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Perspective

The Profound Implications of the Meaning of Health for Health Care and Health Equity

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Policy Points:

- The meaning of health in health care remains poorly defined, defaulting to a narrow, biomedical disease model. A national dialogue could create a consensus regarding a holistic and humanized definition of health that promotes health care transformation and health equity.
- Key steps for operationalizing a holistic meaning of health in health care include national leadership by federal agencies, intersectoral collaborations that include diverse communities, organizational and cultural change in medical education, and implementation of high-quality primary care.
- The 2023 report by the National Academies of Sciences, Engineering, and Medicine on achieving whole health offers recommendations for action.

Keywords: health, biomedical model, whole health.

Health matters to people and society. People generally desire to live longer, continue to function independently, and experience well-being throughout their lives. Yet, despite the United States spending more per person on health care than any other country, population health in the United States is declining and below its peer countries with persistent, stark racial and socioeconomic inequities.[1–3]

One potential contributor to poor US health is conceptual opacity regarding the meaning of health. When health's meaning is opaque, health is tacitly defined narrowly as the absence of disease. This conceptual opacity perpetuates the biomedical paradigm in health care with its focus on diagnosing and treating disease. This tacit biomedical definition yields poor investment in people's inherent health potential relative to drugs and technology, thus fostering a misalignment between the goals of health care and the goals of individuals, communities, public health, and society.

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This paper aims to explore a broader, holistic understanding of health that includes biomedical health in addition to positive health that addresses the enhancement of human capabilities and well-being. We examine how the absence of a clear definition of health defaults to a narrow, biomedical meaning within the health care system with ensuing adverse consequences such as the objectification of people and the undermining of health care's role in fostering the full health potential. Finally, we address the steps and challenges that must be considered to adopt a whole health meaning with the potential to transform and humanize health care and effectively promote equity in whole health.

Health Is a Positive Concept and More than the Absence of Disease

From a population perspective, health represents the quality of life and life expectancy.[4] Life expectancy, particularly health-adjusted life expectancy,[5,6] is highly valued. Generally, people desire healthy years of life in terms of their physical, mental, emotional, social, and spiritual function and well-being.[7,8] These dimensions of health exist holistically within people and were captured in the original World Health Organization (WHO) 1948 definition. Specifically, the WHO defined health in the preamble to its constitution as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity."[9] Although this definition has been widely criticized as utopian, it notably expanded the meaning of health to include a vital positive aspect beyond the traditional biomedical definition.[10]

The WHO defined health promotion in 1986 in its Ottawa Charter as "…the process of enabling people to increase control over and to improve their health. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities."[11] This clarification shifted the meaning of health and health promotion closer to how the public and health care professionals view health.[7] Huber organized a 2-day Health Council of the Netherlands conference on defining health in 2009.[12] A multidisciplinary group of 38 international experts, guided by a review of the literature, discussed the meaning of health. The group supported "a more dynamic one based on the resilience or capacity to cope and maintain and restore one's integrity, equilibrium, and sense of wellbeing."[12] Huber and colleagues drafted a final definition: "the ability to adapt and to self-manage,"[10] and adding the clarifying words "…in the face of social, physical and emotional challenges."[10] Most people also understand health to include notions of well-being embedded in the original WHO definition and the concept of health as a resource for everyday life that enables them to achieve important goals.[7,8]

Health theorists have formalized these concepts. Sen proposed the capability approach, which addresses actual capabilities in the context of their lives that people have to achieve lives they value.[13] Nordenfelt conceptualized health as the ability to achieve vital goals: "Health (or optimal health) is the bodily and mental state of a person such that he or she has a second-order ability to realize his or her vital goals, given standard or otherwise accepted circumstances."[14] Venkatapuram integrates Nordenfelt's vital goals with Nussbaum's theorized human capabilities,[15] stating that health is "a meta-capability, the capability to achieve a cluster of basic capabilities to be and do things that reflect a life worthy of equal human dignity."[16] Venkatapuram's capabilities include those cited by Nussbaum, (e.g., capability of having a normal life expectancy, bodily health, bodily integrity, being able to use all one's senses, etc.) and potential others, such as the Gross Developmental Potential (e.g., the ability to continuously learn, adapt to change, connecting with others, etc.).[17] The Robert Wood Johnson Foundation (RWJF) also adopted a positive definition of health that incorporates resilience, adaptation, and well-being: "Resilience, adaptation, and attaining the highest level of wellbeing that is achievable is the real goal."[18]

