SOCIETY AND HEALTH:

Some health related societal trends in industrialized countries.

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Introduction: on the quality of death.

The task of the medical profession has been seen as that of preventing and curing disease, thereby saving and prolonging life. The focus has been life-oriented, the method has been to seek and destroy the source of disease wherever it can be found, inside and outside the human body. There is no argument with this approach, except that it could perhaps gain in perspective through a more conscious focus also on death, by not only asking the question how we want to live, but also how we want to die. Since life and death are inextricably related this would lead us closer to a model of the ideal human life, or rather in plural, models of ideal human lives, that might serve as a guide for a profession that in many senses is a troubled one. The achievements in prolonging the quantity of life, the number of years lived, have been astounding, impressive; the achievements in improving the quality of life not only in the sense of absence of morbidity, but as the famous "sense of wellbeing"(1) perhaps less so. If what is prolonged is the phase of senility mentally speaking and not a healthy body but a highly medicated, partly artificial body somatically speaking (of course these two categories are heavily intertwined), then how much is gained?(2)

One should not claim to know how people want to die, this in itself should be a subject of serious research and no doubt it is heavily culture dependent and dependent on one's position in the social structure.(3) But three points might at least be suggested as hypotheses:

1. people do not want a long and painful death, a burden not only to themselves, but also to family and friends. From this it does not follow that everybody wants a sudden death, through natural and social accidents, or simply to cross the borderline
between life and death while in their sleep. People might also want a phase of consciousness of leaving this life, both in themselves and in their nearest ones, in order to fulfill social and religious obligations.

(2) a sense of completion; a sense that life has come to its end, that death is not only the biological next step, but also the logical next step. In other words, the acceptability of death depends on the acceptability of one's life cycle. For all kinds of somatic and mental reasons life may perhaps be seen as a curve, rising through childhood and adolescence, flattening out throughout maturity, going down through old age into senility. One ends as one starts, in the care of the nearest ones - the preceding generation to start with, the succeeding generation at the end.

(3) a death from no particular cause. The moment one particular illness stands out as the cause of death, death looks so much more preventable, avoidable. It is like a car coming to the end: as long as only one part is malfunctioning one may try to replace it; if many parts start functioning badly at the same time the car may be given up - it is "worn out". The human body analogy would probably be to die from "old age", which may or may not be analysable as a set of interrelated, simultaneous diseases - possibly as something more fundamental of which today we know very little (if we knew more we might hold the key to a second approach to the prolongation of life, perhaps not only quantitatively but also qualitatively, by knowing what aging is).

Thus, it is assumed that there is a structure and a process to all of this, but how culture-dependent it is would in itself be an important subject of study. In belligerent cultures the distinction was made between the inferior death in bed and the superior death in the battlefield, possibly not only because the latter was more heroic, but also because it was quicker, less painful. There might
be cultures that would emphasize full consciousness in the process of dying, not simply withering away. But in any case, it is assumed, will there be some kind of ideal curve, consciously or less consciously expressed in the culture, and deviations from this ideal curve would be experienced as painful by the dying and the bereaved.

2. The great morbidity/mortality transition.

It is in this perspective the current transition in the morbidity picture and thereby also in the mortality picture should be seen. The transition is at least as dramatic as the accompanying demographic transition, although it may not yet have achieved its expression in terms of recognisable phases. The roughest description might be simply to say that we have been undergoing, in the industrialized countries (and in the "developed" nuclei in the non-industrialized countries), a transition from nature-generated diseases to society-generated diseases, to the so-called civilization diseases. When the president of Singapore with pride announces that in his country more people are now dying from cardio-vascular diseases than from malaria, he is certainly giving expression to an indicator heavily correlated with what has been known as "development" until recently. But has it led to a higher quality of death? How do we, in fact, die?

