



AN ENQUIRY INTO THE THEORIES OF HEALTH

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Abstract

Health is a dual-faceted concept encompassing both private and public dimensions. On a personal level, individuals bear the responsibility for maintaining their well-being, ensuring freedom from illness and diseases through the cultivation of healthy behaviours and habits. Additionally, the surrounding natural and physical environment significantly influences individual health conditions. Simultaneously, health assumes a public dimension, with governments, be they at the central, state, or local levels, tasked with providing socioeconomic support related to health. This involves establishing primary health centres at the grassroots level and advanced public hospitals operated by governmental bodies. Societies and communities, in turn, rely on these health institutions for the treatment of illnesses and diseases. To enhance the effectiveness of health infrastructure and community disease management systems, the implementation of robust project management techniques becomes imperative. This encompasses comprehensive planning, organization, control, and supervision of health institutions, complemented by well-structured public and private insurance systems. Against this backdrop, various health theories have been formulated and advocated by experts, offering valuable insights into contemporary health systems and health management practices both in India and globally. In this paper, the authors endeavour to delineate the key characteristics of these diverse health theories. Such theories serve as invaluable guides, facilitating adjustments and informed decision-making to establish an optimal health system for the collective benefit of society and the broader community. *Top of Form*

I. INTRODUCTION

According to the **World Health Organization (2003)**, health is defined as a state of complete physical, mental, and social well-being, extending beyond the mere absence of disease or infirmity. Health economists view health as a durable good or form of capital that offers ongoing services. These services, generated from the stock of health capital, are continuously consumed throughout an individual's lifetime. At birth, individuals are presumed to possess a given stock of health, and the pursuit of maintaining and enhancing health has been a longstanding human endeavour. The demand for health care, in particular, is derived from the broader demand for health and is influenced by various factors, including price, income, and population. Several factors impact the demand for health care, such as patient-perceived needs, preferences, cost of use, income, transportation expenses, waiting time, and perceived quality of care. The demand for health care is intricately connected to individual consumption during illness, with varying levels influenced by income, service price, education, societal norms, traditions, and perceived quality. Health, as a component of human capital, is pivotal for sustainable development, significantly enhancing individuals' capacities for diverse activities, including productivity. The demand for health care arises from a broader demand for health, with individuals actively investing time and resources in the production of health. Health, conceptualized as lasting over time, undergoes depreciation, akin to a capital good. Health demand consists of two elements: **Consumption effects**: health yields direct utility (i.e.) you feel better when you are healthier. **Investment effects**: health increases the number of days available to participate in market and non-market activities - the novel bit of the model.

$$H \text{ Stock}_t = H \text{ Stock}_{t-1} - \text{dep} \cdot n(\delta) + \text{inv. in } H(I)$$

A person is born with an initial endowment of H, which they add to by investment. The rate of H production will depend on the efficiency of investment in H. There will be δ in the value of the stock of H through age, accident, carelessness, and sudden disease. As we are considering U over a lifetime we also need to be aware of the issue of time-preference. (Ghorbani, Alireza, 2021)

II. THEORIES ON HEALTH

This paper is grounded in theoretical frameworks, primarily drawing upon *Human Capital Theory* and *Grossman's Theory on Health*. Historically, economic thought emphasized that enhancing a nation's economic growth was achievable solely through increased investment in physical capital. The concept of human capital emerged, highlighting that individuals invest in themselves through health and education, augmenting their income potential by elevating lifetime earnings. Recognizing the significance of investing in human capital alongside physical capital, economists began to emphasize the importance of education in the early 1960s. American economist Schultz, in particular, analysed educational expenditure as a form of investment, leading to the formulation of *Human Capital Theory*. In parallel with education, investments in health also play a crucial role in enhancing the quality of labour input. Regrettably, underdeveloped countries have often neglected investment in health. However, a shift occurred in the 1960s as the realization of the connection between good health and factors like poverty, illiteracy, and low productivity became apparent. Health expenditures, akin to educational expenditures, are considered investments in people. Frequently,

individuals allocate resources to both education and healthcare. Improved health not only extends life expectancy but also amplifies the returns on educational investments. Much like education, health is both consumption and investment. It contributes to economic growth by mitigating mortality and morbidity, thereby enhancing both the quality and quantity of labour.