Venkatapuram views capability for health as involving casual components of biological endowments *and needs*, individual behavior, enabling external physical and social conditions, and skills in achieving goals and functioning. Basic material needs including food, water, shelter, safety, etc., have a self-evident contribution to life and health. Less recognized is that satisfaction of basic psychological needs also affects health and well-being. Robust empirical data derived from self-determination theory (SDT) show that satisfaction of three basic psychological needs (i.e., autonomy, competence, and relatedness) promotes motivation, health, and well-being.[19,20] Moreover, evidence supporting the role of these needs in health and well-being extends to SDT-informed interventions that have been shown to enhance motivation and well-being.[19] Interestingly, Nussbaum's capabilities appear to overlap with SDT's three basic psychological needs. In two separate study samples, the satisfaction of these basic psychological needs mediated the association of Nussbaum's capabilities with well-being.[21]

These findings support the concept that satisfaction of psychological needs in addition to material needs promotes health and that health is a resource or meta-capability for satisfying these needs, other capabilities, and personally relevant goals. Social determinants of health (SDOHs) represent conditions of daily life that enable capabilities and fulfillment of not only material human needs but also basic psychological needs. Health (operationalized as a meta-capability) enables improved health over time as represented by Nussbaum's first two capabilities (normal life expectancy and bodily health). Health, particularly early child developmental health, enables educational, occupational, and socioeconomic status (SES) advancement.[22–24] SES in turn affects living conditions, i.e., SDOHs, fulfillment of basic material and psychological needs, and access to and effective use of health care. This reciprocal relationship in which health begets health is embedded in Ruger's health capability model, which

includes both health agency and health functioning, i.e., the ability to achieve health goals.[25] Potentially, factors that promote health capability offer the potential for interrupting downward vicious cycles and replacing them with longitudinal virtuous cycles of health based on bidirectional relationships between whole health and its determinants.

These positive aspects of health point toward the role of health care in promoting health capabilities through patient training, by partnering with communities to create conditions that support capability for health, and by advocating for policies that support equity capability for health.[26,27] For example, patient training could address patient activation, digital health skills, and patient self-management related to health capabilities. Community partnerships can involve community health workers who can provide training and enablement of health capability while policies can direct resources based on need and improve access to early child development, universal prekindergarten, and high-quality schools in low-income neighborhoods. For example, a broad-based, committed coalition of health care organizations and communities might have prevented the expiration of the expanded child tax credit that yielded a 41% increase in child poverty, with proven adverse impacts on child health.[28,29] Thus, acknowledging that health represents human capabilities for which health care shares some accountability could prove transformative.

Conceptual Opacity and the Default Meaning of Health in Health Care

Open debate about the role of health care in promoting health capability is hindered by conceptual opacity, i.e., the lack of clarity regarding the meaning of health. Health is seldom prominently defined in health care, even in the context of health equity. The Centers for Medicare and Medicaid Services (CMS) states the following on their website: "Health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."[30]

The US Department of Health and Human Services (HHS), which includes CMS and the Centers for Disease Control and Prevention (CDC) and numerous other agencies, defines its mission: "To enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services."[31] However, health is not defined on the HHS or CMS web page or glossaries.

The Department of Veterans Affairs (VA) is a notable exception. It adopted a modified version of the WHO definition as part of its Whole Health initiative: "an

approach to care that empowers and equips a person to take charge of their health and well-being and live their life to the fullest."[32] It is notable that the VA chose to rebrand health as "Whole Health" rather than directly challenging the existing tacit biomedical definition of health. A 2023 report by the National Academies of Sciences, Engineering, and Medicine (NASEM) adopted a slightly different definition of whole health: "Physical, behavioral, spiritual, and socioeconomic well-being as defined by individuals, families, and communities. To achieve this, whole health care is an interprofessional, team-based approach anchored in trusted longitudinal relationships to promote resilience, prevent disease, and restore health. It aligns with a person's life mission, aspiration, and purpose."[33]

Conceptual opacity regarding the meaning of health in health care affects many countries, although Canada posts its definition reflecting the previously referenced 1986 Ottawa Charter.[34] Features of US health care amplify harm from this failure to clarify what health means.[35–38] These features include the major role of private for-profit organizations, fragmentation, absence of universal coverage, administrative inefficiency, and a powerful medical–industrial complex involving pharmaceutical and device manufacturers and federally funded research and development.