The health aspect of development has consisted in a systematic struggle to liberate us from nature-generated diseases, highly compatible with the general Western oriented developmental exercise which consists precisely in making us less nature-dependent, more masters of nature. Nature, from the point of view of health, is seen as neither enemy nor friend but as ambivalent and dangerous in at least two regards: there are the hazards of nature (earthquakes, tsunamis, blizzards, heat waves, floods and drought, etc.) and there are communicable diseases. To what extent these are really nature-generated and not also to some extent calamities that man has brought upon himself through his inconsiderate ways of relating to nature we perhaps do not fully know today. But it seems relatively clear that the major causes of death in industrialized societies today, cardio-vascular diseases (around 50%), malignant tumors (20%) have an etiology that no doubt is related to a
family of causes, but in that family two factors seem to stand out: "pollution" and "stress". The pollution one is talking about in this connection seems at least to a large extent to be made up of synthetic organic compounds, such as PVC (not discounting the importance of lead, manganese, sulphur dioxide, etc.) perhaps giving some reason to rethink the arguments made by those who attacked Wöhler when he made his famous synthesis of urine acid (1828): this was a way of tampering with the matters of life and death that belonged to God. And the "stress" that comes to the foreground in this connection definitely has to do with the way of life in advanced industrial societies, however one wants to analyse it.

Pollution and stress together are labels for the contact points between the human body/mind/spirit and the social formation characterized as developed/advanced/industrialized/high income. Analysis will of course not stop at that point but go deeper into the nature of that social formation, for instance pointing out how the structure invariably is vertical: exploitative, conditioning, marginalizing, fragmenting, segmenting. When so many people nevertheless survive it is certainly not only due to medical services, but also because the society still has a reserve structure, a circle of family and friends serving as a protective cocoon around the individual. This structure is not necessarily horizontal but it is at least smaller and more intimate, more integrative. If the big vertical structure is referred to as the "alpha structure" and the other one as the "beta structure" then the alpha structure is used for production and the beta structure for reproduction; not only in the sense of giving birth to new generations who can be fed into the alpha production structure, but also in the sense of putting together the fragmented and segmented pieces so that they can reappear next morning — at least apparently in a relatively good shape. It is when this beta structure also starts crumbling, at the same time as the alpha structure penetrates more and more deeply into all spheres of human life (economists might use the expression "formal sector" versus "informal sector" for the terms alpha vs. beta), that it really starts becoming dangerous,
perhaps first showing up in the field of mental disorder and cardio-vascular diseases if we assume that they are more stress-dependent. But pollution, and not only pollution in the air and in the water, but also of the diet, through all the processing that makes food less and less natural, more and more "chemical" and seemingly more and more dangerous to health, probably has more of a "bite" if the protective devices of the body have been reduced through "stress" and vice versa. Needless to say, body, mind and spirit; cardio-vascular diseases, tumors and mental disorders; pollution and stress and the underlying social structures and patterns of production and consumption all come together in one great and highly interrelated nexus with causes and effects running in all directions at the same time. The labels we have introduced are for convenience only, and probably often inconveniently convenient in making us blind to more holistic approaches.

Having said this it also belongs to the picture to criticise the category "society-generated diseases" from the other side and look at the nature-generated aspects of these diseases. If one assumes that nature and society stand in a dialectic and not a dichotomous classificatory relationship to each other then this way of thinking comes naturally. As at the corresponding point above we shall assume that we stand only outside the building of this type of integrated knowledge, merely peeping in through some small openings under the door, on the side of the windows.

3. Some consequences for the medical profession.

The general perspective taken here has a number of consequences that will now be attempted spelt out.

For one thing, the medical profession in general and the health establishment in particular should not be surprised if the population does not show such clear signs of gratitude at the prolongation of life achievement as one might have expected. There are at least two reasons for this. First, the society-generated diseases may hit later in life (although the trends for
cancer in younger people, including adolescents, even children in recent years seem to be disturbing, possibly because some of the cancers have shorter gestation periods) but that does not mean that they constitute acceptable deaths, and, even less, acceptable lives. They in no sense tally well with the conditions stipulated above. People do not die like Abraham from old age, old and satisfied from "his days". Or like the German philosopher Immanuel Kant, whose last words when he expired in Königsberg, February 12, 1804 were "Es ist gut" (it is good).

But second, and that is perhaps more serious: the medical profession is increasingly seen not only as incapable of identifying the cause of the "civilization" diseases, but also as themselves being more a part of the problem than a part of the solution - to use an old American expression. For one thing, the fight, real struggle, against pollutants, against excessive conditions of stress and against barbarous practices in hospitals in general and mental hospitals in particular seems often to have been fought by patients and the public at large rather than by members of the medical profession in general and the health establishment in particular.

