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MORAL ASPECTS OF SOME HEALTH IDEOLOGIES

INTRODUCTION

The contents of this paper is obviously determined by the interests of its authors who are not philosophers. A sociologist dealing with problems of ethics and a lawyer specializing in problems of health policy put forward the topic of some moral aspects of health ideologies.

In a less equivocal phrasing the main topic of our paper may be defined as a question of responsibility for health – if we accept the assumption that responsibility is one of the prepondering issues of moral analysis at both practical and theoretical levels.

Revealing from the beginning our occupation we intended to make the directions of this paper clear. We recall the statement by R. Titmuss „we have responsibility for making our values clear; and we have a special duty to do so when we are discussing such a subject as social policy which, quite clearly has no meanings at all if it is considered to be neutral in terms of values"[1]. And – as another writer added „To be engaged in social policy – even as a researcher – and to be nonideological, is indeed a contradiction in terms"[2].

Thus the aim of our paper is not so much to answer the question who is responsible and for what in the health field, as to discover normative assumptions and valuation which influence the process of attributing responsibility for health.

Out of many different facets of responsibility for health we are going to focus our attention on its social rather than individual aspects, opposing a stereotype that responsibility for health is mainly connected with conscience

[1] R. M. Titmuss, *Commitment to Welfare*, George Allen and Unwin Ltd, London 1976.

[2] J. B. Mc Kinley, *Epidemiological and Political Determinants of Social Policies Regarding the Public Health*, „Social Science and Medicine" 1979, Vol. 13, No. 5, p. 541–558.

of an individual medical doctor. Unmasking of this stereotype will even prove one of our conclusions.

An attempt to combine a social perspective with the concept of responsibility may face some difficulties if we assume that responsibility is usually attributed to a person. In particular, in utilitarian tradition – which is broadly believed to be the most promising if social aspects of morality are under consideration – attributing responsibility refers to an action: blaming or praising a given person[3]. As O. H. Gablentz pointed out „Moral responsibility may be related only to consciousness; its extreme expression is Dostoevski's statement: Everybody is guilty of everything"[4]. However, in the same utilitarian tradition it is admitted that moral responsibility may also have an objective dimension. According to John Stuart Mill, „A gevernment is to be judged by its action upon men, and by its action upon things; by what it makes of the citizens, and what it does with them; its tendency to improve or deteriorate the people themselves, and the goodness or badness of the work it performs for them, and by means of them"[5].

Responsibility of a government, political parties, or social movements cannot be perceived in terms of individual conscience and consciousness but still may be regarded as moral responsibility. In fact a distinction between moral and political responsibility, accepted in manuals, is very unconvinceable in practice. It seems that as for as social aspects of health matters are concerned it is quite impossible to use this distinction, and many current discussions offer illustrations to this statement.

CONTEXTS OF RESPONSIBILITY FOR HEALTH

The problem of responsibility for health is one of the holtest public issues in many countries. In some countries where some noticeable progress in health status of the population has been achieved in recent years, the question: who is responsible for health might be read: who could be praised for enlightened health policy. In such circumstances – if improvement in health is unquestionable – there are usually many candidates for fatherhood of the success and it is not hard work to discover agents responsible for health.

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[3] J. Hospers, *Human Conduct. An Introduction to the Problems of Ethics*, Rupert Harf-Davis, London 1970, p. 469–471.

[4] O. H. Gablentz, *Responsibility*, [in:] *International Encyclopedia of Social Sciences*, Vol. 11, The Macmillan Company and Free Press, 1980.

[5] As above.

Much more frequent, however, are cases when the question of responsibility is like a police investigation: anyone suspected tries to avoid being blamed. Again, in some countries responsibility is extended not so much to problems of health status as to issues of expenditure going to the health sector. A rising stream of resources supplying this sector is referred to as an explosion of costs. On the political stage somebody is needed to be blamed for explosion of health costs and for excessive spending of taxpayers' money. This problem has strong moral repercussion. Since in the present economics the term costs means opportunity costs – value or utility of all those goods which have been lost because resources have been used for other goals – an agent who is responsible for the decision to spend money for health may be blamed for all other unsolved social problems. Poverty and unemployment, lack of education and decent housing, poor work conditions, unhealthy environment and insufficient sanitation, all become the contents of responsibility for health – or more strictly – for decisions on health policy.

The above example is a bit artificial since the countries with great spending on health have managed to solve a lot of social welfare problems. Developed systems of social assistance ease adjustment and development in many stressful situations. Thus not the general level of unmet social needs is an urgent problem but the lack of equity and fair distribution of opportunities.

Yet, there are countries where health status of the population has deteriorated in recent years. If we use life expectancy as a proper indicator, Poland is a country where – after the years of health progress – an obvious regress has occurred. First – life expectancy of men, later that of women have been shortened. In these circumstances the question: who is responsible for health, has gained a great multidimensional significance.