Engel's 1977 call for a new medical model inspired patient-centered care that focused on medical visits.[39] Patient-centered care has been expanded to person-centered care, i.e., "integrated health care services delivered in a setting and manner that is responsive to the individual and their goals, values, and preferences, in a system that empowers patients and providers to make effective care plans together,"[40] and further expanded, by NASEM into people-centered care: "an approach that focuses on values, priorities, and life-course needs of people, families, and communities."[33] A related concept is the humanization of health care, which aims to humanize the health care system by addressing human relational elements of care, including organizational aspects.[26,41,42] These initiatives notwithstanding, the disease-oriented, biomedical model of health perpetuates and predominates amidst conceptual opacity regarding the meaning of health. This tacit biomedical model is reflected in health care billing that generally requires coding for a recognized disease, billing for procedures that address diseases, and in most quality measures that address either processes or diseases over short horizons, i.e., 12-month time frames. Under the cloud of conceptual opacity, health care defaults to a biomedical, disease-oriented model to the detriment of patients, society, and the promotion of meaningful health equity.

The Harms of Conceptual Opacity

The meaning of health reflects underlying paradigms that inform the design of systems intended to optimize health. Tacit meanings promote confusion that perpetuates a disease-focused, market-driven status quo that rewards hospitals, drug and

device manufacturers, and other health industry entities to tacitly define health in their self-interests, which then drives health care spending, including hospitalizations, prescribing, surgical interventions, and diagnostic testing. A default narrow definition enables health care to overinvest in biomedical curative-oriented technology while underinvesting in people and primary prevention, much less promotion of health, contributing to 90% of health care spent on chronic disease and mental disorders.[43]

Notably, a default biomedical definition contributes to a hidden misalignment of the implicit goals of health care with the HHS-stated goal of our society of improving population health and health equity. A biomedical definition allows health care to avoid accountability for addressing SDOHs while health organizations, pharmaceuticals, and device manufacturers profit from the diagnosis and treatment of diseases resulting from unaddressed SDOHs. Biomedical hegemony, particularly in the United States, tends to marginalize primary care, which has essentially adopted a holistic definition of health.[33]

A limited, disease-oriented, reductionist meaning of health fosters an objectification of people, including patients and health care workers, and potentially a dehumanizing organizational culture. Bell and Khoury define organizational dehumanization as "the experience of an employee who feels objectified by his or her organization, denied personal subjectivity, and made to feel like a tool or instrument for the organization's ends."[44] This mechanistic dehumanization in which employees are interchangeable parts analogous to the mechanistic dehumanization of an exclusively biomedical model views the human body as a collection of interchangeable components that ignore humanity and corresponding fundamental needs for autonomy, competence, and relatedness.

The Harms of Conceptual Opacity to Health Equity

Conceptual opacity in health care preserves an inequitable status quo in health care by hindering public debate regarding the role of health care in promoting health for all. This opacity enables subversion by powerful interest groups who can tacitly operationalize their meaning of health without meaningful engagement from marginalized groups in clarifying the meaning of health. Tacit adoption of an exclusively disease-oriented model of health yields a narrow operationalization of health equity in health care based on the equity in process and treatment. Conversely, the adoption of the health capabilities approach suggests a societal obligation (with health care contributing) to ensure conditions that support the capability of all to be healthy.[25]

Opacity in the meaning of health also obscures inherent health care paradoxes that disproportionately affect minoritized and low-income patients. The implicit

adoption of a narrow mechanistic meaning of health contributes to compartmentalization whereby US health care organizations contribute to adverse SDOHs through the infliction of financial toxicity (i.e., potentially crushing medical debt) on lower-income and minoritized families.[45–47] This compartmentalization also allows health care organizations to profit from treating diseases that result from unaddressed SDOHs in surrounding impoverished communities. Most importantly, this opacity hinders discussion of the role of health care in promoting equity in human capabilities and potential across the life course.

