WHO's Definition of Health: Philosophical Analysis

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Abstract

The notorious World Health Organization definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" has been roundly, and justifiably, criticized by philosophers more or less since it first appeared in 1948. Despite its obvious conceptual, and practical, limitations, it launched a highly productive debate about the nature of health in which two major strategies have dominated: a descriptive or naturalistic approach in which health is operationally defined in terms of normal functioning understood entirely in the language of the biological sciences and a normative approach which insists that health cannot be understood until the salient fact that health is a human good is explained. This debate has revealed a dilemma: any philosophically acceptable definition of health must make a place for our powerful intuitions that health is both intrinsically and instrumentally valuable. Yet, unless the notion is firmly grounded in the biological sciences and

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susceptible to operationalization, it threatens to lose its scientific legitimacy. WHO has more recently and with far less fanfare, developed another definition of health "for measurement purposes" that recognizes the force of the dilemma and attempts, with debatable success, to address it.

Introduction

In the Constitution of the World Health Organization, approved in 1948, health is famously defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1948). The extreme breadth of the definition – "physical, mental and social well-being" – and its unrealistically high threshold of good health, "complete," made it tempting to dismiss the definition as an aspirational gesture emblematic of a new era of optimism in international public health. Yet, philosopher Daniel Callahan took it seriously in 1973 and roundly criticized the definition for fatal overreach, arguing that to define "health" in terms of "well-being" transforms human happiness into a medical outcome and social ills like injustice, economic scarcity, and discrimination into medical problems requiring medical solutions (Callahan 1973).

Despite these limitations, however, in retrospect the WHO definition has considerably enriched the philosophical debate over the nature of health. It set the stage for an important and ongoing dispute between normative accounts of health and far more restrictively biological or biostatistically grounded views. Although there has recently been a resurgence of the strongly normative, WHO-style definitions, ironically WHO itself has taken steps toward a more narrow view motivated by the need to develop a conceptualization suitable to "operationalize health for measurement purposes" (Salomon et al. 2003).

The current situation reflects a dilemma: any philosophically acceptable definition must make a place for our powerful intuitions that health is both intrinsically and instrumentally valuable. Yet, unless the notion is firmly grounded in the biological sciences and so susceptible to operationalization, it threatens to lose its scientific legitimacy. Specifically, without operationalization, scientists will be unable to compare, let alone measure, the difference in the health of two individuals, or the same individual before and after a health intervention, or by extension of the relative health of subpopulations of individuals. The capacity for ordinal, if not cardinal, comparisons of states of health is not merely a scientific desideratum; it is essential for any scientific or policy application of the notion, including in particular the assessment of the performance of clinical health care or public health systems. But if the cost of securing scientific legitimacy is to undercut the commonly held belief that health is a human good (indeed, a plausible human right), then the resulting conceptualization is philosophically objectionable for a different reason. The more recent WHO definition of health "for measurement purposes" was developed with recognition of this dilemma, but it arguably fails to address it adequately.

In this chapter, the philosophical evolution of WHO's contribution to the definition – or more accurately, the conceptualization – of health will be traced and its philosophical impact described. The original, 1948 definition, and its philosophical critique, is the starting point. The critique began a fruitful philosophical debate between two starkly different approaches to health conceptualization represented here by Christopher Boorse's biostatistical account and Lennart Nordenfelt's action-theoretical normative account. What arises out of this debate is a philosophical impasse in which both approaches fall short, for opposing reasons. After a review of a recent resurgence of normativism that so far seems only to have reprised the problems of WHO's original definition, this chapter turns to the current endpoint in the evolution of WHO's definition of health and its limitations.