The political dimension becomes obvious when we realize that health status may be conveniently used as a criterion of the social policy in its general span. Some writers suggest that the term „social policy" should be used to denote the underlying ideology and purposive action adopted by Government, ostensibly on behalf of the public, with the intention of beneficially altering the health and welfare of citizens[6]. If so, also all actions, undertaken or tolerated by the Government, that alter health status leading to its worsening are part of the social policy for which the Government is responsible.

The moral dimension of the responsibility for health is clear as well. It is useful to refer here to the concept of violence, as defined by Galtung[7]. In his approach violence occurs (structural violence), when people are subjected to any kind of influence which causes their potential level of somatic and mental

[6] Mc Kinley, *Epidemiological and...*, p. 541.

[7] J. Galtung, *Violence, Peace and Peace Research*, „Journal of Peace Research" 1969, Vol. 6, No. 3, p. 168.

development to be lower than potentially attainable. In Galtung's view an influence or action defined as violece need not hamper people's potentialities intentionally. For such assessments it is enough that objective results of doings or not doings cause deterioration of opportunities for human growth. We do not declare we accept Galtung's deginition of violence, but the very possibility of using such a concept undoubtedly indicates, that we are on a moral territory.

PROBLEM OF EVIDENCE

The first preoccupation in the process of attributing responsibility to an agent is connected with the length of causal chains leading to tangible health results. The length of causal sequences refers to both the number of interfering factors and the duration of time lag between a stimulus and the resulting, change in health status. This apparently empirical statement has serious consequences as far as the problem of responsibility is concerned. As Rutstein et al. pointed out, the chain of responsibility to prevent the occurrence of any unnecessary disease, disability, or untimely death may be long and complex. The failure of any single link may precipitate an unnecessary undesirable health event. Thus, an unnecessary case of diphtheria, measles, or poliomyelitis may be the responsibility of the State legislature that neglected to appriopriate the needed funds, or the health officer who didn't implement the program, or the medical society that opposed community clinics, or the physician who did not immunize his patients, or the religious views of the family, or the mother who didn't bother to take her baby for immunization[8].

Quite often empirical evidence between identified factors remains unclear. „A great deal of knowledge is needed to understand the relationships between health and the components of particular lifestyles", [...] there are widespread uncertainties and misconceptions about the magnitude and probability of different types of (environmental) risk. [...] The risk to health arising from contamination of water, air, soil and food is often difficult to assess precisely" has been stated in the document on European regional strategy for health for all[9]. It has been emphasized there that subjects and agents responsible for health should be established even if there are some doubts on causal links between factors put under their control and anticipated health results, specially if these are damaging health results.

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[8] D. D. Rutstein et al. *Measuring the Quality of Medical Care: a Clinical Method*, „New England Journal of Medicine" 1976, No. 294, p. 582.88.

[9] *Targets for Health for All; Targets in Support of the European Regional Strategy for Health for All*, Second impression, WHO, Copenhagen 1986.

HEALTH IDEOLOGIES — A GENERAL VIEW

In a jungle of social ideas, values, beliefs, emprical assumptions and visionary speculation a specific wholeness oriented to health can be singled out. Important questions on what health is and what its place is among other values, what its determinants are and what health depends, on what the adjective „rational" as used to attitude, behaviour, organization, reaction in field of health, means – all those questions are answered by health ideologies. Therefore people are given orientation in the health matters as well as motivation to deal with them.

In the contemporary realm of health ideas two great ideologies can be identified: the professional ideology connected with bio-medical paradigm and the ideology derived from the Health For All strategy, linked with socio-ecological paradigm.

In the traditional bio-medical paradigm – as Dubes pointed out – good health was regarded as a sublime state, susceptible to disruption by the insult of injury, pest or toxin[10]. Any diagnosed case of ill-health, any disease, was thought to have its own specific cause. This cause was to be identified and cured on a base of biological and medical science. The only person legitimatized to undertake all those activities was a medical professionalist – due to his technical and moral competence. He assumed the whole range of responsibility for health. The only moral obligation, connected with health which remained to lasy people, was to follow the professional advice and suggestions. There was a claim among them, that the health status of a society was proportional to the amount of resources spent on medical services, so investing in health sector was the most reasonable investment in the society's health.

Being convinced that they are paying enough – simply in money terms, people have come to assume that they can abuse their bodies as much as they want to and the medical services will repair the damage[11]. Even if there is no miracle cure, they feel that one will certainly be discovered in due course. The wonders of spare-part surgery have become an important reason in the process of rejecting responsibility for health: if I don't need to bother even of my heart – since it can be transplanted – my only responsibility for my health is a choice of a proper professionalist I can trust.

It should be stressed that even in the countries where medical service is not supplied with sufficient amount of resources consumption-oriented, passive health attitudes are broadly accepted.

