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Do the developing countries with high disease burdens need to take a more active role in defining health and disease?

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Conclusion

Everyone born in the world should live a full human life. To make this possible, a health care system and hygienic environment and effective livelihood need to be assured for all citizens. In the world today medical advancement is progressing very fast and the quality of life is on the increase, thereby making people live longer and longer. While the medical advancement in the industrialized countries is making progress the availability of medical facilities in many developing countries are abysmal. It is the responsibility of the State to provide with adequate health care especially for the children who are the future hope of the nation and the globe.

In the first place the people, especially those in the rural areas, should be given awareness with regard to health care especially preventive measures to be taken to avoid infection and diseases. Health cares should be not only accessible but affordable – The State should come to the rescue of the poor in providing effective health care system. Primary care centers should be given priority and in State run medical centers all facilities should be extended without any difficulty – Strict laws should be enforced against corruption in providing medical aids and negligence of duty in emergency.

The neighbourhood outreach programme could be introduced in educational institutions especially in medical institutions where the students spend considerable time with the poor, in the slums in cities and rural areas, teaching them hygiene and helping them have health care facilities. The medical students could be asked to spend a couple of years of their service in the rural areas.

Also traditional medicine, such as herbal, Ayurvedic, Sidha etc, could be encouraged by the State which could give effective medical facilities at much lower cost of care. The State should make it clear that the people are the wealth of the nation and health is the first concern as well as area of investment for any nation.

Do the Developing Countries with High Disease Burdens Need to Take a More Active Role in Defining Health and Disease?

- Chhanda Chakraborti
Associate Professor in Philosophy, Department of Humanities and Social Sciences, Indian Institute of Technology Kharagpur, India.
Email: chhanda@iitkgp.ac.in, chhandac@gmail.com
- Rhyddhi Chakraborty
Doctoral student, Department of Humanities and Social Sciences, Indian Institute of Technology Kharagpur, India.

Do developing countries with high disease burden need to take a more active role in developing, or adhering to, a conceptualization of health and disease that is more relevant for them? This paper argues that there are number of reasons to make a rather compelling case to answer in the affirmative.

First, the facts. There can be no doubt that great health disparities still persist among the countries in the world. In spite of great advances in medical technology, medicine, and treatment, and high-spirited initiatives such as Alma Ata (1978), the disparities in health status remain stark between the populations of the developed countries and the developing countries in particular. To date, the poorer countries, as a matter of fact, see more of death, disease and disability.

The WHO fact sheets show that the developing countries in Africa and Asia bear a disproportionately high disease burden from an array of major fatal communicable and endemic diseases. For example, though incidences fell in certain countries, WHO reports that in 2008 Malaria is endemic in 109 countries and *preventable* deaths from Malaria is close to a million lives, with mostly that of children under 5, in Africa[32]. The 1.2 billion people who are at high risk from Malaria are mostly living in the developing nations of Africa (49%) and Southeast Asia (37%). Similarly, the WHO tuberculosis (TB) 2009 report[33] mentions twenty-two high-burden countries, covering 80% of world's TB cases, which almost without exception belong to the developing world. The report also mentions that the co-infection of HIV-TB and the drug-resistant variety of TB in some of these countries are matters of great concern, as one out of four TB deaths in 2007 was HIV-related. Since the burden of non-communicable diseases was found to be no less on the developing

[32] WHO. World Malaria Report 2008. Geneva: WHO. Available at: http://apps.who.int/malaria/wmr2008/ [Accessed on 29 May 2009].

[33] WHO. Key Points: Gobal TB Control 2009. Geneva: WHO. Available at: www.who.int/tb/publications/global_report/2009/key_points/

countries, WHO has named the burden of the developing countries the 'double burden'[34] of diseases.

Although the recent global outbreaks such as the 2009 global spread of *A H1N1* flu showed that the risk from a global pandemic is a great leveler for the countries across the globe, epidemiological models predict that the impact may be more severe for countries with weaker health systems. In case of an influenza pandemic analogous to that of 1918, it is claimed that the maximum loss of life would occur in two developing regions: Sub-Saharan Africa and South Asia[35], two of the world's poorest regions with weakest health systems. The risk disparity is underscored by the fact that the lower income countries with high-disease burdens usually have weak public health infrastructure, poor and inefficient healthcare delivery services, whereas most developed countries have highly sophisticated health systems equipped much better to provide specialized care and protection from bio-risk.