WHO Definition of Health: A Philosophical Evolution

The 1948 WHO Definition and Its Philosophical Critique

The Preamble to the Constitution of the World Health Organization, adopted and signed immediately after World War II in 1946, and entered into force in 1948, set out principles governing the establishment of this first international organization devoted to human health:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
>
> 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.
>
> The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.
>
> The achievement of any State in the promotion and protection of health is of value to all. (WHO 1948)

The first clause, whether it had been so intended or not, was quickly picked up as a definition of health. (Few noticed that it conflicted with the next principle inasmuch as the "highest attainable standard of health" suggests a flexible threshold of health, but the definition itself sets that threshold at "complete.") Implicit in the Preamble as a whole was a view attributed to sociologist HE Sigerist that health must be more than the absence of a problem; it must also be something positive (Sigerist 1941; Breslow 2006). Health is not merely an enjoyable state; it is something people seek out because it is both intrinsically and instrumentally valuable. The other innovation of the WHO definition – that health had mental and social dimensions – reflected the commonplace view that people are complex, biological, psychological, and social entities. Neither these two aspects of the definition were particularly controversial; it was the identification of health with human well-being that critics balked at.

In 1973, philosopher Daniel Callahan argued that the definition caters to a "cultural tendency" to define social problems as health problems, thereby blurring the lines of responsibility between the political order and the medical profession (Callahan 1973). Callahan noted, as others before him had (e.g., Wylie 1970), that the current rhetoric "medicalized" social problems because of a "grandiose" faith in science to cure sickness in all forms, biological, psychological, and social. This unbounded optimism, he insisted, was simply without empirical support. Neither is it plausible to suggest that all social evils are either caused by or examples of bad health: it is far more likely that political injustice and economic scarcity are the causes of these problems. Finally, transforming all human evils into health problems undermines human freedom and responsibility.

The ideological assumptions bound up in the WHO definition led philosophically to an abuse of language and common sense, Callahan concluded. Surely, the normativity of health can be preserved without insisting that it is the source of all human value. Health is undoubtedly a human good, but it is not the only human good. Some minimal level of health is probably essential to achieve any possibility of human happiness; yet, at the same time, some degree of ill-health is perfectly compatible with happiness, given that no one could hope to be in a state of "complete physical, mental, and social well-being."

To explain what might have gone wrong, Callahan observed that health is intuitively both a natural norm and an ethical ideal. Viewed as a norm, health is simply a matter of the heart, lungs, kidneys, and other body parts functioning up to a threshold of normality that can be established empirically and statistically. Yet, Callahan noted that thinking about health as a norm is unsatisfying because it does not address the obvious question why anyone would care about statistically normal functioning unless dipping below that threshold was unpleasant, inconvenient, painful, or generally a bad thing. Why too should society take any interest in subnormal bodily functioning unless, in the aggregate, it has socially adverse implications? There is no escaping the intuition that health is not merely the description of a state of biological affairs, matched against some statistically determined norm; it is also an ideal people take very seriously indeed. Health is a morally significant normal bodily functioning.

The philosophical challenge, however, is to do justice to both health as norm and as ideal. To insist that health describes a state of affairs, in principle reducible to biological and psychological functioning, and assessed in light of norms generated by population statistics (the basis for what came to be called descriptive theories of health) fails to capture intuitions about what makes health valuable; yet, accounts that focus on the normative significance of biological and psychological functioning (normative theories) fail for their part to provide a sound conceptual basis for the health sciences. The WHO 1948 definition thus became the starting point for an increased philosophical interest in the conceptualization of health. Whether motivated by a rejection of the WHO definition or an affirmation of its underlying insights, the subsequent philosophical literature took the definition as its starting point.

Normative and Descriptive Accounts of Health: Boorse and Nordenfelt

The most prominent advocate of the descriptive approach to health is Christopher Boorse who in a series of seminal articles in the mid 1970s mapped out what has come to be called the "biostatistical theory of health" (Boorse 1975, 1976, 1977). Initially, his concern was to reject normativism in health, especially in the characterization of mental health and in particular a rejection of the WHO definition. He did so in terms of the conceptual difference between a disease and an illness, the first being a biological state of pathology and the second a normative disvalued experience, roughly linked to pathology. Only the first is directly relevant to the conceptualization of health.