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[10] R. Dubos, *Mirages of Health*, Polish edition: *Miraże zdrowia. Utopie, postęp i zmiany biologiczne*, PZWL, Warszawa 1962.

[11] P. O'Neill, *Health Crisis 2000*, WHO, Regional Office for Europe, Copenhagen 1983.

In the ideology derived from HFA which benefited a lot from Capra's analysis health is taken as a dynamic equilibrium within a complex hierarchy of systems and subsytems[12]. According to the systems perspective living systems such as societies, social organizations, human beings form a set of interdependent units where the higher-level system is made of lower-lever subsystems. This hierarchy of units is perceived in the background of a larger framework which can encompass even the Universe. It depends on a researcher's cognitive capacities to out-off limits of the system under consideration[13].

Within such a system, health can be defined as a state of dynamic balance – or more approprietely as a process maintaining such a state – within any given subsystem, such as an organ, an individual, a social group or a community. This balance can partly be explained as the results of the individual's or the community's autonomous capacities to keep adverse forces under control. Under normal condition when individuals are adapted to their environment and the environment does not impose any unusual risk on them, they will be able to maintain an internal dynamic balance. An imbalance not exceeding a certain level is tolerated and may be seen as normal. Values of many parameters describing living systems tend to oscillate permanently and that does not have to mean a lack of balance. Even changes in the environment or changes in the system itself, exceeding certain normal intensity or duration, will not upset the balance leading to ill-health if the mechanisms of coping are strong enough. It can be assumed that coping potential and the process of coping itself are very much determined by the capacity of the subsystems of the individual to react adequately and effectively. The reaction may occur at the level of immune system, physiological process, behaviour or intelectual response. It any case it means that an indicidual is able to mobilize resources to cope adverse stimuli. Quite often, coping with adverse environmental conditions is not limited to individual activity, but involves social action and interaction.

A prerequisite to maintain health balance – and the second key concept of a socioecological paradigm – is the health potential. The health potential refers to either the capacity or the particular type of interaction between person and environment that is required to maintain health equilibrium and to reestablish it when it is lost.

At the individual level health potential can mean good nutritional status, immunological resistance, physical fitness, emotional stability, adequate health knowledge and attitudes, healthy personal lifestyle, effective pattern of coping with psychological stress.

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[12] F. Capra, *Turning Point*, Polish edition: *Punkt zwrotny*, PIW, Warszawa 1987.

[13] H. Noack, *Concepts of Health and Health Promotion*, [in:] *Measurment in Health Promotion and Protection*, ed. T. Abelin, Z. J. Brzeziński, U.D.L. Carstairs European Series No 22, WHO, Copenhagen 1987.

At the community level, health potential refers to the capacity required – or to the activities undertaken – to prevent health imbalance and to maintain or reestablish health balance. Important elements of a community's health potential is a content of the health policy, the proportion of the budget allocated to health promotion, prevention and social welfare, the level of unemployment and conditions of employment, income and social security, the quality of housing, the safety of the physical and technical environment, living conditions, nutrition, education, recreational activities, social and cultural activities as well as health beliefs, health practices and access to health service.

All those factors enumerated above, affecting health potential, health balance or both, are under control and influence of many individuals, groups, communities and societies. All of them may be regarded as taking part in responsibility for health.

HEALTH IDEOLOGIES — A LITTLE DEEPER VIEW

It is quite elegant to divide health ideologies into two groups – the professional ideology and the HFA ideology, but the reality is not so simple. To be a bit more specific, each of the great ideologies should be subdivided in nerrower and more homogeneous entities. There are three versions of the professional ideology: traditional, dogmatic and modern (or open). There are two version of the HFA ideology: magagerial and participative.

In the traditional professionalism what was strongly emphasized was the ethical aspect of the responsibility of an individual physician for the health and success of an individual patient. This would develop a firm personal contact between them with essential elements of respect or even friendship. Each problem defined by the patient as medical would be dealt with by the physician – no matter whether it was of strictly medical nature or not. The physician would consider his personal duty to satisfy fully his patient's health need viewed as only one of the factors contriburing to the overall image of the health status of the person under his care.

While analyzing the patient's state of health the physician would take into consideration his life and family situation and no elements of the situation were neglected at both diagnosing and treatment planning.

The physician's instrumentarium contained not only the means whose effectiveness had been confirmed by medical researches but all hormless methods including the traditional folk medicine as well.

In the dogmatic professionalism scientific bases for medical performance prove to be of fundamental importance. Since the conditions affecting the health status are perceived mechanisticly and monocausally, alll factors whose

share in the etiology of particular diseases has not been confirmed strongly enough with scientific methods, become unnoticeable. Physicians claim not to be interested in „nonmedical" problems – whereas only those problems are considered medical which can explicitly be described by means of the classification of diseases. In this way the ranges of problems perceived as those conerning health by the patient and by the physician coincide no longer. However, the effect of this restricting tendency is effectively reduced by the enlarging interpretation of the criteria qualifying problems as medical. Various social problems, even those once only partly connected with the idea of health begin to be conceived as medical.

