SOCIETY AND HEALTH*:

Some health related societal trends in
industrialized countries.

by Johan Galtung

Goals, Processes and Indicators of
Development, UN University Project,
Institut universitaire d'études du
développement, Geneva

1. <u>Introduction: on the quality of death.</u>

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, <u>models</u> of ideal human <u>lives</u>, 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" perhaps less so.[1] If what is prolongued 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) <u>people do not want a long and painful death</u>, 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 them-
selves and in their nearest ones, in order to fulfill social
and religious obligations.

(2) <u>a sense of completion</u>; 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 seni-
lity. 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) <u>a death from no particular cause</u>. The moment one particular
illness stands out as <u>the</u> 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 quantita-
tively 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.[4] 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.[5] The roughest description
might be simply to say that we have been undergoing,in the industria-
lized countries (and in the "developed" nuclei in the non-industrialized
countries),a transition from nature-generated diseases to society-
generated diseases,[6] 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[6] 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 dis-
eases, highly compatible with the general Western oriented develop-
mental 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 industria-
lized societies today,[7] cardio-vascular diseases (around 50%), malig-
nant 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.[8] 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.[9] 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.[10] 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.[11] 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,[12] 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"[13] - 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 intro-
duced 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-gene-
rated diseases may hit later in life (although the trends for

cancer in younger people, including adolescents, even children [14] 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 sserious: 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 hospi-
tals in particular seems   often   to have been fought by patients
and the public at large rather than by members of the medical pro-
fession in general and the health establishment in particular.
On the contrary, it has often looked as if a sluggish health esta-
blishment has to be stirred into action, often by dramatic forms of
confrontation, and is not easily moved by its own inner debate and
dynamism. [15] 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 professionnelle that he usually
receives very little training in the social sciences, and the net
balance of this would tend tp 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 under-
lying 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 evi-
dently know much more about the cure, 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 professio-
nals". 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, Socra-
tes, 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 con-
trol 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 pro-
fessionalism 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. <u>The green wave of health self-reliance</u>.

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 alterna-
tive ways of life movement can be seen in this light:[18] 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 <u>green</u> 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 move-
ments 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 "civili-
zation diseases". This <u>green</u> pole of development is clearly posited
against the <u>red</u> and the <u>blue</u> poles of development[19] 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[20]
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 twelvth commandment, "Thou shalt not smoke".[21] 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.

6. On the social future of industrialized countries: some processes.

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.[22] 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.[23] This approach, inci-
dentally, is more an expression of "green epistemology" than of
its red and blue counterparts.[24] 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 in-
sufficiently 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 power-
ful 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 (parti-
cularly 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.[25] In the East, the
socialist countries[26] - some of them much more industrialized
than the mediterranean countries, including the North African coun-
tries - there might be an objective basis for much more criti-
cism 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, insig-
nificant still for some time to come.

Western Europe and North America.

Hence, it is in the Northwestern corner of the industria-
lized 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 in-
fluence in the international economy.[27] 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.[28]

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.[29] 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 develop-
mental 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 comm~~unication 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 [30] (when the industrial revolution converted mercantile capi-
talism into industrial capitalism), there might be a tendency to-
wards a "green-from-above-movement" in the South and the East.
The social logic would be something like this: the health establish-
ments 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 oppo-
site numbers in the Northwest do, possibly copying without
having any popular or grassroot 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.[31]

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 "equaliz-
ing 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.[32]

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 establish-
ment of prestige, power and privilege. In short, a projection on the field
of medical services of the general hard vs. soft technology problématique.[33]

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. (34) 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 (35) 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, (36) 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 resourses 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 pro-
fession 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.

N O T E S

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Health Development Advisory Council, Copenhagen 17-18 March 1980,
and as a paper for the Goals, Processes and Indicators of Develop-
ment Project of the United Nations University, Alfaz del Pi
April 1980. See the report from the Copenhagen meeting from the
WHO Regional Office for Europe, EUR/RC30/8.

1   From the WHO definition of health, which is person-centered,
"well-being". On the other hand, there is also a WHO society-cen-
tered approach, from resolution 30.43 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 dangerous
in as much as they see human beings as instrumental to social and
economic ends - defined by whom?

2   The prolongation of old age has coincided with the breakdown of
the extended family, and then even of the nuclear family as a
center of care for the old; or top of that comes the increasing
incidence of prolonged and painful deaths from malignant tumors.
It is as if circumstances have entered a pact against old people,
already tormented by arthritis, bronchitis, etc.

3   This is a subject for the dialogue project of the GPID, on
visions of good societies and good lives.

4   Thus, in many African cultures what matters is not the exten-
sion of one's own life-span as that of the family, by securing a
male offspring. In the choice between a long life-span without a
son and a short life-span with a son the latter would be favored.
Evidently this does not tally well with individual-centered Western
medical practices except in its fight against infertility.