If we consider these key differences among the developed and developing countries in health and disease status, and in the capability of the health systems, consequently in the health needs, a question rises whether given their own contexts the lower income countries should become more involved in articulating how they want to conceptualize 'health' and 'disease'. The question is both timely and pertinent. For, health sector reforms and health policy formulation have been and are at present on the agenda of many developing countries. Though some studies[36] regard them as being driven and directed primarily by the conditions laid down by the World Bank credits, the efforts at health sector reforms are likely to affect positively the provision, financing, human resources, and overall healthcare management. India, for instance, is in the process of making some major changes in the health sector. In 2005 the National Rural Health Mission was launched by Government of India to provide accessible, affordable, and quality health services to even the poorest in remotest rural regions by directing increased government financing to the state public health systems. The latest review (2008) of the Mission finds that, among other things, there has been a general improvement in the utilization of public health services[37]. The Ministry of Health and Family Welfare, India, has also initiated a National Bill on 'Right to Health'[38] which is at present at the drafting stage but when passed would arguably confer on every citizen an entitlement to health and healthcare. Apparently China also has launched health-sector reform plans[39]. Similar efforts are on in different stages of development in many of the African countries, such as Nigeria, Zambia. Thus, at this stage bioethical deliberations among the developing countries on the nodal concepts of 'health' and 'disease' will be of constructive assistance.

It is a question of ethics also; for, a definition of health, even an operational one, is necessary as a guiding principle for the health sector reforms. Similarly, we need a definition of 'disease'. Definitions of these key concepts shape the vision on which public health policy may be formulated and public health system may be organized. The implications of the definitions cover, among other things, the conditions under which budgetary increments will be allocated to healthcare resources and services, how the healthcare priorities are to be set nationally in terms of research and intervention programs, and who will be treated in need of care and who will not be.

However, like many other abstract concepts, e.g. 'peace', 'welfare', the concepts of 'health' and 'disease' too have many available definitions. The panoply of various definitions of health could be appreciated from the following observation of Hood et al:

"…health is difficult to define. Health is described in various sources as a value judgment, a subjective state, a relative concept, a spectrum, a cycle, a process, an abstraction that cannot be measured objectively. In many definitions, physiologic and psychological components of health are dichotomized. Other sub-concepts that might be included in definitions of health include environmental and social influences, freedom from pain or disease, optimum capability, ability to adapt, purposeful direction and meaning in life, and sense of well-being."[40]

As for 'disease', at least two approaches, a normative or evaluative one advocated by Engelhardt Jr[41] and an objective or value-neutral one offered by Boorse[42], are well-established in the literature.

This indicates, among other things, that the concepts are open to interpretation. It also suggests that the differences in the available definitions of these concepts, like in case of other definitions, largely reflect the differences in the social and political milieu from which they emerged and in the interests that have driven them. For example, preoccupied traditionally with the task of prevention and medical solution of the problem of diseases and disease-causing agents ('germs'), the *clinical* or the *medical* model naturally found health in the simple dichotomy as 'the absence of

[34] WHO. Surveillance of noncommunicable disease risk factors Available at: http://www.who.int/mediacentre/factsheets/fs273/en/e

[35] C.J.L. Murray, A.D. Lopez, B.Chin, D.Feehand, K.H.Hill. Estimation of Potential Global Pandemic Influenza Mortality on the basis of Vital Registry Data from 1918-20 Pandemic: A Quantitative Analysis. *Lancet* 2006; 368: 2211-2218.

[36] Shiner, A. Shaping Healthcare in Tanzania-Who is pulling the strings? *Lancet* 2003; 362:829-830.

[37] Ministry of Health and Family Welfare, Government of India. 2008. *Second Common Review Mission.* National Rural Health Mission. New Delhi, India: Govt of India. Available at: http://www.mohfw.nic.in/NRHM.htm [Accessed on: 25 May 2009]

[38] Ministry of Health and Family Welfare, Government of India. The National Health Bill. 2008. Available at: http://mohfw.nic.in/nrhm/draft_bill.htm

[39] Chen, Z. Launch of the Healthcare Reform Plan in China. *Lancet* 2009; 373 (9672): 1322-1324.

[40] Hood, Lucy, J. Susan Leddy, J.Mae Pepper. 2005. *Leddy and Pepper's Conceptual Bases Of Professional Nursing*. 6th Ed. Lippincott Williams and Wilkins, 203-204.

[41] Engelhardt, Tristram, Jr. The Disease of Masturbation: Values and the Concept of Disease. Bulletin of the History of Medicine, 1974; 48 (2): 243-248.