Developed scientific bases for professional performance are subject to the process of specialization. Consequently, the knowledge used by particular professionalists – although deeper – must be narrower. The picture of the patient's health status seems to resemble a mosaic of separate problems. The decomposition on the level of knowledge is accompanied by desintegration on the level of the medical service organization. It turns out very difficult not only to integrate the scattered aspects of the medical knowledge but also to organize the very process of treatment so that it would afford possibilities for complex care. In fact, in the framework of the philosophy of the dogmatic professionalism the problem discussed cannot be solved since the prestige and qualifications of the general medicine representatives prove not to suffuce to co-ordinate specialistic activities.

In the open professionalism, the same faithfulness to the ideal of the scientific precision leads to the consequences entirely different from those in the dogmatic professionalism. The departure from the mechanistic interpretation of phenomena made it possible to include the aspects of environment, behaviour and consciousness in the sphere of interest of medical professionalists. Treated as co-determinants of the health status, they are perceived in both diagnosing and treatment. Rational division of labour enables cooperation of multiprofessional teams. The interdisciplinary approach serves well integration of different points of view in analysing problems of patient's health. The physician's authority makes the coordination of activities easier, while professionalists in other fields preserve considerable independence in realizing partial tasks. The appreciation of the significance of coordinating functions for effectiveness of the medical care contributes considerably to the restitution of the prestige of the general medicine as „sui generis" specialization or to the encouraging of holistic specializations.

Intentionally created, the ideology of Health For All is much more homogeneous internally. But even here, because of the stresses being distributed differently, two variants of the idea can be distinguished.

The managerial variant of Health For All directs the attention of the health protection organizers at efficiency of the management system. Rationally

defined goals should be assigned rationally distributed means. General assumptions of the health policy realized on a country scale and particular solutions employed are consistent due to an efficient planning process. All essential conflicts among supporters of different conceptions or priorities are solved within a rationally controlled political process. What conditions and guarantees its efficiency is a balance between actual centralizing and decentralizing tendencies in the management system. However, organizational mechanisms suggested in this variant put the central decisional centre in a privileged position. The sphere of its activities should cover all phenomena – environment, behaviours – which affect the health status of the population.

In the participative variant of HFA the emphasis is put on participation of people, especially members of local communities, in the activities related to health and its protection. The very term „activity for health" is to a great extent, devoid of the instrumental character. If health is perceived in the categories of balance and health potential, then man's acting or non-acting is, in a sense, always connected with his health. The concept of „life style" conceived as rationality and wisdom is treated as health itself rather than a factor determining it. Health as a way of life is realized socially within a local community which is a selffulfilling entity of both social and political nature. Autonomy of communities and their sovereignty in taking decisions concerning the largest scope of health problems possible is the primary postulate of this variant of HFA. Although the consistency of local decisions with the national health policy is assumed here as well, the coordinating mechanism is no longer identified with the competently working management but with the efficient system of political negotiations.

INSTEAD OF CONCLUSIONS

General conclusion of our paper looks trivial: actually, the process of attributing responsability for health depends largely on ideological assumptions. We hope it locked less trivial to reveal how gigantic differences can be occur between answers to the problem who and for what is responsible, when these answers result from different versions of health ideologies. The reality proved to be more complicated than it was assumed.

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MORALNE ASPEKTY NIEKTÓRYCH IDEOLOGII ZDROWIA

Jednym z problemów, który wart jest pogłębionej refleksji badaczy rzeczywistości społecznej jest zagadnienie odpowiedzialności za zdrowie. Kwestia ta nabiera tym większego znaczenia, im wyżej plasowane jest zdrowie w hierarchii społecznych wartości. Odpowiedzialność za zdrowie może dotyczyć także tych wszystkich stanów rzeczy – dóbr czy wartości – dla osiągania których zdrowie jest warunkiem koniecznym. Istotną przeszkodą w procesie orzekania odpowiedzialności za zdrowie jest skomplikowanie kształtujących je zależności przyczynowych. Bardzo często słabość empirycznych dowodów nie pozwala na jednoznaczne ustalenie przyczyn i skutków.

Autorzy formułują tezę, że dla sądów o odpowiedzialności za zdrowie fundamentalne znaczenie ma wyraźne odniesienie się do określonych ideologii zdrowotnych. Te kognitywno-normatywne konstrukty nie tylko pozwalają zinterpretować niejednoznaczne zależności empiryczne, ale wskazują także główne podmioty odpowiedzialności za zdrowie: rządy, społeczeństwa i profesjonalistów.