On the contrary, it has often looked as if a sluggish health establishment has to be stirred into action, often by dramatic forms of confrontation, and is not easily moved by its own inner debate and dynamism. Rather, it may look to many as if the medical profession still is trying to see diseases, predominantly society-generated, in the old terms as being predominantly nature-generated, by keeping alive the hunt for a virus in order to find something that one can ultimately seek and destroy, even eradicate (except for some specimens that will have to be kept alive for future generations to study and compare with new types of disease vectors). And then, to top it all: the way the whole system of preventive and curative medicine is organized is in itself a part of society's alpha structure, as vertical, conditioning, marginalizing, fragmenting, and segmenting as anything else, thereby placing the medical profession as a part of the problem...
rather than the solution. In the field of the mental hospital as an approach to mental disorder this theme has received its now classical formulation in the movie "One Flew over the Cuckoo's Nest."

One factor that enters into this complex is the way in which the medical profession is trained. The standard formula calls for a solid basis in physics and chemistry at the very beginning of the study, and the extensive training in anatomy and physiology and pathology of course opens for all the life sciences. Thus, the medical man is essentially a natural scientist, professionally trained to see disease, its prevention and its cure in natural science terms. It belongs to his déformation professionelle that he usually receives very little training in the social sciences, and the net balance of this would tend to make him more prone to see disease as nature-generated than as society-generated. People who argue, and often over-argue, the society-generated perspective will be likely to draw a blank when confronted with the medical profession; they will simply refuse to answer or even to listen; in many cases because they refuse to understand. The failure of communication in this regard will be more and more serious as our social formations continue on the road they have been travelling so far, making human beings less and less nature-dependent and more and more society-dependent. This will lead to cleavages not only between the medical profession and the population at large, but also within the medical profession as the younger generation of physicians increasingly will pick up the loose social ends and try to weave them together in a more holistic picture of the various health-disease-health-disease careers offered to the population (including to physicians themselves).

It is unpleasant to see oneself the way others may tend increasingly to see one: as a part of the problem rather than as a part of the solution one is supposed to bring about, a factor underlying the deeply emotional over and undertones debates in this field tend to have, and increasingly so. There is little to indicate that it will become more pleasant in the near future, a factor that may make the medical profession less popular and prestigious, more beleaguered.
4. From the dictatorship of the profession to dialogue with the population.

There is another aspect to this which has to do with the way in which the medical profession has gone about preventive medicine as long as diseases are seen as nature-generated. About earthquakes and tsunamis, floods and droughts there was not so much to be done—although it might perhaps be added that the medical profession, belonging to the upper strata of any society, would have a tendency to live far away from the danger zones themselves. But about infectious diseases there was something to be done: sanitation, hygienic practices to slow down or stop contagion, inoculation, etc., to strengthen the defences of the human body. Much of this could be done by individuals themselves when properly motivated or ordered: they could wash their bodies in general and hands in particular, be responsive to calls for X-rays and inoculation, clean up sewers, swamps. Information about this, both in the sense of knowledge and in the sense of moralizing commandments, could be disseminated from above and internalized below, for instance in school curricula. People above had the knowledge, people below had the need for knowledge—there was a perfect fit between the knowledge structure and the social structure in general. The eleventh commandment, "Thou shalt wash your hands" would with no difficulty fit into a literate, religiously inclined community (additionally Hindus and Moslems have probably adhered much more to this commandment than Christians).

But not so with society-generated diseases. For one thing the medical profession itself is ambiguous, uncertain, and partly ignorant when it comes to etiological aspects. There is no obvious knowledge gap between them and the population at large. They evidently know much more about the care, but not about the prevention. As a consequence the setting should be almost ideal for a triangular dialogue physician/patient/people at large, not giving 100% weight to the opinions of the former and 0% to the other two as the situation almost has been under the "dictatorship of the professionals". A dialogue is between equals. Everybody makes an input and gets out of the dialogue stimulation, enrichment, added insight which then may or may not be pulled together into collectively
shared insight. A dialogue should of course not be confused with the caricature of a dialogue written up by Plato and put in the mouth of Socrates. This is clearly seen if instead of reading all the wisdom that comes out of the mouth of Socrates one reads that which is put in the mouth of the poor partner to the "dialogue": "Yes, Socrates, you are right, Socrates, now I see it fully, Socrates, what a fool I have been". A "dialogue" of that kind is only a clever, even tricky way of carrying out education in the old way, as brainfilling from above.\(^{(16)}\) Yet this has been the professional model.

