report of Technical Preparatory Committee, *Chronicle of the World Health Organization*. April 1946:6.
- ⁷ The term "health" had been inserted into the U. N. Charter at the request of the Brazilian representative, both in Article 55 and in Article 57, declaring that specialized agencies shall be brought into relationship with the United Nations.
- ⁸ Before World War I, there had been 11 international sanitary conferences in Europe, between 1851 and 1903. In 1907, delegates from twelve states signed the Rome Agreement for the creation of the Office international d'hygiène publique (OIHP) (International Office for Public Health). It was to monitor global health and deal with public health emergencies. The activities of the OIHP were suspended at the outbreak of World War I. The War brought in its wake horrific epidemics of typhus and other diseases. It was estimated that the 1918 influenza pandemic had taken over 20 million human lives. Plans for a single organization under the auspices of the League of Nations had come to naught.
- ⁹ *Chronicle of the World Health Organization*;1:1947:3.
- ¹⁰ Caraka Samhita. 1949. Jamnaga, India:II, 4, 13. Cited by Temkin O. Health and Disease, in Wiener PP, editor. *Dictionary of the History of Ideas*. New York: Charles Scribner's Sons, 1973;II: 397.
- ¹¹ Andrija Stampar, Suggestions Relating to the Constitution of an International Health Organization. *WHO Official Record*. I Annex 9.
- ¹² The British draft specified, in the section on the organization's scope and functions, that "It should be made clear that health includes mental health." Annex 6.
- ¹³ The U.S. draft held that the new organization's purpose would be to "improve the physical and mental health of all peoples through international cooperation and mutual assistance." Annex 7.
- ¹⁴ The purpose set forth in the French draft, likewise, was that "of protecting and improving, with the cooperation of all concerned, the physical and mental health of the inhabitants of every country of the globe." Annex 8.
- ¹⁵ Annex 9.
- ¹⁶ Annex 10.
- ¹⁷ Erik Gustaf Geijer, "Odalbonden."

- ¹⁸ Hesiod, *Works and Days*: 90-103.
- ¹⁹ Temkin. *Health and Disease*:395
- ²⁰ More T. *Utopia* (1516). Mineola, N.Y.: Dover Publications, 1997. Book II:52.
- ²¹ See Searle J. *Speech Acts*. Cambridge University Press; 1970:55; and my discussion of definitions of "violence," in *Mayhem: Violence as Public Entertainment*. Perseus Books; 1999:6--7.
- ²² Such definitions are often called "persuasive" definitions. See Charles Stevenson C. *Ethics and Language*. New Haven: Yale University Press; 1950; and Halldén S. *True Love, True Humour, and True Religion*. Lund, Sweden: C. W. Gleerup; 1960.
- ²³ Aristotle. *Nicomachean Ethics*, tr. Terence Irwin, 1.7, 1098a.
- ²⁴ Diener E. Subjective Well-Being: The Science of Happiness and a Proposal for a National Index. *American Psychologist*, January 2000.
- ²⁵ See for example, Downie, Fyfe. *Health Promotion*; Seedhouse. *Well-Being: Health Promotion's Red Herring*.
- ²⁶ Sigerist later wrote, in describing his friendship with Stampar, that the latter had played a leading part in founding the World Health Organization and that, as chair of its Interim Commission, "is largely responsible for the superb and progressive Preamble of its Constitution." Sigerist HE. *Autobiographical Writings*. Selected and translated by Sigerist Beeson N. Montreal; 1966: McGill University Press:31.
- ²⁷ Sigerist HE. *Medicine and Human Welfare*. (1941) New York: Oxford University Press; 1970; *Civilization and Disease* (1943) Chicago: University of Chicago Press; 1962; *Medicine and Health in the Soviet Union*. New York: The Citadel Press; 1947.
- ²⁸ Sigerist . *Medicine and Human Welfare*:
- ²⁹ Callahan. WHO Definition of 'Health':87.
- ³⁰ Boorse C. Health as a Theoretical Concept." *Philosophy of Science*:542
- ³¹ Kass L. Regarding the End of Medicine and the Pursuit of Health. In Caplan AL, Engelhart HT Jr., McCartney JJ, editors. *Concepts of Health and Disease: Interdisciplinary Perspectives*. Reading, Massachusetts: Addison-Wesley Publishing Company, 1981:5-6.
- ³² *Ibid*:18.
- ³³ Daniels N. *Just Health Care*. Cambridge: Cambridge University Press; 1985:28.
- ³⁴ Nordenfelt, On Medicine:72.
- ³⁵ Callahan. *What Price Better Health?*:87.
- ³⁶ *International Covenant on Economic, Social, and Cultural Rights*. Article 12.1
- ³⁷ Committee on Economic, Social, and Cultural Rights. Agenda Item 3. General Comment No. 14. Geneva, 2000:2--4.
- ³⁸ Salomon *et al*. Quantifying Individual Levels of Health: 303.
- ³⁹ U Than Sein. Constitution of the World Health Organization and Its Evolution. *Regional Health Forum*;6: (1).
- ⁴⁰ World Health Organization. *Basic Documents*; 2001:160-162.
- ⁴¹ Declaration of Alma-Ata. Article I. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978:1.