Boorse argued that biological functions can be fully described in terms of a hierarchy of goals ascribable to different levels of organisms: cells have metabolism functions, organs have body level functions such as blood circulation, whole organisms have eating and moving around functions, and all of these functions causally contribute to the species-typical goals of survival and reproduction. But this teleology need not be normatively understood since at the end of the day this is simply how organisms behave. So understood, the health of an organism is functional normality. The notion of a biological function is central to Boorse's approach (Boorse 1976), and philosophically it has drawn the most criticism from those who, in general terms, are otherwise quite sympathetic to Boorse's descriptivism (e.g., Engelhardt 1984; Caplan 1993; Beauchamp and Childress 2001).

All descriptivists concur that functional normality can be neutrally described, despite the fact that the state of functional normality tends to be judged as desirable. This is because the evaluation of normality is based on grounds and for reasons that are only tangentially relevant to individual biology or evolutionary theory. Thus, it is quite easy to imagine a "better" normal functioning than that which evolution has provided human beings; on the other hand, in some circumstances having a disease contributes to overall well-being (if, e.g., the disease would disqualify a person from military conscription). Describing and valuing are fundamentally different operations, and there is no reason to think they must be essentially linked in the conceptualization of health.

Pressed to explain the biological significance of "normal functioning," Boorse argued that normality is primarily a statistical construct guided by scientific assumptions about or hard evidence about species-typical functioning levels. Diseases are theoretical entities health scientists defined in terms of signs and symptoms of less-than-optimal functioning at some biological level – ultimately, reflecting the evolutionary imperative of species survival. Other descriptivist accounts have put more reliance that Boorse did on the power of evolutionary theory and homeostasis to account for normality in functioning (Bechtel 1985; Kovács 1998; Ananth 2008).

For Boorse's part, he acknowledged that functional normality was neither a necessary nor sufficient condition of health (red hair is not statistically normal, and there are diseases such as tooth decay that are nearly universal). But as an

operationalization of disease (or more generally ill-health), functional normality is the most reliable indicator. Should the biological sciences devise a more sensitive indicator – perhaps one that incorporates epigenetic insights or some other more fundamental level of explanation – then scientists would turn to it. But, philosophically, the quality and reliability of the indicator of functional normality are irrelevant: at the bottom, the concept of health is in principle fully describable in normatively neutral terms. That health is universally valued and decrements in health caused by disease and injury universally disvalued are sociological facts that explain health-seeking behaviors, but they are conceptually independent of the nature of health and decrements of health.

Although on the first blush nothing could seem to be further from the WHO definition than Boorse's account (and such was his intention), in fact they are not incompatible in at least one respect: no advocate of the WHO definition would deny that health and mechanisms involve in impairing health are at the bottom biological phenomena. Arguably, the WHO definition only tells us the manner in which health is valuable to human beings – why it is individually and socially important – but leaves to biological scientists the description of states of health and ill-health. The normativist, in short, need not advocate the abandonment of the biological sciences or medical practice – he or she is merely interested in a different, but more salient, conceptual feature of health: why we value it.

Lennart Nordenfelt has been the leader in this second, normativist approach to health conceptualization, arguing that health cannot be understood philosophically unless and until it is clear why it is valuable. Health is not merely a biological norm, it is an ideal (Nordenfelt 1987, 1993). Health is about the capacity to act and to live a full life according to one's life plans. More formally, a person is healthy just in case he or she is in a bodily and mental state such that he or she has the ability to realize all his or her vital goals, in standard circumstances. A vital goal for an individual is one that is necessary for minimal happiness (understood robustly as a version of Aristotle's eudaimonia and not merely positive affect).

Nordenfelt took care to avoid some obvious traps of his theory. He took into account and sought to explain some apparent counterexamples, e.g., that people are often mistaken about what they believe will make them happy and that they can sincerely hold unrealizably vital goals or can, by pure luck, achieve minimal happiness despite utterly lacking the ability to do so. In particular, he recognized that a person may achieve minimal happiness with acceptable health, a level far below complete health. Like Boorse, in short, Nordenfelt begins with the WHO definition, but in his case he is more sympathetic to it and hoped to preserve it by crafting a philosophically sophisticated version that avoids obvious criticism.