One might now argue that there is a contradiction in the two points just made: that medical man knows too little about society and that there should be a dialogue on these issues. What will happen when medical man starts knowing more about society, will he not make use of that knowledge and convert it into a broader basis for the dictatorship of the professional? This may be true, but in that case he will have to compete with quite a lot of other specialists in social matters, particularly among them those social specialists (the social scientists and people in general!) who take the trouble of trying to learn some of the more conventional health matters. In a sense this should be easy if anyone in the population made better use of the fact that all of us sooner or later will hit the health establishment, when we are socially defined as "patients"\(^{(17)}\). More willingness to teach on the part of the physician and more willingness to learn on the part of the patient, making use of such opportunities, would make for a much more informed public - but sometimes the public gets the impression that medical man prefers to keep the knowledge for himself so as to retain monopolistic control over the execution of his profession. However this may be, it may be true that we are right now entering a phase where openness is not only necessary but even possible before a new medical professionalism gains the upper hand again. The phase should be made use of as effectively as possible, making for a multiplicity of dialogues about health problems enriching all parties concerned.
5. The green wave of health self-reliance.

But the public is not likely to be satisfied with this. On the contrary, large segments of the public will probably draw the conclusion that the best they can do is to exercise their own preventive and curative medicine. A major portion of the alternative ways of life movement can be seen in this light: it can be seen as acts of self-defence, as efforts to build structures less dominated by "processing" and "stress". We know these elements very well from the green wave of politics and development: the fight against pollution, the fight for the right to live in a more natural environment and enjoy more natural foodstuff; the fight against alienating structures, in favour of more integrative, more communal styles of living. The alternative ways of life movements in general, it seems, have picked up exactly the key points, and maybe much before it really dawned upon the medical profession as such that these could be essential in understanding the "civilization diseases". This green pole of development is clearly posited against the red and the blue poles of development in the health field: public health in general and the ministries of health in particular; the corporations in the health field, pharmaceuticals, the manufacturers of hospital equipment, surgical instruments and so on.

This is important because the struggle inside the red/blue/green triangle is a general theme in industrialized societies, and can be found in all fields of production, in education, arts and sciences, communication and transportation and so on. There is a public, formal sector way of doing things, a private, formal sector way of doing things and an informal sector way of doing things, the latter under the "small is beautiful" banner. This trend only partly originated in the field of health. Actually, it may even be meaningless to ask the question where it originated as everybody will tend to say that it started in the field of his/her particular competence and interest. It is more correct to see it as a general wave expressing a certain logic of how to do things in social life,
a certain way of life in general. As such it received its expression in the sector of health, and among its many expressions medical man is most likely to pick up the environmental aspect. Why? Partly because his training in natural sciences makes it fit more easily into his areas of competence. And partly because the type of action often envisaged, environmental control by strengthening the public sector control over the private sector is entirely compatible with the setting in which public health itself is operating. And in the most important field so far, that of smoking, it is even compatible with the old pattern of knowledge dissemination combined with moralism leading to the twelfth commandment, "Thou shalt not smoke". In this field individual acts of volition, in this case restraint, even abstinence, can be seen as health productive.

The green wave, however, would certainly not be satisfied with that. The green wave wants to hit at the aspects of our society that generates such phenomena, among them certainly also the tobacco manufacturers. But that would be only one example among many: the green wave in general would like to build down the "big is ugly" aspects of society, decentralizing the public sector by giving more power to local administrative units, decommercializing the private sector through partial demonetization of the economy, giving much more weight to the informal sector, and detechnification and deprofessionalization of health and various fields of social life in general. The medical profession as it has shaped up in general, and the health establishment in particular, are not in for a very pleasant future if and when the green wave becomes more predominant. Some members of the profession will see this ahead of the others and join the green wave and not only because of ideological sympathy, maybe also for their own mental health in the years to come.