Health as a form of Human Capital: The pivotal insight lies in recognizing that, beyond health care being an economic good, health itself can be conceptualized as a distinct good with unique characteristics. It can be viewed as a fundamental commodity genuine object of people's desires, with more tangible goods and services, such as health care, serving as a means to attain it. This theory traces its roots back to the works of **Becker (1965)** and **Grossman (1972)**, but its origins can be found in 18th Century economists like **Jeremy Bentham (1780)**, who described "the relief of Pain" as a "basic pleasure." Accepting health as a fundamental commodity allows for the analysis of the demand for health improvements like other goods and services. A notable difference lies in the fact that, as health is non-tradable, it cannot be examined within the traditional market framework—direct purchase of improvements in health is not feasible. Instead, the focus shifts to the production of health as the primary means through which individuals express their demand for it. This may involve the acquisition of goods and services, constituting an indirect purchase of health improvements. Health care, in this context, emanates from the demand for health. While this analytical approach can be applied to various goods and services, its significance in health is underscored by the fact that the consumption of health care is often not pleasurable; rather, it is undertaken solely to enhance health (**Morris et al., 2007**). In the 1970s, **Michael Grossman** developed a model of the demand for health, treating investment in health as a form of investment in human capital (**Culyer and Newhouse, 2000**). This general model of human capital, initially formulated by **Gary Becker** in the context of education investment, logically extends to health (**Becker, 1975**).

General Theory: Health represents a crucial facet of human capital, exerting a positive impact on worker productivity by augmenting both physical capacities, including strength and endurance, and mental capacities, such as cognitive functioning and reasoning ability. Substantiating this connection is an increasing body of evidence at the macroeconomic level, as observed by **Schultz (1999)**. Moreover, a discernible link exists between health and income on a macroeconomic scale. Robust cross-country correlations, established between measures of aggregate health (such as life expectancy or child mortality) and per capita income, are well-documented, as noted by the **World Bank (1993)**. While social scientists commonly interpret these correlations as indicative of a causal link between income to health, there has been a recent challenge to the conventional perspective. The possibility that the income-health correlation may also be explained by a causal link operating in the opposite direction—from health to income—has gained attention in recent years. Increasing incomes stand out as a significant catalyst for the heightened demand for health care, a trend observed in countries with higher income levels that typically allocate more resources to health care. The approximation of national income often involves the use of real Gross Domestic Product (GDP) per capita. The income elasticity of demand (ϵ) serves as a metric gauging the impact of GDP growth on healthcare spending. In the health economics literature, a prevalent finding is the robust positive relationship between GDP growth and health spending, as highlighted by **Gerdtham and Lothgeren (2000)**.

However, consensus remains elusive regarding whether a percentage increase in income correlates with a larger percentage increase in health care consumption, categorizing health care as a luxury good ($\epsilon > 1$); a smaller percentage increase, designating it as a necessary good ($\epsilon < 1$); or an equivalent percentage increase, signifying health care as unit elastic ($\epsilon = 1$). The empirical estimate is contingent on various factors, including the functional form, the countries encompassed in the analysis, the chosen independent variable, and the timeframe considered. Despite ongoing debates, recent studies employing aggregate national data from industrialized countries have leaned towards the assertion that health care is indeed a luxury good. Public economics serves as the theoretical foundation for government involvement in the delivery of health care services, particularly as governments play a crucial role in providing goods and services, with health care being of paramount importance. The argument posits that specific health services exhibit the characteristics of merit goods, generating substantial externalities, and possess a non-rival, non-excludable nature. Given the uncertainty surrounding the occurrence of ill health and the acknowledgement of health as a fundamental human right, government intervention becomes imperative in furnishing healthcare services either free of charge or at subsidized prices.