5   Using the excellent US publication, Healthy People: The Sur-
geon General's Report on Health Promotion and Disease Prevention
Washington, 1979, a fairly typical image of the transition can be
obtained:

Death for Selected Causes as a Percent of All Deaths: US 1900-77

                    Figure here

The transition is summarized as follows: "If mortality rates for
certain diseases prevailed today as they did at the turn of the
century, almost 400,000 Americans would lose their lives this year
to tuberculosis, almost 300,000 to gastroenteritis, 80,000 to
diphteria, and 55,000 to poliomyelitis. Instead the toll of all
four diseases will be less than 10,000 lives" (-,3). This should
be compared with the following: "Today, 75 percent of all deaths
in this country are due to degenerative diseases such as heart dis-
ease, stroke and cancer. Accidents rank as the most frequent
cause of death from age one until the early forties" (-,3).
The article "The British Way of Death", New Scientist, 30 August
1979 p. 610-5) gives a very similar picture: of the
deaths in the 50 million population of England and Wales in 1975
vascular diseases accounted for 284,000 (heart attack for 110,000
and stroke for 80,000); respiratory diseases for 75,000 (but for
10,000 more in bad influenza years), cancers for 99,000 (lung
cancers for 33,000) and "other diseases" for 90,000. This should
be compared to the Third world picture: the prevalence of disease
being described as hookworm, 700 million; trachoma 400 million;
schistosomiasis 200 million; filariasis 200 million and malaria
150 million. When these diseases are conquered the US/Britain pic-
ture then tells us the medical future of the Third world countries
if no other health development path can be found.

FIGURE 1-A —11—

DEATHS FOR SELECTED CAUSES AS A PERCENT
OF ALL DEATHS: UNITED STATES,
SELECTED YEARS, 1900-1977

Tuberculosis   Major cardiovascular diseases
Influenza and pneumonia   All other causes
Cancer
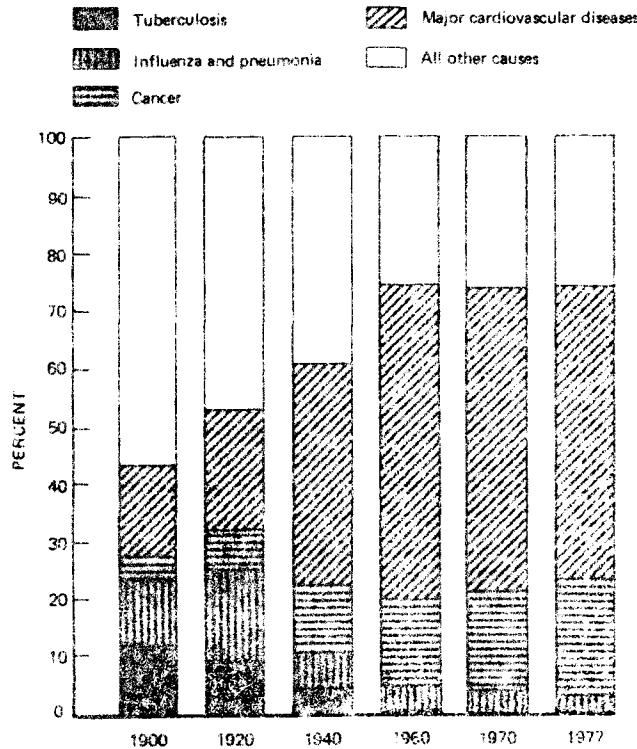
NOTE: 1977 data are provisional; data for all other years are final.

Source: National Center for Health Statistics, Division of Vital Statistics

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, eg as "senility" 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 preval-
ent 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-health-disease
careers. It is only that I would prefer not to see the "person",
a body with a mind and a spirit, xnxmxnxxmxnxxnxxxx as an empty bil-
liard ball tossed around by these forces; but as capable of producing
its own diseases and, consequently, its own health through anti-bo-
dies, and will-power to generate health (I am grateful to Carlos
Mallmann for this emphasis on the person as such). However, re-
gardless of how one sees this such 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, malaria and tuberculosis have
social aspects, hypertension not only stress-related, etc. (I am
grateful to Assen Jablensky for emphasizing this point).

7. See footnote 5 above about the transition. Also see all the data on this from various industrialized countries in John Irvine and Ian Miles, in cooperation with Johan Galtung, Dag Poleszynski and Monica Wemegah, editors, The Poverty of Progress, Pergamon Press, 1981 (a publication from the GPID Project).

8. As it is put in the Encyclopedia Britannica (1980, 2.943), "the vitalists ... maintained that natural products formed by living organisms could never be synthesized by ordinary chemical means. The first laboratory synthesis of an organic compound, urea, by Friedrich Wöhler in 1828, was a blow to the vitalists but not a decisive one. They retreated to new lines of defense, arguing that urea was only an excretory substance — a product of breakdown and not of synthesis". It may not be recognir, the argument of the vitalists that one case can be made, but it is a telling indictment of our sciences that they have not been able to develop a good theory of which compounds are (and by implication which ones are not) detrimental to human life s.