The question then is how these years to come are going to be in the industrialized countries. Of that we know little, but only the intellectual coward would refrain from trying to make use of the little knowledge we have in making some projections. The methodology
behind such projections would certainly not be founded on time series with hard data. Rather, the methodological foundation would be configurations of rather soft data, an indication here and an indicator there, that when interpreted holistically seem to point in certain directions rather than others. This approach, incidentally, is more an expression of "green epistemology" than of its red and blue counterparts. And that is actually at the root of some of the socio-political issues in today's industrialized societies: many people, particularly young and the young in spirit, sense things intuitively where the directors and managers in the red and blue poles of society, the ministries and the corporations, feel unmotivated or incapable of moving into action unless they have the hard data time series to underpin their decisions (and to defend themselves against criticism if proven wrong).

The green wave is based on a multitude of small local level groups that do not have to move in the same way at the same time. If they make a mistake based on their intuition the consequences are theirs, mainly to be suffered locally. If the ministry or the corporation makes mistakes they may be for the whole population or for groups distributed all over the country as the corporations have learnt to realize when the consequences of insufficiently tested, prematurely and brutally marketed drugs become evident. Incidentally, again it looks as if it is the victims, ordinary people often helped by some marginally placed medical men, no doubt many of them with a class background that increases their sensitivity, who have been fighting this uphill battle against extremely powerful corporations in many countries rather than medical professionals as such and the health establishment in particular. Consequently, ministries and corporations will feel this need for a hard data basis, but they may also be professionally detrained in knowing how hard data and soft data can be combined into an even better basis for action. And they may use the call for hard data as a pretext to postpone decision and action because it takes time before a deteriorating situation produces sufficiently hard data.

The most likely trends as far as one can see right now for the industrialized countries would be different for three regions: for the Northwest, the Southwest and the East — meaning the
countries. In the less rich Southwest (in which we would also classify Yugoslavia, Greece and Turkey) the delight in trying to catch up with the industrially more developed Northwest (particularly in the European NIC's, newly industrializing countries) seems to be at such a high level that it will nurture the red and blue poles of development, but not the green. In the East, the socialist countries, some of them much more industrialized than the mediterranean countries, including the North African countries - there might be an objective basis for much more criticism of the red/blue combination known as state capitalism (and not that different from what is found in social democratically governed countries in Northwestern Europe, incidentally). But the lack of freedom of expression, if not in words at least certainly in action, will make the green wave inward-looking, skimpy, insignificant still for some time to come.

Western Europe and North America.

Hence, it is in the Northwestern corner of the industrialized region of the world, North America and Northwest Europe, that the contradiction between the red/blue pole of development on the one hand and the green wave on the other will be most pronounced. The best prediction right now will probably be that they all will continue to grow for some time, but that the corporate sector will suffer some decline as unemployment becomes more rampant, partly due to more automated production (the micro-processors), partly due to decreasing markets as the Southeastern corner of the world (the Japan-China-Southeast Asia triangle) gains more and more influence in the international economy. The red pole will have to try to clean up when corporations enter into bankruptcy, putting severe strains on already strained public budgets in terms of unemployment insurance, guarantees and loans to threatened industries and to new industries in outlying districts, etc. As a consequence, the green wave is likely to progress further, partly capitalizing on the failures of the other two, partly generating its own momentum. But it will also be fiercely counteracted by a possible brown, more fascist wave clinging to the status quo.
If one should derive some health implications from this type of projection it might be as follows: the projection would be relatively optimistic for the Northwestern part of the region: partly because the population would protect itself increasingly against some of the sources of the "civilization diseases", and partly because so large portions of the population would be engaged in productive conflict that in itself seems to produce, and certainly not reduce, mental health. It may also be that these countries - due to their traditional freedom of expression - would be in a position to engage in fruitful dialogues. The perspectives for the other two parts of the region would be less optimistic: the conventional developmental process would continue increasing the tolls on the population in terms of partly painful - increasingly seen as meaningless - deaths at the same time as the medical profession would become more deeply entrenched, increasingly hostile to alternative approaches.

Eastern and Southern Europe.