But Nordenfelt was also keen to reject Boorse's biostatistical theory, not because he thought that health was not rooted in biology but because the mechanisms that limit individual health cannot be identified as diseases or injuries simply because they result in statistically abnormal levels of biological functioning at some level of the organism. That is not how medical theorists have identified diseases and other decrements of health, he insisted. Always in the forefront is the view that only abnormalities in functioning that also reduce the ability of the individual from

realizing his or her vital goals, and so achieving minimal happiness, are decrements in health. Diseases are identified through the lens of vital goals in the first instances and only then in terms of biological abnormality of functioning.

Nordenfelt and normativists generally characterize their views as being holistic in the sense that health is intuitively attributed to individual persons and only metaphorically and by extension to cells and organs (or by aggregation to populations). And on this they have common intuitions on their side: "To be healthy is to function well. It is to feel strong and vital. It is to lack pain and disability. It is to be able to work, to be able to handle one's daily life and enjoy one's life." (Nordenfelt 1993, 83) A concern about cells, organs, and biological functions is the (perfectly legitimate) concern about the mechanisms behind the phenomena of health and disease. Scientists need to know about the bodily machinery to inform their health sciences. But conceptually, the biomedical sciences cannot explain why it is commonly understood that hearing or vision loss, pain, infections, or diseases like diabetes, spinal cord injury, or cancer matter very much to human being or why societies invest social resources into responding to these problems in living. Conceptually, the only way to explain these hard facts is an account of health that centers on what matters to people with respect to their bodily and mental functioning, and this must, in one way or another, analytically connect with human well-being.

Recent Resurgence of Interest in Normativism

The philosophical debate between Boorse and Nordenfelt and their defenders was at its height from the late 1970s to the early 1990s, primarily in the English-speaking philosophical world. It was also during this period that the WHO discovered that it could make good political use of its 1948 definition to further the cause of international public health. In a series of important declarations and other pronouncements during this period, WHO was able to transform its definition into a successful advocacy tool by highlighting an implicit theme of the definition: that health promotion is not exclusively a matter of developing more and more sophisticated medical diagnostic and prevention tools; it is also, and often more importantly, a matter of isolating the social determinants of ill-health across the population. As one of WHO leading advocates of the human right to health Jonathan Mann put it, the WHO definition "helped to move health thinking beyond a limited, biomedical and pathology-based perspective to the more positive domain of "well-being."" In addition, by explicitly including the mental and social dimensions of well-being, WHO radically expanded the scope of health and, by extension, the roles and responsibilities of health professionals and their relationship to the larger society (Mann et al. 1994; Kickbusch 2003).

Perhaps because of the lasting significance of the 1948 WHO definition in international public health, there has been a resurgence of interest in normative conceptualizations of health in recent years. Although some philosophers found some common ground in the two approaches (Schramme 2007), others, especially in the area of mental health, argued that the Boorsian natural function approach was

unable to account for why mental illnesses are viewed as problematic (Varga 2011). Normativism seems to have won out. Unfortunately, the rejection of descriptivism has also led to normative accounts that lack the philosophical rigor of Nordenfelt's theory with the result that they have reprised some of the peculiarities of the WHO 1948 definition.

In 2011, Machteld Huber and colleagues proposed an "adaptation" of the WHO definition made necessary by the profound epidemiological shift in the worldwide burden of disease since 1948 from acute and communicable diseases to noncommunicable diseases, a shift made more dramatic by population aging and the fact that people are living longer with chronic diseases (Huber et al. 2011). These facts convinced the authors of the need to take into account the increasing importance, in public health, for individuals to adapt to environmental changes and to self-manage their chronic illnesses.

For a descriptivist, adaptation and self-management are irrelevant to the conceptualization of health and ill-health, although certainly significant to frame health intervention at clinical and population levels. If self-management, for example, helps to limit the range of potential comorbidities or functional consequences of a chronic condition such as high blood pressure, then interventions should properly focus on developing self-management skills. Chronic health conditions are by definition incurable – although their onset may be preventable – so addressing adaptation and self-management seems imminently sensible.

