9

Physical Health and Autonomy

How can the satisfaction of basic needs be empirically evaluated? The reader will recall the distinction drawn in Chapter 4 between the ultimate goal presumed by our theory – the avoidance of serious harm regarded as the fundamental and sustained impairment of social participation – and the basic needs for physical health and autonomy. These needs were seen to be the universal conditions for achieving this goal. Our intention here is to operationalise physical health and autonomy and to suggest cross-cultural indicators of both.¹

Figure 9.1 elaborates the top part of Figure 8.2 and illustrates the major steps in our approach. First, we consider direct measures of

---

¹ L. Doyal et al., *A Theory of Human Need* © Len Doyal and Ian Gough 1991
survival and of disability, conceptualised as the restricted ability to perform an activity regarded as normal for a human being, where this restriction is the result of physiological or emotional impairment. Second, we turn to cross-cultural measures of physical disease utilising the biomedical model. The remaining three sections operationalise the three components of personal autonomy distinguished in Chapter 4: mental illness, cognitive deprivation and restricted opportunity to participate in socially significant activities. By the conclusion we hope to have shown how the basic need for physical health and autonomy can be charted empirically.

It will be apparent from Figure 9.1 that we conceptualise and operationalise health and autonomy in the negative way argued earlier. The WHO in a famous definition puts forward a positive definition of health as ‘a state of complete physical, mental and social well-being’. However, though frequently quoted it is just as often ignored, and for good reason: it is unclear how such a positive conception of health can be measured (Caplan, 1981, parts 1, 5). Our approach is to define and measure physical health negatively as the minimisation of death, disability and disease. And similarly to define and measure autonomy negatively as the minimisation of mental disorder, cognitive deprivation and restricted opportunities. However, we consider that these two negatives make a positive: together they constitute a rounded, yet operational, conception of that state of objective well-being which the WHO has sought to identify.

**Survival and disability**

We have seen that survival is, so to speak, the bottom line of the need for physical health. Unless individuals are alive, they do not even have the chance of becoming ill, much less of doing anything else. Provided we leave aside some interesting questions about long-term coma, there is not much dispute about what survival means empirically. You are surviving as a person if you are capable of any intentional activity. We have argued that individuals have a right of access to the means to survival to the degree that they are physically capable of it. Of course, if they do not survive it would be strange to say that they are then in any way deprived. The dead cannot be deprived of anything since they cannot do or participate in anything. It is this fact that makes death such a personal tragedy