Given the flow of communication within the region, and the general tendency for the East to imitate the West and the South to imitate the North after the point of gravity became located in the Northwest (when the industrial revolution converted mercantile capitalism into industrial capitalism), there might be a tendency towards a "green-from-above-movement" in the South and the East. The social logic would be something like this: the health establishments in the Northwest will learn from the green wave, they will coopt some of the best ideas, and occasionally some people, and try to build them into red and blue structures (more decentralized public health, more emphasis on the primary physician and less on the secondary physician, commercialization of herbs and all kinds of "natural" medicine as the pharmaceuticals pick up the tricks). The health establishment will do this partly because they start believing it, partly as a survival strategy preempting further green advances, and partly in order to control such approaches. In the longer run this may deprive the green health wave of some of its momentum.
Health establishments in the East and in the South will be less interested in this and more interested in what their opposite numbers in the Northwest do, possibly copying without having any popular or grassroots basis for such actions, no inner dialectic changing the structure of the health sector. Consequently, the results will probably not be too impressive but like so many other things in societies with an authoritarian bent become a part of the pressure from above. Thus, there is a lot of difference between an anti-smoking campaign that has come out of popular movements, picked up, strengthened and developed much further by the health establishment and then given a chance to rebounce on the public, and an anti-smoking campaign launched from above on a largely unmotivated public.

The Third World: some remarks.

It goes without saying that all of this will be watched carefully by countries in the Third World. But in most of these countries the problems highest on the health services agenda will be:

-- institution-building in the medical sector (in all countries)
-- equalizing access to the institution (in some countries)

Of course, these are concerns that will continue also to be important in the high income countries. There are still regional differences among and within countries, between classes and other groups (such as the sexes). Moreover, is it obvious that we shall tolerate age-specific morbidity/mortality differentials but less so the sex-specific differences, and even less so the class-specific differentials? Egalitarian ideology will stimulate the "equalizing access" approach. Some countries will be deeply concerned with this - socialist, social democratic regimes particularly, others will at least have to pay lip-service to it. They will start with regional and sex differences, then attach class differentials, and one day they may even ask why there should be such a difference among age groups.(31)

However that may be the entire approach will lead to rising medical establishments as only they can operate on a country-wide scale (and even inter-governmentally). They will tend to scoff at self-care, mutual care, community participation and restructuring of the societies in general and the medical sector in particular as the cheap way out, a way of depriving people of harder (capital -- and research - intensive) health resources and the medical establishment of prestige, power and privilege. In short, a projection on the field of medical services of the general hard vs. soft technology problématique.(32)
It is not obvious that the bridge-building function of more recourse to traditional medicine in the less industrialized countries will work to even out the contradictions between these two seemingly divergent trends. Just to mention one important aspect: the attitude to death. Western individualism and idea of progress have combined into the intense conviction that important things will and must happen in my lifetime, if not with me as the cause, at least with me witnessing (and enjoying since it will have to be progress) the effects. Imagine this attitude moves into the non-industrial countries, and the pressure on the society to deliver longer lives, more quantity of health, will go up. Western medicine will be seen as doing this among other reasons because it works so quickly. Imagine at the same time that this attitude becomes less prominent in the industrialized countries, that death is seen less as an enemy never to be talked about and more as a phase in a broader concept of life. In that case there may be more pressure on the society to deliver less quantity and more quality of life - or both if there is not a trade-off to be taken into consideration here. The point being made here is actually only one: so much depends on the basic orientation of the societies in question, the cosmologies. And about them it is difficult to make predictions beyond what has just been said: that we are probably in for some kind of cosmology exchange which will leave its deep imprint also on the relation between society and health - and not only in the industrialized countries.

7. Conclusion: on the quality of life.

This article started with some reflections on the quality of death leading, implicitly, to a conclusion: could it be that there has not been that much medical progress this last century? We live longer, but as to how we die, maybe we have gone from the ashes into the fire? Looking at the three criteria hypothesized for a preferable death - not long and painful, compatible with a sense of completion, from no particular cause - comparing this with incidence of cancer, the gestation period for cancer, the rates of growth of morbidity and mortality from cancers: are we really making progress? The blame for this is not to be put at the feet of the medical profession, exposed to considerable criticism already, but applies to the pattern of social development as a whole. And if we project a little into the future it does not look much better, not only because of the
rates of growth for the "civilization diseases" but because of the increasing costs in curing them, to be born by economies under considerable pressure. If the middle-aged continue to run the society, is it to be expected that they will set aside sufficient funds to alleviate the pains of the old and prolong their lives further when work already is structured in such a way that they no longer can make a contribution because they are (pre) pensioned off, and therefore increasingly will be seen as "burdens" on society? Is it not more likely that the middle-aged will try to channel medical resources in the direction of themselves and their children? And what will all of this do to the social relations among the age groups in society, already highly problematic as they are? In this connection it should also be born in mind how much weaker old people are than, for instance, university-educated middle-aged women who have been the leaders of the feminist movement, and even they have a difficult struggle against the middle-aged male establishment.