Implications for Resolving the Meaning of Health

Promoting health in health care requires investment in human capabilities and potential by enabling people to manage their health and by supporting their autonomy, competence, and healthy relationships while supporting equity in SDOHs that are critical to promoting equity in human potential and well-being. This approach requires a paradigmatic and cultural shift in health care with implications for health care leadership, organizational culture, human development, funding allocation, care models, training, measurement, accountability, and health equity. Doing so requires organizational and delivery reforms, systems for bidirectional relationships with community-based human service organizations, intersectoral partnerships to promote community health, and advocacy for "health equity in all policies" (Table 1).

Adopting a holistic meaning of health could foster investment in human development and potential, i.e., patients and families, enabling them to promote health for themselves and their families. This investment should be driven by scientific findings that support a life-course approach to promoting health.[48] This approach necessitates cross-sector partnerships[49] to optimize child and adult capabilities while seeking to enable all patients and families. This process entails implementing evidence-based health care interventions, e.g., universal access to contraceptives, reproductive planning, preconceptual counseling, and support for families preparing for and having children while minimizing the risks of pregnancy and childbirth, particularly for minoritized women. Adoption of a life-course approach by health care entails the advocacy for social policies that invest in the first thousand days of a child's life[50] and optimize children's potential through partnerships that use population strategies to engage families and address human needs in early child development programs, high-quality children care, prekindergarten, and high-quality education and continue to end-of-life, implementing the best available evidence. Systematic reviews support the effectiveness of resilience training interventions for children, adolescents, and adults[51–53] and parenting interventions.[54] Delivering these interventions through health care organizations or more often through community

Table 1. Operationalizing a Holistic Meaning of Health in Health Care and Communities

	Provision by Health Care Organizations	Referrals to Community-Based Organizations	Intersectoral Partnerships	Advocacy for Policy Changes
Person/family level				
Person-centered care	√			
Behavioral health integration	√		√	
Patient skills	√	√		
Wellness self-management	√			
Social needs	√	√	√	√
Address basic psychological needs in all processes	√	√	√	√
Supportive health information infrastructure and system integration	√	√	√	
Optimal composition of team skills	√	√	√	
Community level				
Community health interventions	√	√	√	√
Organizational level				
Organizational leadership	√			
Health care processes that promote health equity	√			
Organizational culture	√	√		
Employee diversity and benefits	√			

partnerships could enhance a core component of health, i.e., the capability to adapt and self-manage life challenges. With equitable deployment and cultural adaptation, these interventions could potentially improve equity in this central facet of health.

Importantly, implementing a holistic meaning of health entails effective use of data to identify key patient and family social, behavioral, and psychosocial needs and connect patients and families with relevant resources that offer evidence-based, culturally adapted interventions. Health care systems can use their data, health information communication technology, and outreach workers to connect people with social needs with resources. Promoting health requires investing in evidence-based interventions that strengthen people's health capabilities and implementation within health care or through community partners. Examples are delivering interventions that foster patient activation, health literacy, digital health literacy, patient understanding, shared decision making,[55–62] and medication adherence. Promoting health requires a similar investment in interventions that address key behavioral determinants of health that are largely responsible for chronic diseases, disability, premature death, and high health care spending.[63] Examples involve interventions that promote healthy eating, physical activity, and sleep; cessation of tobacco, excess alcohol, and drugs; and reduce stress.[64–75] Often, these interventions will need to be adapted to meet the needs of diverse of patients and families.[76] Implementing lifestyle interventions, particularly physical activity, may also improve mental health.[77,78] Implementing psychological interventions could further promote well-being.[51,79]

