

A critical look at health

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When defining health, it is clear that good health is not simply a state in which there is an absence of disease. A progressive definition of health conceptualises health more holistically and views it as a state of complete physical, psychosocial and spiritual well-being. Further, it is important to understand the role of factors such as cultural and economic ones in maintaining wellness and, ultimately, health in individuals, communities and societies. Maintaining and promoting health in developing countries is a major challenge, because these countries are under-resourced. The health experience of individuals must be located within the context of gender, class and ethnicity/race. These variables are important in shaping health outcomes. Measuring quality of life in developing world contexts is crucial if one is to effect change and influence the way in which health outcomes are determined in the future.

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Introduction

The word 'health' is defined in the Concise Oxford Dictionary as "soundness of mind or body" and is derived from Old High German and Anglo-Saxon words meaning 'whole', 'hale', and 'holy'.¹ Historically, in the East, West and in Africa the importance of being 'healthy' has been emphasised and systems of healing have been developed to heal the 'sick' and 'dying', and to promote health.

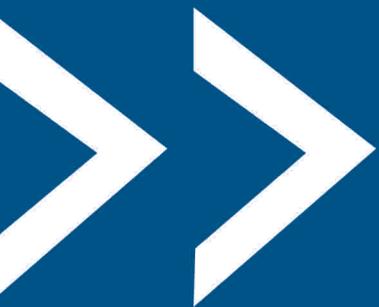
In an attempt to approach the concept of health more holistically, the World Health Organisation (WHO) defined health as: the state of complete physical, social and spiritual well-being, not simply the absence of illness.² This definition takes cognisance of factors outside the disease continuum. In reviewing the literature that explores health issues critically, it is pointed out, however, that there are still

essential elements of health that the WHO's definition does not consider. Cultural, psychological and economic factors also play a crucial role in maintaining wellness and, ultimately, health in individuals, communities, and societies. The complexities around health are reflected in the following definition: it is a state of being with physical, cultural, psychosocial, economic and spiritual attributes, not simply the absence of illness.³ This definition of health implies that a state of health is determined by the interrelationships between physical, cultural, psychosocial, economic and spiritual attributes.

While the multifaceted definition of health reported above is a progressive one, it is nevertheless a reminder that it is something of a challenge to attain an ideal state of health. In developing countries, especially those developing countries in which the majority of indi-

viduals are disempowered economically, socially and educationally (such as countries in Africa and Asia), and consequently live with limited resources, it becomes an arduous task to promote a nation of healthy individuals. One has to first attempt to address the fundamental nature of these disempowering factors.

In South Africa, just as in other countries in Africa, colonisation and the effects thereof has had a negative effect on economic growth. This lack of sustained economic growth has further impacted on economic, social, educational and other important developments that build resources to help sustain a nation, promote health and enable citizens to enjoy a reasonable quality of life. Other factors that may disempower individuals and hinder the development of healthy individuals are sociological and psy-



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chological ones. Marginalised groups, such as the poor, women and children, are particularly affected. Women and children are vulnerable because they often suffer the consequences of repressive and oppressive sociological practices that render them psychologically disadvantaged, more especially in societies in which the patriarchal system is firmly entrenched. A paper examining the socioeconomic context of health in South Africa notes that, in the past, measures of inequality and access were dominated by the variables of race and class and their combination.⁴ The transition to "the new South Africa" has made room for the consideration of additional variables, which provide a deeper analysis of social and economic development, namely gender, the environment and living space.⁴

Factors that shape the health experience of individuals

In developed regions such as North America, the patterns of disease and death have changed from infectious diseases to chronic, lifestyle diseases. In developing countries such as South Africa, however, disease patterns present differently for different population groups, and include both infectious and chronic disease. The differences in the health experience of individuals in developed countries compared to those in developing countries, as well as within-country differences, must be conceptualised within an economic, political, ecological, social and cultural context. In keeping with this conceptualisation, gender, class and ethnicity/race must be seen as three systems of stratification.⁵ These work separately and together to shape institutions, social location, opportunity, interpersonal relations, the distribution of disease and the experience of illness. In the health context, therefore, gender, class and ethnicity/race must be considered as important variables that shape health outcomes.

A large number of individuals in the developing world face poverty, and poverty is seen to have the greatest influence on health. It is the greatest cause of ill health and mortality. Human

well-being in sub-Saharan Africa is amongst the worst in the world and two-thirds of Africans are said to live in absolute poverty. The situation appears bleak, considering that 4.4 billion people out of a world population of 5.6 billion live in developing countries. Half of the world's population is not able to receive treatment for common diseases or have access to the most essential drugs. Furthermore, two-thirds of all deaths in developing countries occur before the age of 65, and nearly one-third before the age of five, compared to developed countries, where almost two-thirds of deaths occur after the age of 65.

Differences in health outcome have also been observed within countries.⁶ Premature mortality rates, illness and disability are higher among the more disadvantaged sections of certain national populations, such as in Australia, Ireland, Spain and Sweden.