For a normativist, the importance of adaptation and self-management takes on a very different role in helping to explain the underlying human value that effective health interventions enhance. This focus leads Huber and colleagues to conclude that since an adequate level of capability to adapt and self-manage enhances one's well-being, it follows that health *is* the capability to adapt and self-manage. Moreover, since they are eager to affirm that "social health" is an essential component of health, they require a version of this self-management capability for the social sphere. For this purpose, they included in their account the capability "to participate in social activities including work."

The end result is a definition of health that falls victim to two substantial logical confusions (that normativist accounts tend to be prone to). The first is to conflate cause and effect: in our example, to confuse the impact of a plausible social determinant of health – for example, unemployment rates or some other force limiting the effectiveness of an individual to secure "social health" – with a component of the concept of health. Another more blatant example of this confusion at work can be found in the so-called Meikirch Model of Health in which good health is conceptualized as "individual potentials" – either biologically given or "personally acquired" – that produces a capacity that allows an individual to adequately or optimally respond to the "demands of life" in a context shaped by social and environmental determinants (Bircher and Kuruvill 2014). Personally acquired individual potentials are claimed to include "all of the physiological, mental, and social resources a person acquires during life" – that is to say, resources such as a good job, loving family relationships, educational attainment, and income level. Here again, plausible determinants of health are conflated with components of the concept of health.

The second logical error inherent in the Huber et al. definition is reductivism. For his part, Nordenfelt was careful to characterize the normative essence of health in very open and general terms, namely, as "a bodily and mental state sufficient for the ability to realize one's vital goals." Arguably, the ability to adapt and self-manage is part of that general ability, and indeed it may well be a necessary condition of the ability to realize vital goals. But it is very unlikely to be a sufficient condition for that general ability. If a person has a low level of self-esteem or personality characteristics that undermine his or her motivation to use highly developed skills to adapt and self-manage, then it is unlikely that this person would be able to realize his or her vital goals. Alternatively put, although it would be helpful to one's health to be able to adapt and self-manage, it is certainly imaginable that a person who was a terrible self-manager, by good luck, nonetheless enjoys full health. By reducing the normative essence of health to a single, albeit important, capability, the Huber et al. account is vulnerable to damning counterexamples.

Recent normativist accounts have also reprised what, to many critics, was the main problem with the WHO definition: an exaggeration of the importance of health as a human value. One recent normativist theory demonstrates this problem in stark terms. Building on Amartya Sen's influential capability theory (see, e.g., Sen 1999), Sridhar Venkatapuram has conceptualized health in terms of its potential as a "meta-capability" (Venkatapuram 2011). Incorporating but greatly expanding Nordenfelt's account of health, Venkatapuram has argued that health is both a necessary and sufficient capability to achieve all aspects of the good human life, well-being at its most expansively defined – a veritable *summum bonum*. The social impact of this normative inflation is noteworthy: Venkatapuram argues that the importance of health is such that a truly just society will be organized so as to effectively respond to every potential determinant of health so as to eliminate all forms of inequalities, physical or social, in the name of population health. This is health overreach on a grand level.

WHO's New Approach

The recent proliferation of normativist definitions of health reflects a continuation of the tradition which begun with the WHO definition in 1948, inspired by the insight that health is an aspect of human flourishing and so intrinsically a good thing for all to enjoy. What makes health a good thing and whether it is the only human good or just an especially or uniquely important one are open questions, and a normative theory will gain or lose credibility depending on how it addresses them. But though the WHO definition can be credited with the "normative turn" in conceptualizing health, recently as part of a multiyear project for health system performance assessment (WHO 2000), WHO has taken a step clearly in the direction of a descriptivist approach to health, a conceptualization of health "for measurement purposes."

Although informed by Boorsian descriptivism, WHO's more recent account of health was only possible because the development of WHO's *International Classification of Functioning, Disability and Health* (ICF) (WHO 2001). ICF is an

epidemiological standard, a classification and coding system for health and disability data. Significantly, it is grounded in the notion of human "functioning," which parallels Boorse's own notion of "function" (Boorse 1976). ICF is a classification of domains of human functioning, discrete body functions (including mental functions), bodily structures, and the full range of simple to complex human behaviors, actions, and complex social patterns of behaviors and actions (such as being a sibling, being employed, participating in community activities). The ICF, in short, is a complete classification of human functioning for the purpose of operationalizing health.