Furthermore, the adoption of a clear, holistic meaning of health entails not only enabling individuals but also addressing the SDOHs in the community that enable peoples capabilities. Improved clarity regarding health and nonhealth sectors' roles in its promotion could accelerate progress in establishing effective health care/non–health care partnerships.[80] Accountability for health and health equity could foster genuine partnerships among health care, public health, and communities based on a shared goal. Examples include health care systems that partner with communities to promote affordable housing, address food deserts, and ensure transportation.[81] Too often, health care organizations neglect SDOHs that are directly under their control, e.g., access barriers related to costs, language, disability, etc.; antiracism culture and policies, wage scales, employment, and contracting policies; health care career pathways for minoritized workers; and billing practices that can saddle families with medical debt.[82–89] Embracing a broader notion of health could encourage health care systems to become champions for health and equity in all policies to address structural factors related to poverty, education, and economic opportunity, in addition to policies related to a healthy environment, healthy eating, physical activity, tobacco, alcohol, and early child development.[90]

Last, health is relevant to the well-being of people working in health care in addition to patients. High physician and nursing burnout in the United States preceded the COVID-19 pandemic.[91,92] Burnout is related to thwarted psychological needs.[93]

Qualitative data reveal that primary care physicians' sense of professional dissonance results from working in health care systems that appear to have values counter to theirs, i.e., caring for patients.[94] Physicians wish health care leaders would foster a cultural shift within the institution that acknowledged them as multidimensional human beings.[94] Adoption of health as a central goal within health care and steps to address conditions that foster health among people who work in health care could stem burnout and the exodus from the field. Embracing health as a goal of health care is an important step toward the humanization of health care.[42]

Next Steps and Challenges

The first step is to create a shared understanding within health care of the multifaceted concept of health. Chandra and colleagues assert that the achievement of this shared understanding of health as a cultural value will be driven in part by addressing mindset and expectations.[95] This is a plausible assertion and applies to a shared understanding of health within health care. No doubt there are daunting economic, political, and institutional challenges to replacing a biomedical model with a holistic model. Doing so will require a cultural change within health care. Indirect strategies have involved the promotion of person-/patient-centered care, the development of patient-reported outcome measures, the RWJF intersectoral "culture of health" initiative, the VA's "Whole Health" initiative, value-based payment, implementing high-quality primary care, and single-system solutions.[41,96–100]

Notably, the NASEM report *Achieving Whole Health: A New Approach for Veterans and the Nation* offers a potential roadmap for enabling capability for health based on five foundational characteristics:

> (1) be people-centered—understand peoples' needs, goals, and priorities in the context of their family, community, and cultural environment, (2) be comprehensive and holistic—collaboratively and comprehensively address the entirety of a person's well-being, spanning conventional medical care, complementary and integrative health, spiritual care, and social needs, (3) be upstream-focused—address health behaviors and the social and structural determinants of health, the root causes of poor health, (4) be equitable and accountable—ensure accountability for people, families, and communities and proactively engage with them to equitably address their prioritized needs, and (5) ensure team well-being—ensure the well-being of the entire care team by supporting them to do their jobs within a positive work environment and helping them achieve whole health themselves.[101]

The central NASEM goals and recommendations are shown in Table 2.[33] Each of these initiatives offers the potential for health care change and the adoption of a whole health approach to health care. The VA's Whole Health approach in addition to Southcentral Foundation/the Nuka System of Care and Mary's Center cited

Table 2. NASEM Whole Health Goals and Recommendations[36]

Goal 1. Commit to the shared purpose of helping people achieve whole health.
Recommendation 1.1: To scale and spread whole health, the VA, the HHS, other federal agencies addressing health and social services, state and local governments, health systems, social services, community programs, and external environment actors (payers, corporations, educators, and others) should make whole health a core value.
Goal 2. Prepare for a whole health approach to care.
Recommendation 2.1: National, regional, and facility VA leaders should ensure that all sites are ready to offer the whole health system of care to all veterans by ensuring that each site understands and adopts the whole health mission and vision and has the resources and services it needs to transform its care delivery approach. Recommendation 2.2: Health care systems, community programs, social services, and public health organizations committed to helping people achieve whole health should ensure that all sites are ready to offer whole health care to the people, families, and communities they serve.
Goal 3. Integrate across systems, services, and time to support whole health care throughout the life span.
Recommendation 3.1: The VA should integrate the delivery of whole health services between the Veterans Benefits Administration and the Veterans Health Administration. Recommendation 3.2: Health care systems should create and strengthen the infrastructure needed to partner with community programs, social care, and public health systems.
Goal 4. Deliver all foundational elements of whole health care across the life span.
Recommendation 4.1: The VA should fully incorporate all whole health foundational elements into its whole health system. Recommendation 4.2: Health care systems, community programs, social services, and public health organizations should model whole health approaches after the VA and other early adopters. Recommendation 4.3: Building on its existing health center program, the Health Resources and Services Administration should lead the scale and spread of whole health care in the community.