Gender and health

Historically, women have been valued only for their biological ability to bear children and consequently have been marginalised in all sectors of society, including the health sector. Research on health-related issues has almost exclusively focused on men. This is particularly true for those studies conducted on coronary heart disease and type A behaviour, and psychological factors and cancer, which have previously exclusively used male participants. Attitudes have since changed and women's health-related issues are now given priority in research, both in the medical and the social sciences. In industrialised societies today, men die earlier than women, but women have poorer health than men.⁷ Women have higher morbidity rates but lower mortality rates and suffer more non-fatal chronic illnesses (such as hypertension, kidney disease and autoimmune diseases) and more acute illnesses. Compared to men, women also suffer twice the rate of depression. Men, however, have a shorter life expectancy and suffer more injuries, suicides, homicides and heart disease.

Differences in gender distribution in terminal illnesses such as HIV and AIDS lend support to the call for a shift

in emphasis from men's health to women's health. Sub-Saharan Africa has the highest prevalence of AIDS transmitted through heterosexual intercourse and just as many females as males are affected. It is estimated that about two and a half million women in sub-Saharan Africa had been infected with the HI virus and about a quarter of a million have already developed AIDS. Many of these women with AIDS are of child-bearing age. In the late 1980s, 5-10% of all infants in central Africa were HIV positive.

Many additional issues relating to gender differences in health are highlighted in the literature.⁸ The fact that women report higher rates of illness than men could be due to clinical differences in morbidity, or to differences in illness behaviour, symptom perception or symptom reporting. A study on gender differences in the participants' general evaluation of their health and symptom reporting found that women with mild hypertension were more than twice as likely to report their health as poor and reported more symptoms than men with mild hypertension, although they received the same treatment. An important observation in this study, however, was that these women had less education, were less likely to be employed or married, and reported higher levels of distress and dissatisfaction with family functioning. These factors were found to outweigh the influence of sex per se on symptom reporting. There are clearly, then, many factors linked to health outcome and illness behaviour.

If there is a gender difference in morbidity and mortality, then men and women may also differ in the way they experience psychological stress. This difference begins with the types of stressful encounters they experience, as well as the way in which they appraise the encounter. If one locates this understanding within the stress and coping paradigm in which coping is defined as "the cognitive and behavioural efforts made to master, tolerate, and reduce external and internal demands and conflicts among them", then the way in which an individual copes with a stressful event such as suffering physical ill-health or poor

psychological well-being, depends on both intrinsic and extrinsic factors.⁹ Because women are seen to be the marginalised group in developing countries, including those countries in Africa, they are severely challenged when coping with stressful encounters due to limited social, economic and psychological resources.

An increasing number of publications focus on the importance of considering gender differences in health outcomes. Women, particularly those inflicted with chronic diseases such as RA, have become the focus of research attention because they have been historically prejudiced, both in a social and an occupational context, and, consequently, are expected to have worse health outcomes than men.^{10,11} In addition, biological differences between men and women must also be considered when trying to understand the differences in health outcomes based on sex. It is known, for example, that there is an increased physiological risk of arthritis among women.

Measuring health status and quality of life

To measure the health status and general quality of life of both diseased and non-diseased individuals in a society is a massive and expensive undertaking. Health-related quality of life could be defined as an optimum level of mental, physical, role and social functioning.¹² In keeping with this definition, therefore, psychosocial measures and measures of disease and disability should form the core in a quality of life measure. In a developing country such as South Africa, a prac-

tical starting point would be to assess the quality of life of those diseased and non-diseased individuals who seek health care in the private and public sector.

Inexpensive quality of life (QoL) measures need to be developed for use in the state services. Existing scales that have been found to be valid for use in certain populations (such as the Beck Depression Inventory (BDI) and Health Assessment Questionnaire (HAQ)), may be used to guide and inform the development of a new, comprehensive QoL measure. The BDI, for example, may be used as a screening tool to detect depression that may otherwise not be detected in an overburdened health service. Appropriate steps can then be taken to treat the depression, which may lead to an all-round improvement in the health status of the patient, as it has been established that psychological factors, along with other factors such as socioeconomic ones, play an important role in mediating health outcomes.

Conclusion

This paper highlights the complexities of health and calls for the health practitioner to interrogate the various factors that impact on health status and the overall quality of life of those individuals who are recipients of the health care they provide. The quality of care provided by health practitioners is largely dependent on their ability to take a critical look at health and not only adhere to traditional models of health and health care. Practitioners should not be responding only to the symptoms of those individuals who seek health care, but should attempt to formulate an understanding of these

individuals within a biological, psychological and socio-political context. The fact that the health landscape in South Africa embodies both developed and developing world scenarios must be taken into account seriously. Finally, practitioners need to practice gender-sensitive health care in order to maximise the quality of life of the recipients of this care.

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