[42] Boorse, C. On the Distinction between Disease and Illness. Philosophy and Public Affairs 1975; 5 (1): 49-68.

disease'. The straightforward but narrow focus of this definition obviously misses out the social, environmental, the genomics, and other determinants of health, but it remains true to its point of interest: To define undesired, treatable conditions as disease, and to restore health by eradicating disease. The ecologically dedicated *environmental model* of health, similarly, depicts health as the state of equilibrium or adjustment between human and natural environment. Obviously, there can possibly be different interpretations of what counts as 'equilibrium' or what are the necessary conditions for such 'adjustment'; but the model is able to draw our attention to the place of humans as just another member in a larger ecosystem. The WHO, on the other hand, because of its commitment to positive health, and not merely to 'absence of disease', has tried to define health as holistically as possible: as *a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*[43]. This highly idealized and too wide a definition has been criticized by many. However, it has accomplished its goal of including many *well-being needs* under *healthcare needs*. As Beauchamp and Walters put it, 'The broader the conception of health, the broader the potential list of needs'.[44] Boddington and Raisanen[45] claim that there is also a political dimension to this widening of the definition in the post-world war days. They argue that health as a human right requires a huge commitment of resources, and with the broadness in the definition using a larger context, the resources could come, not just from standard health care, but from many different social, economic and political sectors. The Alma Ata (1978) declaration pronounces a similar holistic definition of health as a 'world-wide social goal'. Similarly, the concept of 'disease' also is interpretable. From the viewpoint of healthcare professionals, it may be a pathological condition, a deviation from normal functioning; while some may interpret it as a deviation from socially expected roles or from social etiquettes.

Given that contextual interpretations and interests shape definitions, it may be more fruitful if the developing countries, specially the ones with high disease burdens, draw from their own contexts to enrich the international deliberations with inputs about which conceptualizations of 'health' and 'disease' would be more suitable for them. These inputs could also help us to understand developing world bioethical issues better. We generally assume that we as a society are obligated to promotion of health and protection from disease and disability; and expect that governments as important machineries would translate this collective will into action. From the perspective of developing world bioethics, it would be interesting to find out how exactly the high burden developing countries would own and justify this obligation.

Lately, in the developed countries, there have been many theoretical discussions on health, healthcare, and macro-allocation and micro-allocation issues in health policies at different levels. There are debates about how to ground the social obligation towards health on a sound ethical theory. Many consider it purely a matter of social justice. Drawing from Rawls' theory of justice, Daniels, for example, has chosen to view health as 'normal functioning' or '…absence of …deviation from the natural functional organization of a typical member of a species'[46] to argue that health is of *special moral importance* because of its connection to social justice. He argues that health, when understood in the abovementioned sense becomes the precondition for enjoying the 'normal opportunity range' (NOR) or the total range of reasonable life-plans in a given society that the society's members with relevant skills and competence can pursue[47]. A just society should have an obligation to protect the individual fair share of NOR, i.e. 'the set of plans of life a person functioning normally could pursue, given her talents and skills (developed under just conditions)'[48]. Thus, Daniels contends, a just society should have an obligation to protect the health of its members.

In a similar line but focusing more on the social obligation to remove health disparities within a society, Anand *et al*[49] has brought out the equity aspect of social commitment in public health. Extending Sen's *capability approach* [50] to human development, Nussbaum[51] too has understood human development in terms of development of not just the GNP but of ten basic human capabilities, which includes bodily health. In contrast to these theories in which health has been promoted as *instrumental* for making other important life-choices, WHO, however, has claimed health as an *end*, or a human value in itself, in its declaration of health as a human right.

These efforts are indeed valuable, but these are yet to take place in the developing countries. This invites the question whether the developing countries should simply 'borrow' the thoughts. Is it necessary for them to do so? It appears that there may be practical and conceptual difficulties in assuming so, and we do not just mean the operational problem of implementing a typical western concept and a western approach in a non-western culture, though with the example of Australian aboriginals Boddington and Raisanen have argued that ideas of health and disease may vary in different cultural contexts and the notion of importing an

[43] WHO, 1947. Available at: http://www.who.int/about/definition/en/print.html

[44] Beauchamp, T.L. & L.Walters. Eds. Contemporary Issues in Bioethics. 3rd Ed. Belmont, CA: Wadsworth Publishing Co, 73.

[45] Boddington P & U.Raisanen. Theoretical and Practical Issues in the Definition of Health: Insights from Aboriginal Australia. *Journal of Medicine and Philosophy* 2009; 34: 49-67.

[46] N.Daniels. 2008. *Just Health: Meeting Health Needs Fairly*. New York: Cambridge University Press, p.37.

[47] Ibid. p.36.

[48] Ibid., p.37.

[49] S. Anand, F.Peter, and A.Sen. Eds. 2004. *Public Health, Ethics and Equity*. New York: Oxford University Press.

[50] Sen, A. 1985. *Commodities and Capablities*. Oxford: Oxford University Press.