This necessity for government financing of healthcare services brings forth another vital consideration—determining which categories of healthcare should be financed by the government. Public economics delineates the categories of health care that warrant government support. The contention is that non-patient-related preventive health care, due to its externality component and non-excludable characteristics, should be provided by the government free of cost, as argued by **Paul et al. (1990)**. Economic evaluation stands out as a crucial analytical tool for decision-making, as it encompasses both the cost and benefits aspects, each influencing the other. On the cost side, there is an examination of the expenses associated with establishing and implementing the project under evaluation. This involves considering opportunity costs. Moreover, in principle, the focus is on determining the marginal cost rather than the average cost, as it represents the cost incurred for producing one additional unit—the cost at the margin, which is of primary interest. Turning to the benefits side, it involves evaluating the utility generated by the implementation of a new project. This utility encompasses the value of the health outcome that can be derived for an individual patient, as well as for other stakeholders, such as the patient's relatives. In the healthcare field, economic evaluation employs four distinct methods, as outlined by **Drummond et al. (1997)**. These methods are known as Cost-Minimization Analysis (CMA), Cost-Effectiveness Analysis (CEA), Cost-Utility Analysis (CUA), and Cost-Benefit Analysis (CBA). CMA is utilized when comparing two interventions that yield the same outcome. In this scenario, the focus is solely on determining and comparing the costs of each intervention. The intervention incurring the lowest cost is considered more rational to implement if the primary objective is to minimize costs. The specific cost categories are identified based on the chosen perspective.

The Germ Theory of Disease: The bacteriological theory of disease, pioneered by figures like **Pasteur and Koch (1882)**, marked a significant advancement in understanding infectious diseases. This theory identified specific biological organisms responsible for transmitting infectious diseases, reducing the spread of disease to the transmission of these bacteria. Consequently, the causes of diseases were conceptualized as localized biological factors. Koch's pivotal work in isolating and culturing the tuberculosis virus, demonstrating its artificial induction in animals, exemplifies an instance of Hacking's 'entity realist' stance, where causality,

manipulability, and reality are interconnected (Marcum, 2008). While the bacteriological theory brought precision to disease understanding, it introduced a more individualistic and local perspective, potentially overshadowing the broader, non-local focus of public health on the determinants of human health. Nonetheless, public health, adaptable by nature, swiftly integrated microbiological advancements into its practices. This integration facilitated disease identification and intervention strategies. The establishment of local and government public health departments, primarily tasked with monitoring populations concerning communicable diseases, represented a crucial development. Over time, this infrastructure expanded to accommodate other initiatives, including screening programs. In 1948, the concept of an agency responsible for the control and monitoring of infectious diseases was elevated to the international level with the establishment of The World Health Organization (WHO) by the United Nations. Although the WHO's scope has expanded well beyond infectious diseases, encompassing various demographic issues believed to impact health, its origins highlight the ongoing evolution and adaptability of public health practices. Epidemiology and public health share a common concern in understanding the transmission of diseases, a focus often approached at a broader level. Molecular epidemiology serves as a bridge between molecular biology and epidemiology, contributing insights into transmission mechanisms and potential responses to halt disease spread. The integration of genetic screening and engineering holds the potential for increased control over disease transmission, even raising the prospect of eradicating certain diseases. On a more practical level, it opens avenues for more targeted intervention strategies. Consequently, the local, biomedical model utilized by public health can seamlessly merge with the broader, global issues more typical of the latter's operational approach.

Theoretical Development: Human Ecological Approach: Health is a fundamental concept within the framework of human ecology, an approach that delves into the study of human interactions with the surrounding environment. The significance of a human ecological perspective on health lies in its integrative, holistic, and positive nature. Human ecology draws attention to the direct and indirect health impacts stemming from unsustainable development, anthropogenic environmental changes, and associated social inequities, as highlighted by Parkes et al. (2003). The authors emphasize the necessity of investigating reciprocal relationships among humans and their biotic and abiotic environment, acknowledging the role of social, cultural, and economic development as a driving force behind ecosystem changes on various scales. The pertinence and application of a human ecological perspective become particularly evident in research and policy responses addressing the challenges posed by adaptation, vulnerability, and resilience to environmental changes, including the broader issue of global climate change, as underscored by Barnett (2001).

Risk Factor Epidemiology Approach: Various scholars have proposed diverse theories and models to comprehend the relationships between health and the environment. The 'Germ theory,' rooted in causal-effect relationships, had a linear nature. In understanding the progression of infectious diseases, scholars introduced the "agent-host-environment" triad, conceptualizing the relationships between environment and health. The "risk factor epidemiology" approach played a crucial role in shaping epidemiology in the latter half of the 20th century. This approach becomes particularly influential when causal pathways, as in the case of cardiovascular disease, become less apparent. The evolution of social epidemiology enables a more comprehensive understanding of the host factors that may influence exposure (and response) to environmental hazards, as noted by McMichael (2006). Environmental health makes significant contributions to overall well-being, creating conditions where both society and individuals can thrive. This involves ensuring the provision of safe resources such as water, air, and food, along with a safe environment encompassing home, work, and leisure spaces.