The motivation for WHO's new definition of health is measurement, without which it is not possible to compare health over time between individuals, individuals over time, and across populations and over time (Salomon et al. 2003). Without meaningful measures of health, the goals of public health are unachievable: it would be impossible to know whether public health interventions changed health or reduced health inequalities across subpopulations. Without measurement there is no proper science of health. It has been a standard practice, at least in public health, to "measure" health states of populations in terms of standardized health indicators, such as incidence of chronic illnesses, infant mortality rates, or population survivorship rates (see examples in Goldsmith 1972; Bergner 1985; McDowell 2006). Indicators are, of course, proxy measures, and it was the goal of WHO to achieve a more robust measurement of health by means of an operational conceptualization of the notion. At the same time, the authors appreciate that little would be gained if the resulting conceptualization was too distant from the common notion of health and in particular our intuitions about health as a human value. Thus, the first step in the development of a new WHO definition of health, therefore, was to identify "consensus points" about the concept of health:

1. Health is a separate concept from well-being, and is of intrinsic value to human beings as well as being instrumental for other components of wellbeing;
2. Health is comprised of states or conditions of functioning of the human body and mind, and therefore any attempts to measure health must include measures of body and mind function; and
3. Health is an attribute of an individual person, although aggregate measures of health may be used to describe populations. (Salomon et al. 2003, 303)

It follows from these simple propositions that there is a clear, conceptual distinction between health and its determinants and consequences, a confusion that is the downfall of many normativist accounts of health. The distinction between determinant and concept follows straightforwardly from the first clause of the third consensus point, as does the core descriptivist premise that the language of health is that of the biological sciences. Income levels, employment rates, and social networks – all of these phenomena are likely determinants of a person's health, but for all of that, they are not attributes of an individual person and so not part of the concept of health.

The second consensus point is the essence of the new WHO account of health as "an intrinsic, multidimensional attribute of individuals" with universal, cross-population, and cross-cultural validity. The account is universal simply because it is grounded in states or conditions of functioning of the human body and mind. The ICF

is a classification of these domains of functioning, decrements in which are impairments if the limitation is in a body function (or structure) or activity limitations and participation restrictions if the limitations is in what the person does or performs. The account, however, requires that these "states or conditions of functioning" refer to intrinsic capacities of an individual, rather than descriptions of what individuals do or perform in their actual environments. This is an important qualification, and as the philosophical plausibility of the WHO conception of health depends on it, it is worth developing the distinction between capacity and performance more fully.

As the model of functioning and disability embodied in the ICF makes clear, the nature, quality, and extent of what a person *does* (acts, executes, performs, behaves, and so on) often depend considerably on features of the environment in which the person acts. This is especially significant when the concern is to determine the state of a person's health, with limitations on what the person can do because of their intrinsic biological state. Thus, a person who has an impairment in hearing may in fact be able to hear with a hearing aid; similarly, a person with lower body muscle wastage may not be able to climb stairs in a public building because they are too steep but will be able in their own home where the stairs have been modified to accommodate this impairment. In short, to accurately assess a person's functioning in different domains – hearing, seeing, walking, climbing, grasping, carrying an object, and so on – it is important to discount the impact of the environment in which the person performs actions that depend on these functionings. Features of the physical and social environment may make it possible for the individual to perform better than he or she can intrinsically (when assistive technology or environmental modification facilitates performance); by the same token, other features may hinder performance. In either instance, to get at a person's health, the positive or negative effect of the individual's environment needs to be discounted. The result, in the ICF language, is the person's intrinsic functioning capacity.

But given the substantial number of bodily and person-level functionings that constitute the full repertoire of human functioning, it would be impractical to define health operationally in terms of all of these functionings. Though a practical rather than a conceptual issue, it is a measurement challenge that the WHO conception needs to resolve. Conceptually, the new WHO definition is completed by the three guiding principles quoted above, but as the point of the conceptualization is practical operationalization for measurement purposes, the authors are very much obliged to offer a solution to the challenge of identifying which human functionings are at the conceptual heart of the notion of health.