Continued

Table 2. (Continued)

Goal 5. Evaluate to iteratively refine whole health care systems and create generalizable knowledge.
Recommendation 5.1: Systems fielding a whole health approach should systematically and continuously evaluate and participate in external evaluations of the implementation and adaptations of the approach and disseminate lessons learned. Recommendation 5.2: Building on its overall mission to study the care of people and the allocation of PCOR Trust funding to disseminate evidence to practice, the AHRQ should fund research to evaluate whole health care as well as research that disseminates evidence on whole health practices. Additional research support will be needed from other national and international organizations, foundations, and private payers.
Goal 6. Design public and private sector policies and payments to support whole health as a common good.
Recommendation 6.1a: The VA, Congress, and regional third-party administrators should determine how the MISSION Act applies to deliver whole health services. Recommendation 6.1b: Regional third-party administrators of the MISSION Act should streamline the process for enrolling community providers in community care networks and define and enforce standards for health record transfer between community care systems and VA as a condition for reimbursement. Recommendation 6.2: The VA, in partnership with the HHS, should create a national center for whole health innovation to design and advance the policies and payments for whole health care.

Abbreviations: AHRQ, Agency for Healthcare Research and Quality; HHS, Department of Health and Human Services; MISSION, Maintaining Internal Systems and Strengthening Integrated Outside Networks; PCOR, Patient-Centered Outcomes Research; VA, Department of Veterans Affairs.

by NASEM[33] offer potential templates for scaling nationally. Lessons include continuous learning and adaptation during the process, outcome evaluation based on a range of implementation strategies tailored for multiple perspectives, team-based care, leadership, and synergy involving high-level drivers of system change.[101]

National leadership is critical. An obvious convener, if not a leader, is HHS based on its responsibility for administering federal health and human services agencies. Other potential conveners include the NASEM or possibly the RWJF. The leader could convene a diverse multistakeholder group to develop a multifaceted family of core health concepts.[102] Stakeholders should include diverse patients and families,

federal health care, health and research agencies, state Medicaid, health departments, health plans, quality organizations, hospitals, academic health centers, federally qualified health centers, and diverse communities among others. Key steps would include 1) clarifying the meaning of health, including the role of positive health, 2) clarifying the potential role of health care organizations, i.e., when they are a deliverer vs. a partner, in promoting positive health, and 3) developing graduated implementation plans that consider novel care models, health information and communication technology, payment reform, workforce and training, measurement and accountability, and internal and external reallocation of funding to support partnerships. Federal research agencies, e.g., the National Institutes of Health and the Agency for Healthcare Research and Quality could fund research designed to bridge the gap between equity-focused whole health interventions and adoption by health care.

Organizational leadership that acknowledges a holistic meaning of health is also critical to humanizing health care.[103] A servant leadership style in this context offers the potential for humanizing organizations and actualizing health defined holistically in health care.[104] Greenleaf, who founded the servant leadership movement, in describing the concept wrote, "Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, and more likely to become servants? And what is the effect on the least privileged in society; will they benefit or, at least not be further deprived?"[105] Two meta-analyses mostly conducted in non–health care sectors show that servant leadership was strongly associated with employee outcomes.[106,107] Compared with authentic, ethical, and transformational leadership styles, servant leadership showed stronger associations with organizational citizenship behavior, engagement, job satisfaction, overall commitment, and trust.[107] Furthermore, improved worker engagement and reduced burnout not only improve task performance, but these changes are associated with worker adaptive performance (i.e., stress management, reactivity, creativity, and interpersonal adaptivity), suggesting that servant leadership enhances worker capabilities.[108] The RWJF funds leadership training through its culture of health initiative. It could develop and scale a dedicated health care track to train future health care leaders to operationalize this culture within health care organizations and in partnership with communities.[109]