Holistic Approach: In comprehending the emergence and spread of diseases, as well as health care practices and their connection with ecology, adopting a 'holistic approach' proves advantageous. The holistic approach in medical anthropology strives to consider as many environmental variables as possible. A notable contribution in this regard is the work of Parkes et al. (2003), where they explored the inter-relationship among driving forces, ecosystems, social systems, and health. They developed a framework called the 'Prism Framework,' rooted in the ecology and health approach, integrating various perspectives that have emerged in recent decades. This framework aims to comprehensively study all components influencing human health. Furthermore, some scholars have coined a new term to capture the holistic nature of studying health and its close relationship with ecology: 'Health ecology.' This term reflects the interconnected study of health and its environment, emphasizing the intricate interplay between various factors. As per Morteza Honari and Thomas Boleyn (1999), "Health Ecology is concerned with a comprehensive picture of human health at the individual, societal, and global level. It is used to illustrate patterns of human health about the environment; physical and social, micro and macro, cultural and technical, individual and universal." This approach is inherently multi-dimensional and integrative, viewing health as a fundamental domain of human life. It provides a theoretical framework for interactions across various levels, including the individual, institutional, and community levels. Health Ecology encompasses the assessment and management of resources at risk to establish a healthy ecosystem. This approach not only offers a holistic perspective for social, environmental, and health planning but also provides a framework for development and environmental impact assessment from a health standpoint. Additionally, it proves advantageous in understanding people's perceptions of changing environmental conditions, offering valuable insights into the intricate interplay between human health and the surrounding environment.

Health Ecology Approach: The *Health Ecology Approach* is inherently holistic, encompassing various aspects and parameters that impact health. Defined as "the study of the interactions of humans and their health with their environments," this approach integrates issues related to "Global Environmental Change, Climate Change, and Human Health," as utilized in other models such as WHO (2003) and the 4th Assessment Report of IPCC (2007). It goes beyond examining changes in environmental conditions solely driven by anthropogenic (development, agriculture, deforestation, and unsustainable utilization of natural resources) or natural (earthquake, land-sliding, forest, and other disasters) activities that result in alterations in climatic conditions, biodiversity loss, changes in land cover and physiography, and freshwater depletion and contamination. The health ecology approach also focuses on socio-economic and political factors that either directly affect health or exacerbate health problems caused by

environmental changes. In doing so, it provides a comprehensive understanding of the intricate interactions between human health and the environment, taking into account the multifaceted influences stemming from both natural and human-induced factors.

Eco-Health Approach: The health and well-being of communities are intricately linked with the surrounding environment, land, and the culture shaped by this environment, as highlighted by **Greenwood and Leeuw (2007)**. The notion that the 'natural environment is the source of illness and diseases rather than the basis of life' is challenged by scholars such as **Parkes et al. (2003)**, who emphasize the need to consider anthropogenic social processes contributing to environmental change and associated health impacts. This perspective advocates for a holistic approach that recognizes the significance of an ecosystem approach to health. This holistic viewpoint resonates across various interdisciplinary fields, including health ecology, ecological public health, Eco-Health, environmental health promotion, and human ecology. Each of these fields contributes to a nuanced and comprehensive understanding of health to environmental changes within societies. Eco-Health, an emerging paradigm in health research, establishes connections between ecological and social determinants of health. Described as a "participatory, system-based approach to understand and promote human health and well-being in the context of social and ecological interactions" by **Waltner-Toews (2008)**, Eco-Health recognizes the ecosystem as the life-supporting foundation for health and well-being. It builds upon the enduring understanding of the relationship between health, environment, and socio-economic conditions within a community, as highlighted by **Corvalan et al. (2005)** and **McMichael et al. (2006)**. This interdisciplinary field seamlessly integrates ecology, anthropology, geography, public health, and epidemiology, contributing to the broader realm of 'ecosystem approaches' that deal with health, as noted by **Waltner-Toews et al. (2008)**. Beyond reconnecting health with the ecosystem and socioeconomic factors, Eco-Health emphasizes trans-disciplinarity, equity, sustainability, and participation, as emphasized by **Parkes (2011)**. It demands a systematic understanding of the ecological and social dimensions of health. Eco-health is an evolving field of research that delves into the impact of ecosystem changes on human health. This discipline scrutinizes alterations in the biological, physical, social, and economic environments, establishing connections between these changes and human health. Eco-health practitioners are dedicated to developing innovative and practical solutions aimed at mitigating or reversing the adverse health effects stemming from ecosystem change.