9. This is the typical structure of modern societies, found both inside societies as a way of organizing individuals and groups and between societies as a way of organizing the world. Thus, at the international level the structure of imperialism is made up of such components as explored, for instance, by Johan Galtung in The True Worlds, The Free Press/Macmillan, New York 1980, pp. 113-138.

10. Japan seems to be relatively unique among industrialized countries in combining so far, this very hierarchical structure with a "protective concern" not so much in the family as among workmates and colleagues.

11. See Eleonora Masini, ed. Visiones de sociedades deseables, CEESTEM, Mexico, 1979, chapter i, "Sobre Alpha y Beta y Sus Muchas Combinaciones". English edition Pergamon Press, London 1980 forthcoming. The approach is used in Johan Galtung, "Structure, Culture and Mental Disease", Papers No. 42, Chair in Conflict and Peace Research, University of Oslo.

12. For interesting recent books, see A.R. & A.K. Biswas, Food, Climate and Man, Wiley, New York, 1979 and T.L. Cleave, The Saccharine Disease, Keats Publishing Co., 1975. There are two arguments, one that processing destroys certain natural ingredients not giving natural diets 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 Poleszynski for emphasizing this point). The two factors work independently of each other in the sense that natural fibres or "ingredients" 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.

13. When are there going to be some real breakthroughs in the understanding of the interplay between mental/spiritual and somatic 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 fall 1980 to collect money for the fight against cancer (in one of the world's richest countries, capable of more than 3% 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 change of lifestyle than availability of money). According to the Surgeon General's report (see footnote 5 above) the same holds for the US: accidents no. 1, then cancer, then birth defects (p. 35).

15. Thus, conditions at a mental hospital in Norway were brought to the attention of the public in general when a conscientious objector doing his alternative service at the hospital as a physician helped one of the inmates escape so that the story could be told. It belongs to the picture that he was convicted, the authorities not, but the system had been shaken in its very foundations.

16. A problem is to find a setting for this type of dialogue. It takes place, sometimes, between one physician and the individual patient, but it should be made more public. When patients organize physicians tend to become very defensive and for good reasons as the organization is often directed against them, such as organizations of psychiatric patients in Norway and Denmark — the latter also organizing over six festivals with nothing positive said about the psychiatrists.

17. The best definition of this is probably still in the famous chapter 10 of _The Social System_, by Talcott Parsons (Glencoe, The Free Press, 1951).

18. See analyses of this in the book referred to in footnote 7 above.

19. This scheme of actors is commonly used in the debate about development in Nordic countries. They should be seen as denotative of actors (red for the ministries, blue for the corporations, green for the more local level) rather than of ideologies: obviously there is a sense in which one can be "green" ideologically without necessarily being "red" or organizationally, believing in ministries.

20. By "informal" economy is meant three different things:
— production for own consumption (kitchen garden, handicraft, energy)
— production for exchange, but on a barter basis
— production for exchange against money, but in local economic cycle

The green position is not necessarily that this should be the only economic system found in a society but that it should account for much more of the economy than in the present red-blue dominated formations (in the field of health the red-blue would be the ministry of health-health industry complex).

21. See the excellent issue of _World Health_ prepared for the world health day 7 April 1980 with the editorial by Halfdan Mahler. "Smoking or Health, The choice is yours!" However, it is hard to find in the issue a sustained attack on the tobacco industry in general and its advertising in particular. But it is very much in line with the Surgeon General's Report, p. 10 "simple measures to enhance the prospects of good health":
— elimination of cigarette smoking
— reduction of alcohol misuse
— moderate dietary changes to reduce intake of excess calories, fat, salt and sugar
— periodic screening for — high blood pressure and certain cancers
— adherence to speed laws and use of seat belts
"Use of antihypertensive medication" is also mentioned as a habit to be changed, but "cigarette smoking is the single most important preventable cause of death" (p. 7), and from Britain: — smoking kills perhaps 100,000" (p. 640). All of this, with the exception of the "periodic screening" that perhaps can best be organized on a centralized basis, is very much within the frame of reference of the green movement. Moreover, "half of all mortality in 1976 was due to unhealthy behavior or life-style" (Report, p. 14).

22. Very little can be said about the future on the basis of hard data except if one believes that the same variables will be relevant and the shape of the trends to come to be predictable on the basis of the parts of the curve already known — but these are usually very uncertain assumptions.

33. And it belongs to that problematique that elites in Third World countries will tend to import hard technology to make the country "modern" and then try to monopolize the use of that technology inside the country. As hard medical 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-generated diseases, partly because they are the most exposed to the society-generated diseases of the new types.

34. A personal experience: being exposed to a tough 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 impatience made me opt for the chemistry of the West. The fever disappeared, probably with side effects — but the process was a quick one!

35. Hen Seltun, Heiestad, Ruden, "On the Last 2500 Years of Western Civilization, And Some Remarks on the Coming 500", in The New Cambridge Modern History, 1979, Companion Volume, c' 12

36. As an example see the excellent articles in Der Spiegel, Nos. 34-35/1980, "Le mahana Illusionen"