

What is health? What is disease? What is normality?

Health

Ancient philosophers have thought about this issue. “Plato understood health in a hierarchical order, whereby health would mean the supremacy of the soul over the body, and thus the rational part would surpass the desirous one. From Aristotle’s view that motion is an actualization of a potentiality, health can be interpreted as the ability to accomplish goals, being healthier the one with more options or possibilities.” ([Catita et al., 2020](#)) Plato’s view of health is more abstract, and he views health, not merely as physical well-being, but a higher state where the rational soul would keep in check the physical body’s desires. Aristotle’s view on health is more pragmatic, and he believes that being healthy means the ability to accomplish goals, and functions in one’s environment.

According to WHO, “health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity” ([WHO, 1946](#)). Proponents praised it for being holistic, while critics condemned it for being unrealistic. Moreover, such a definition appears to be vague, as it does not provide guidance on when to seek treatment if one is not healthy.

However, others may equate being healthy with normality or being normal, but what is normal and what reference class or baseline is considered normal? Health may not mean normality, as explored in subsequent sections.

To sum up, in order to understand health, an understanding of disease is necessary, which will be explored in the next section.

Disease

There are several schools of thought when it comes to “What is a Disease?” In this journal, a few will be presented.

The first is the Biomedical Model. It is an approach to health and illness which defines health as the absence of disease, portraying the human organism as either functioning ‘normally’ or else dysfunctional and therefore diseased. The biomedical model has strengths but also weaknesses: it oversimplifies health problems in particular ways. ([Russel L, 2013](#)) There are several assumptions and drawbacks with this approach. For example, it assumes all illnesses and diseases have a specific cause linked to it, the body is a form of machinery that has to be fixed by medical doctors, diseases must be treated and it discounts emotions. Most importantly, it looks at disease from only a scientific and biological lens, and discounts other factors such as socioeconomic status and the environment.

The second is the Biopsychosocial Model. The biopsychosocial model instead “focuses on individual’s perception of their symptoms and how they and their families respond to symptoms they are experiencing”. ([Taukeni, 2019](#)) It also looks at social factors, such as poverty, in the wider context in which biological processes take place. For example, a person suffering from pneumonia may be living in a home with musty air and bad air circulation. As such the biomedical model targets the symptoms, but not the *root cause* of the disease.

There are other factors to consider when classifying something as a disease. For example, business leaders and big pharma have searched for new markets (classifying new diseases)

to improve the bottom line. This poses ethical questions as to whether companies should be allowed to lobby and help shape the direction of the industry and the classification of diseases. Additionally, diseases can be shaped by one's personal perceptions too. For example, some Deaf people ('Deaf' in uppercase to indicate the cultural grouping) consider themselves a linguistic minority. As such, if this group of people do not consider themselves as having a lower quality of life, or is disabled in any way, then this group of people may not see themselves as diseased.

Normality

There are many approaches to determine normality, and this journal will focus on one. One approach is the biostatistical approach. The biostatistical approach looks at 1. Biological Function and 2. Statistical Normality. However, there are some problems with this approach. Firstly, it is quite rigid and has hard cut-off limits. This brings up issues about people who straddle the limits. What if a person is suffering (i.e. having physical or mental pain), but is still classified as normal? The second problem brings about greater challenges. Many issues and questions arise when attempting to define the reference class, and specifically the appropriate reference classes to different groups of people. For example, what is the ideal population which should be used as the reference class? This would have to be well designed so as to prevent stereotypes from forming. For example, there is a questionnaire to assess if someone has a risk of dementia, named Mini Mental State Examinations (MMSE). However, some questions in this questionnaire may not be relevant to the elderly in Singapore, and could be mis-diagnosed because they fail to understand the question. An extract from a paper published in Singapore supports this point. *"This 10-item questionnaire was developed by Kua and Ko, who felt that most instruments constructed in the West, where literacy is high, may not be applicable in the current cohort of elderly in Singapore because of cultural differences or low literacy"* ([Chin, 2002](#)) Singapore has done well in this regard, by adapting the questions and also translating to Chinese.

Normality is a shifting marker, a type of social compact that is defined by society. What may be considered normal now, may not be considered normal in the future as society have conversations on what they hope to see collectively. Singapore launched Healthier SG in 2022, and the general idea is preventive care through changes in diet, exercise and preventive screening. In Singapore, there is a taboo in seeing doctors, (cultural factor) where one only visits when he/she is sick. The underlying motivation is to change norms and have a mindset shift to go for preventive screening. Without preventive screening, a person may not be familiar with his baseline ("normal health"). However, the narrative is shifting as it becomes normal for a person to consult doctors on how to improve one's health, and do screenings, amongst others.

Reflections

The readings and questions raised are thought-provoking. An example is osteoporosis which was believed to be a part of normal ageing until 1994, when WHO switched it to a pathology. Advances in biomedicine most probably allowed for improved understanding and the reclassification. Such classifications also inform the general public that osteoporosis can be intervened pharmacologically, by taking calcium. Additionally, cultural & ethical changes can affect the classification of whether something is a disease, for example, homosexuality. To conclude, the advance of biomedicine and science, the environment, and changing social and cultural norms will collectively shape society's view on health, disease and normality.

References

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