Theories of Illness: George Peter Murdock (1980) presented theories of illnesses based on his comparative study of 186 societies. His categorization, although more cumbersome than that of **Morley (1978)** and **Foster and Anderson (1978)**, covered both indigenous and archaic states such as Egypt, Babylon, Roman, Aztec, and others. The theory of animistic causation links health with a personalized supernatural entity, such as a soul, ghost, spirit, or deity. On the other hand, magical causation attributes illnesses to the "covert action of an envious, affronted, or malicious human being who employs magical means to injure his victims." Murdock's theories aim to provide a comprehensive explanation of the diverse causes of maladies and ailments.

Theories of Disease: Anthropologists **George Foster (1913–2006)** and **Barbara Anderson (1926–1973)**, pioneers in the field of medical anthropology alongside Khwaja Hassan, introduced three distinct disease theory systems to elucidate the nature of illness. The first, known as **Personalistic Disease Theory**, posits that illness arises from the actions of an external agent, such as a witch, sorcerer, or supernatural entity like an ancestor spirit or ghost. In this framework, healers are required to employ supernatural means to uncover the cause and facilitate the cure of the illness. The second theory, **Emotionalistic Disease Theory**, attributes illness to negative emotional experiences. An illustrative example is cultural illness - a condition prevalent in Latin American cultures where anxiety or fright can lead to lethargy and distraction. This theory prompts psychotherapists to explore the interplay between emotions and physical health. Finally, the **Naturalistic Theory** of illness posits that health issues arise from impersonal factors such as pathogens, malnutrition, obstructions (e.g., kidney stones), or organic deterioration (e.g., heart failure). With roots tracing back to the work of Hippocrates, naturalistic theory occupies a prominent place in the education provided by modern medical schools. The collective insights of these anthropologists have significantly contributed to understanding diverse cultural perspectives on illness within the broader scope of medical anthropology.

A. Theories of Natural Causation: Theories of natural causation explore explanations for events and phenomena based on inherent and intrinsic factors rather than external or supernatural influences. These theories posit that events occur due to the inherent properties, processes, or conditions within the natural world, without invoking supernatural or external forces. Examples include scientific theories explaining the causes of natural phenomena, diseases, or other occurrences within the framework of observable and measurable natural processes. Theories of natural causation are: *Infection theory* attributes many health problems to microorganisms, such as bacteria, viruses, fungi, or parasites. These microorganisms can invade the body, causing diseases or infections. **Example:** Common infectious diseases include the flu (caused by influenza viruses), pneumonia (often caused by bacteria), and various viral or bacterial infections. (**Louis Pasteur and Robert Koch**); *Stress theory* suggests that psychological or physiological stress can contribute to health problems. Chronic stress may weaken the immune system and contribute to the development or exacerbation of various conditions. **Example:** Stress has been linked to conditions like cardiovascular diseases, digestive issues, and mental health disorders. (**Hans Selye**); *Organic Deterioration theory* focuses on the gradual breakdown or deterioration of bodily tissues and functions over time. Aging and degenerative processes are central to this theory. **Example:** Conditions like osteoarthritis, Alzheimer's disease, and certain cardiovascular diseases are often associated with organic deterioration; *Accident theory* pertains to health problems resulting from unintentional injuries or events. Accidents can cause immediate harm or lead to long-term health issues. **Example:** Injuries from falls, car accidents, or workplace accidents are instances where the accident theory is relevant; and *Overt Human Aggression theory* involves intentional harm or aggression directed toward individuals, resulting in health problems. It includes physical violence or other forms of overt aggression. **Example:** Physical assault, domestic violence, or war-related injuries can lead to a range of health issues, from physical injuries to psychological trauma. Each theory provides a specific perspective on the causes of health problems, and often, multiple factors may contribute to the development of a particular condition. These theories help guide research, medical interventions, and public health strategies by providing insights into the multifaceted nature of health and disease.