[51] Nussbaum, Martha C. 2000. *Women and Human Development: The Capabilities Approach.* Cambridge University Press, Cambridge.

external idea sits uneasily on a community[52]. We think that the systemic differences between the two kinds of societies are large enough to be skeptical about supposing what a developed society finds suitable as a pursuable notion of health and acceptable notion of disease would naturally be appropriate for a less developed one also.

For instance, consider Daniel's version of 'health' as a precondition for protection of 'normal opportunity range' (NOR) that an individual may enjoy in a society. This depiction, however, seems to presume that an exercisable NOR, or a set of life-choice plans, exists (should exist) for *every* individual member in any given society. Perhaps that presumption is correct in most developed societies. But, how safe is that assumption in case of hugely populated developing countries, where the available basic NORs can not exist for every individual because necessarily there are more takers, with relevant skill and talent, than opportunities? Most individuals in many such societies simply do not have the luxury to exert individual choices over life-plans, or over the career path, that they *want* to pursue. Instead, they follow just whatever opportunity by 'natural lottery and social lottery' becomes available. And, with that decision usually there is very little connection to the considerations of the state of 'natural functional organization' of one's bodily system. It is a survivability issue.

Daniels' theory appears to rely upon a 'decent minimum' threshold of just distribution of Rawlsian primary opportunities and liberties in a society as a pre-requisite. Based on that, he views health as a necessary condition for living a chosen life in that society. However, in many developing countries, for a variety of reasons it may not be possible to socially guarantee that minimal threshold for everyone. There, the onus often is largely on the individual to ensure that welfare remains above a certain threshold at all times. Since the applicability of the pivotal concept of individual's fair share of NORs is doubtful, the grounding of Daniel's approach within the context of developing countries becomes questionable. Though Daniels has claimed his theory is globally applicable, the process of its real-world applications remains largely unclear.

This is *not* to argue that developing countries must never follow the precepts from the developed nations. Rather, the point is that it is not safe to assume that they must always blindly do so.

So, how should the high burden countries proceed? One initial suggestion may be that, as has been already discussed above, diseases and disabilities, more than health, seem to be relatively weightier considerations for these countries. At least given the fact of large number of lives lost in these countries because of preventable, treatable diseases, perhaps they should start first with how they would like to approach the concept of 'disease' and may consider making 'absence of disease' a more ethical and pragmatic priority in their health policies. 'Health' may follow as a subsequent goal.

This may sound to some as just verbal jugglery; they might ask, what is 'absence of disease' if not health? In response, let us remind ourselves that 'absence of disease', except for medical model, is not health. A person who is generally dissatisfied with life and therefore cannot keep up his performance at job does not have to have a disease, but may not be healthy either. Someone who has only one kidney has absence of health but need not be considered diseased. An aged person may not be in health, but need not be diseased. In fact, the concepts of 'health' and 'disease' need not be mutually exhaustive. Hoffman, for example, has interestingly suggested a *disjunctive model* in which 'health' and 'disease' are opposite but partly disparate concepts with 'epistemological, taxonomical, etymological, axiological and practical differences' [53] between them. Explorations are necessary to find out what would suit the developing world health policies and action plans better.

Finally, one might object that if all the countries, developed and developing, do not commit themselves to a universal and common understanding of 'health' and 'disease', then particularly the developing countries with high disease burdens may suffer. For, they then would disassociate themselves from the purview of the universal discussions, such as health as a human right, and that of universal policies, such as increased financing in the health sector to ensure global health security. To this, the response could be that this is *not* a proposal for high burden countries to delink themselves from the international discourse on health and disease. Rather, this is to urge them to carve their own niche within the discourse. Also, for many developing countries engaging themselves in the task of defining, or choosing a definition of, crucial concepts such as 'health' and 'disease' for themselves could augur the beginning of a realization about accepting the larger responsibility of health and healthcare for their general populace. The possibility always remains that health reform efforts, when done purely under external pressure, be it the compulsion of complying to the conditions laid down by increased international finances, or pressure from international bodies and grassroots NGOs, may not be sustainable in the long run. As such the distance between having effect on the policies and having effect in actions is long; imposition of concepts could make it more difficult to traverse that distance.

[52] Boddington, P., & U.Raisanen, op.cit., note 14, pp.62-63.

[53] Hoffman, B. Simplified Models of the Relationship between Health and Disease. *Theoretical Medicine and Bioethics* 2005; 26: 369.

Darwinism and Humans

- K. K. Verma, Ph.D.
Retd. Professor of Zoology, HIG 1/327,
Housing Board Colony, Borsi, Durg – 491001, India.
Email: kk.sheel@gmail.com

Recently, in August 2008 we have celebrated 150th anniversary of publication of the Darwinian Principle of Natural Selection. 2009 is the year for celebrating the 200th birth anniversary of Charles Darwin. Darwinism is for the life system on the Earth. It has relevance to