**Conclusion:** the quality of life has the quality of death as an extremely important component and it is only by putting the burden of death on the old alone that we try to escape from that conclusion. Somehow this should influence the way medical policies are formulated and give to that profession a broader normative basis than extended quantity of life alone. And it should also be an important consideration in how we construct our societies - do we try to improve quality of life at the expense of the old and their quality of death, or can we try aim for the quality of the total life-cycle.
NOTES

* Originally presented at the first meeting of the WHO Regional Health Development Advisory Council, Copenhagen 17-18 March 1966, and as a paper for the "Policies, Processes and Indicators of Development" Project of the United Nations University, Al-Faraz del Di April 1966. See the report from the Copenhagen meeting from the WHO Regional Office for Europe, W/H/200/6.

1 From the WHO definition of health, which is non-society-centered, "well-being." On the other hand, there is also a "health society-centered approach," from resolution 20.43 of the World Health Assembly, the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Such formulations may be seen more as "principles," as instrumental to social and economic ends - defined by society.

2 The exception is one that coincides with the breakdown of the extended family, the older era of the nuclear family, as a social unit - the only one that can be described as the increasing incidence of prolonged and painful deaths from malnutrition. In the circumstances into which our youth are entering a major problem for young people, already troubled by arthritis, bronchitis, etc., is this a subject for the dialogue between the UN, on visions of the society and its lives?

3 Thus, in many African cultures what matters is whether the extension of health appears to be a new male aspiration; in the absence of any "life-span without a son and a child," the "life-span without a son" would be favored. Yet this does not tally well with individual-centered western medical practices except in its fight against infertility.

4 Main in the excellent US publication, Healthy People: The United States General's Report on Health Promotion and Disease Prevention for 1970, a fairly typical image of the transition can be obtained:

Death for Selected Causes as a Percent of All Deaths: 1960-77

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent of All Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>4.0%</td>
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Here the transition is summarized as follows: "If mortality rates for certain diseases are added today to the rate at the turn of the century, almost 600,000 Americans would lose their lives this year to arteriosclerosis, 3.0 million to asthma, 800,000 to arthritis, and 55,000 to diabetes. Indeed if the toll of all four diseases will be less than 100,000 lives" (8). While this should be compared with the following: "In 1970, 75 percent of all deaths in this country are due to degenerative diseases such as heart disease, stroke and cancer. Accidents rank as the most frequent cause of death from one to nine until the early 1970s" (9).

The article "The British War of Death," New Scientist, 30 August 1970, pp. 455-457, gives a very similar picture: "The death in the 50 million population of 62,000 a year from vascular diseases amounts to 28,000 (heart attack) for 11,000 and stroke for 8,000); respiratory diseases for 75,000 (but for 10,000 more in bed outside rooms), cancers for 90,000 (lung, cancers for 33,000) and "other diseases" for 80,000. This should be compared to the "Third World picture": the prevalence of disease here depicted as back pain, 700 million; tuberculosis 400 million; malnutrition 200 million; illiteracy 200 million and malaria 150 million. The three diseases are compared to the "British picture" that tells up the medical future of the Third World countries if no other health development can be found."
6. Actually, it might be better to conceive of three types, adding person-generated diseases. I am thinking of processes such as "aging" that cannot be said to be nature-generated or society-generated but rather can be seen as processes belonging to the person system sui generis. There may also be mental and spiritual processes of which we know little that may sooner or later show up as mental disorders, or as "sanity" without any clear organic base. To try to attribute all of this to either "nature" or "nurture" outside the person is in line with the type of reductionism prevalent in modern science, but perhaps time has come to have a more open mind on such issues? Let it only be added that by "nature" we mean the physical environment, both man-made and not; and by "society" we mean all levels of social organization: micro (primary group), meso (secondary groups), macro (or the country), regional and global. All these structures impinge on the individual one way or the other and interact with nature in producing health-disease-illness-careers. It is only that I would prefer not to see the "person", a body with a mind and a spirit, as an empty billiard ball tossed around by these forces, but as capable of producing its own diseases and, consequently, its own health through anti-bodies and will-power to generate health (I am grateful to Carlos Mallmann for this emphasis on the person as such). However, regardless of how one sees this kind distinctions should be regarded as analytical rather than empirical in the sense of clearly separating diseases from each other. Rather, one should think in terms of diseases"predominantly nature-generated", "predominantly society-generated", etc. Thus, infectious diseases are very closely linked to patterns of human social ecology, malnutrition not only stress-related, etc. (I am grateful to Assen Jakobovski for emphasizing this point).
As for footnote 5 above about the transition, also see all the data on this fascinating industrial development later. Janowicz and his friends, in one of the best books of the genre, "Słownik frałceskii" (Warsaw, 1962), significant from the "society of man".