B. Theories of Supernatural Causation: Theories of Supernatural Causation are: *Mystical causation theories* attribute health and illness to supernatural or divine forces. These forces are often beyond human comprehension and control. Mystical beliefs may involve spiritual entities, divine intervention, or cosmic energies influencing an individual's well-being. **Example:** A belief that an illness is caused by the displeasure of a deity or is a result of cosmic alignment. Healing practices may involve rituals, prayers, or ceremonies to appease the mystical forces; *The theory of Animistic Causation* is based on the belief that non-human entities, such as spirits, animals, or objects, possess the power to influence health. These entities are thought to have agency and can impact an individual's well-being positively or negatively. **Example:** Associating illness with the displeasure of a particular spirit or attributing good health to the protection of a guardian spirit. Rituals or offerings may be performed to seek favour or protection from these animistic forces. (**Sir Edward Tylor and Sir James Frazer**); and *Magical causation theories* involve the belief that magical practices or supernatural actions can directly influence health outcomes. This may include the use of charms, spells, or rituals believed to have healing or protective properties. **Example:** Using an amulet or charm to ward off illness, performing a ritual to break a curse thought to be causing sickness, or employing magical symbols for protection against health-related threats. (**Bronislaw Malinowski (1884–1942) and Sir James Frazer (1854–1941)**). These theories are often deeply ingrained in cultural traditions and can coexist with modern medical beliefs. In many societies, individuals may seek both traditional and modern healthcare depending on the nature of the ailment and personal beliefs. These theories highlight the cultural diversity in how people conceptualize health and illness and the varied approaches to healing that are influenced by cultural, spiritual, or supernatural beliefs. (**Baer et al. 2003**)

Social Cognitive Theory (SCT): SCT describes the influence of individual experiences, the actions of others, and environmental factors on individual health behaviours. SCT provides opportunities for social support through instilling expectations, and self-efficacy, and using observational learning and other reinforcements to achieve behaviour change. Key components of the SCT related to individual behaviour change include: *Self-efficacy:* The belief that an individual has control over and can execute a behaviour; *Behavioural capability:* Understanding and having the skill to perform a behaviour; *Expectations:* Determining the outcomes of behaviour change; *Expectancies:* Assigning a value to the outcomes of behaviour change; *Self-control:* Regulating and monitoring individual behaviour; *Observational learning:* Watching and observing outcomes of others performing or modelling the desired behaviour; and *Reinforcements:* Promoting incentives and rewards that encourage behaviour change. (**Bandura, 1986**)

Theory of Reasoned Action/Planned Behaviour: Two closely associated theories – The Theory of Reasoned Action and the Theory of Planned Behaviour – suggest that a person's health behaviour is determined by their intention to perform a behaviour. A person's intention to perform a behaviour (behavioural intention) is predicted by (1) a person's attitude toward the behaviour, and (2) subjective norms regarding the behaviour. Subjective norms are the result of social and environmental surroundings and a person's perceived control over the behaviour. Generally, positive attitudes and positive subjective norms result in greater perceived control and increase the likelihood of intentions governing changes in behaviour. (**Icek Ajzen, 1985**)

III. Conclusion

The Human Development Index (HDI) considers key parameters such as Health, Education (measured by Gross enrollment ratio), Life Expectancy, and Standard of Living (indicated by Per Capita GDP). These parameters are intricately interconnected and equally crucial in assessing overall societal development. A thriving society necessitates the well-being of its individuals, achievable through a comfortable life that encompasses the fulfilment of happiness. Investing in human capital is pivotal for enhancing societal health, considering humans as capital due to their capacity to generate economic benefits for both current and future generations. Governments worldwide, including developing nations like India, accord significant importance to human welfare. This commitment is evident in the establishment of various socioeconomic structures, including the construction of hospitals at the grassroots and higher levels. Such investments facilitate societal access to essential socio-economic infrastructure. Numerous health theories proposed by experts offer recommendations and suggestions to enhance the health conditions of individuals and society as a whole. The theories, including Grossman's Theory, General Theory, Germ Theory, Disease Theory, Theory of Illness, etc. provide valuable guidelines for healthcare management authorities, contributing to the holistic well-being of society.

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