They approach this challenge by sketching out functioning domain selection guidelines: the domains of functioning sufficient for operationalizing the concept of health for measurement purposes should be those that have intuitive, clinical, and epidemiological significance; are classified in the ICF; are amendable to self-report, observation, or direct measurement; are cross-population comparable; and, finally, are "comprehensive enough to capture the most important aspects of health states that people value" (Ibid. 310).

This last criterion is not so much a measurement concern as a matter of face validity. When measuring health, it is important to measure what it is about health

that makes health something perceived to be both intrinsically and instrumentally valuable. This should be taken as a gesture toward the normativist challenge, but it is not a complete answer to it. In effect, the new WHO definition of health turns the issue of the normative significance of health into a technical challenge, leaving unexplained why health matters to us. Given that the definition is held out to be cross-culturally universal as well as scientifically adequate, the failure to pinpoint the source of the value of health can fairly be seen as a significant failure of the WHO definition, at the conceptual level. Even if we are confident that the domains of functioning we select serve the purposes of scientific measurement, the resulting operationalization does not, on its own, give us an explanation why, in every culture, health is conceptually understood as a human good.

Conclusion

The 1948 WHO definition of health and the current, descriptivist WHO definition "for measurement purposes" reflected a persistent dilemma in the philosophical challenge of defining health. Any philosophically acceptable definition must take into account our powerful intuitions about the intrinsic and instrumental value of health. Health may not be the same as well-being or the summum bonum, but it is a component (or determinant) of human well-being and indisputably a human good and a central one at that (see Daniels 2008). Yet, unless the notion is firmly grounded in the biological sciences and understood as an attribute of the person, the concept resists operationalization and threatens to lose its scientific legitimacy. It is not just the World Health Organization that requires a notion of health in terms of which we can compare the health of an individual before and after a clinical intervention or a population of people before or after a health promotion or other public health intervention. As an unexplained, ineffable, indefinite, or inherently subjective phenomenon, the notion of health is not of particular use to us, nor would it have any useful input into how we structure our social institutions and systems to respond to actual human need. This is the philosophical challenge of defining health.

Definitions of Key Terms

Descriptive theory of health	A philosophical theory of health based on the premise that health is an attribute of an individual fully explainable in the language of the biological sciences.
Normative theory of health	A philosophical theory of health premised on the view that it is of the essence of health that it is an intrinsic and instrumental human good.
Operationalization of health	The process by which a conceptualization of health is transformed into a set of operations, procedures,

	or explicit criteria that define elements of health that can be measured in one manner or another.
Functioning	(In the International Classification of Functioning, Disability and Health, WHO 2001) a domain of health including specific body functions and structures and all human behaviors, movements, and actions, from the simplest individual movement or action to the most complex, socially constructed, action that constitute human activity.

Summary Points

- The 1948 Constitution of WHO defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
- Though strongly criticized, the WHO definition of health set the stage for an ongoing philosophical debate about the definition of health.
- The dominant theories of health emphasize either the biological and scientific core of the notion (descriptivist or "naturalistic" accounts) or the consensus that health is an intrinsic and instrumental human good (normativist accounts).
- Despite decades of high-quality philosophical debate about the concept of health, there remains a persistent dilemma: neither a descriptivist nor a normativist account of health is adequate, but these two approaches are in fundamental conflict.
- After two decades of relative inactivity in philosophical treatments of the concept of health, recently there has been a resurgence of interest in normativist definitions.
- It is essential for the scientific status of health sciences, and in particular for assessing the effectiveness of individual and population health intervention and comparing the health of individuals and populations, to use a conceptualization of health that is operationalizable for measurement.
- Although the 1948 WHO definition remains in use, WHO itself has based its own scientific work on a very different, basically descriptivist, account of health "for measurement purposes."
- The most recent WHO definition of health, although it gestures toward the normativist approach while being firmly descriptivist, nonetheless fails to adequately account for the common perception that health is both intrinsically and instrumentally valuable.

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