Both undergraduate and graduate medical education provide important opportunities for training in the holistic meaning of health. The biopsychosocial model is widely taught but often undermined by the hidden curriculum in which trainees witness attending physicians focusing mainly on biomedical issues.[110,111] Addressing this significant challenge will require leadership and culture change coupled with training including mindfulness and role-modeling in self-care.[111–115]

Primary care has long embraced the concept of positive health and the central role of SDOHs.[116–122] The implementation of high-quality primary care as recommended by the NASEM could provide a platform and be a cultural change agent for

health while helping transform health care from an exclusively biomedical paradigm while providing a foundation for promoting health and equity in health in health care.[96,123,124] An HHS initiative to strengthen primary care aims "to provide a federal foundation to strengthen primary health care for our nation that will ensure high quality primary care for all, improve health outcomes, and advance health equity."[125] Arguably, primary care's long-standing support for a holistic meaning of health has marginalized it from the US health care system. Conversely, the adoption of a holistic meaning of health by health care could galvanize support for primary care, including the critical role of longitudinal relationships in promoting health.

Payment and corresponding measurement of holistic meanings of health are important to its operationalization. Payment should reward investments in human capability for health, including the health of communities that enable people to live healthy.[126,127] Some of the measures from the VA's whole health program may prove suitable.[128,129] Furthermore, the Institute of Medicine developed *Vital Signs: Core Metrics for Health and Health Care Progress*.[130] These include traditional population health measures, health care system measures, behavioral determinants, and community health measures. Measures that capture patient empowerment/activation, capability, and condition-specific self-management capability offer promise for assessing important elements of holistic health.[126,127,131] The RWJF has compiled a host of measures for its culture of health program. CMS could partner with the National Quality Forum to foster the development and endorsement of novel measures of holistic health.

Barriers to change are substantive. These include current system inertia, economic incentives, political differences regarding the role of government if not health care in promoting health rather than treating disease, legacy systems, institutional barriers, and costs of retooling among others.[132–135] There are no simple solutions. Some of the solutions overlap with those of establishing a "culture of health," i.e., clarifying and demystifying the concept, grounding community intervention in broader structural change, and building consensus in a divided nation. Adoption of best practices for dissemination to policymakers while featuring the role of patient and family autonomy and choice as the VA has done through its "Whole Health" initiative may help.[99,136,137] In 2020, 43% of Americans reported health should be a top federal government priority and that government generally should do more in health.[138] Demand for improved health coupled with high frustration from employers and the public over growing costs and unaffordability may drive change.[139,140]

Skeptics may argue that clarifying the meaning of health is a fool's errand that will distract from the central task of transforming and humanizing health care, including the potential scaling of the VA's Whole Health initiative. There are drawbacks to both strategies. A key risk to striving for consensus on the meaning of health is that the process could become protracted amidst debate on health's precise meaning. The VA and NASEM avoid this potential pitfall by defining the term "whole health" and by

embedding people's choice of what this means within the definition. This ingenious approach allows the task of operationalization of whole health outside the VA to start.

The downside of skirting the clarification of the meaning of health is that this avoidance fails to challenge a flawed biomedical paradigm that dominates funding for research and health care. Similarly, adopting an approach in which health means whatever one defines it to mean yields conceptual confusion. These end-around approaches may postpone the inevitable struggle regarding resource allocation for research needed to inform the optimization of health and for health care to effectively operationalize its optimization and deliver it equitably to individuals, families, and communities. Potentially, a two-track strategy involving public consensus regarding a multifaceted meaning of health that allows people and communities to prioritize facets of health most important to them while simultaneously proceeding with the implementation of the NASEM recommendations might be the most prudent course.

In 2021, US health expenditures increased by 2.7% to $4.3 trillion, or $12,914 per person, and accounted for 18.3% of the gross domestic product.[141] This level of spending crowds out sufficient funding for optimizing health beyond pilots. The United States cannot afford to continue to invest so heavily in a flawed model of health. Our nation deserves a model of health that is aligned with people's, communities', and our national goals for health and well-being.

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