"The vitalistic" - maintained that natural materials formed by organisms could never be synthesized by artificial means - the first laboratory synthesis of an organic compound, e.g., by Friedlieb Fries in 1828, was due to the vitalist. In 1841, one of the major figures in the field of this subject, a Russian, T. M. Y. C. A. (1810-1887), recorded in the Annals of the \[\text{year}\] that one year can be made, but it is a total indulgence of an opinion that they have not been able to develop a new theory of which grounds are (and by implications which ones are not) deprivation to human life.

10. Japan seems to be relatively unique among industrialized countries in conflict, so far, this new hierarchical a mixture with all-constructive power not so much in the family as among scientists and colleagues.


13. The authors of this book have certain natural ingredients not giving natural diet the proper chance to prevent and cure, another that the chemical additives (to give color, to preserve, etc.) may have a toxic effect. Which is the more important would vary from product to product (I am grateful to Dag Galleszinski for emphasizing this point). The two factors work independently of each other in the sense that natural fibres or inhibitors in general may be intact yet there are additives, and vice versa - pointing to the significance of having both aspects in mind in the work for better diets. It is here that one can be some real breakthroughs in the understanding of the interactions between mental/spiritual and sensory factors - or is even that categorization one of the reasons why we seem to be so slow at coming to grips with these phenomena?

14. In Norway, for instance, this is now the second cause of death among children (after accidents) according to the campaign called to collect money for the fight against cancer (in one of the world's richest countries, capable of more than 30 increases in military expenditure, the only NATO country to follow the US in this, one should believe that this would not be left to personal charity - moreover the fight against cancer is probably more a question of chance of lifestyle than availability of money). According to the Sun for General report (see footnote 6 above) some hands for the US: accidents No. 1, then cancer, then birth defects (No. 3).
15. Today, conditions at a mental hospital in Norway were brought to the attention of the public in general when a psychiatrist clinic demanded of the inmates during the same time that he was married, the authorities noted, but the system had been shaken in its moral foundation.

16. A problem is to find a setting, for this type of dialogue.

17. The best definition of this is essentially given in the famous chapter on the social sector, by Talbot Barana (Science, 1966 crop, 1967).

18. One example of this in the book referred to is indicated above.

19. While workers in the economy are commonly used in the debate about development in Nordic countries. They could be seen as a representative, and as a common denominator. The common labor market of the Nordic countries, there is a sense in which one can be "ideal" without necessarily being "real" or "organized", following in ministries.

20. "By informal" economy meant three different things.

21. See the excellent article on "ideal health" prepared for the world health day, 7 march, 1965, with the editorial by Charles Seaton.

22. Very little can be said about the future on the basis of hard facts except if one believes that the same variables will be relevant and the stone of the trends are going to be predictable on the basis of the experience of the curve already known — but these are usually more
33. And it is clear that many of these elites in Third World countries will tend to import hard technology to make the country "modern" and then try to monopolize the use of this technology inside the country. As hard technology is related to civilization diseases, particularly cancers and cardiovascular diseases, this monopoly makes sense for the elites as they are the most likely to suffer from such diseases; partly because they have benefited disproportionately from health-improvement schemes in the fight against nature-operated diseases, partly because they are the most exposed to the society-operated diseases of the new times.

34. A personal experience: being exposed to a viral disease in Malaysia I had the option between Chinese traditional herbs and Western chemistry. The Chinese herbs might have worked after some time, but my Western practitioner made me take the chemist of the last. The fever disappeared, probably with side effects - but the process was a quick one!


36. As an example for the excellent articles in connection, see 26-36/1980, "The World of Science"