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## Multidimensional Well-being in Palliative Care: Operationalizing WHO's Constitutional Vision Across Clinical and Public Health Systems

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### Background:

In 1948, the World Health Organization (WHO) defined health as a state of complete physical, mental, and social well-being. Despite this foundational vision, contemporary health systems continue to prioritize biomedical outcomes over multidimensional well-being. The growing global burden of serious health-related suffering, particularly in the context of non-communicable diseases and population ageing, underscores the urgency of operationalizing well-being within palliative care and public health systems.

### Objective:

This paper aims to conceptualize and operationalize multidimensional well-being in palliative care by integrating WHO's constitutional definition with contemporary empirical evidence and health systems frameworks.

### Methods:

A narrative, conceptually driven synthesis of global policy documents, randomized clinical trials, health systems research, and well-being measurement literature was conducted. Key sources include WHO policy resolutions, the The Lancet Commission on Palliative Care and Pain Relief, and peer-reviewed empirical studies on early palliative care, dignity-based interventions, caregiver outcomes, and cost-effectiveness.

### Results:

Evidence demonstrates that early and integrated palliative care improves quality of life, reduces depressive symptoms, enhances existential well-being, decreases avoidable hospital utilization, and strengthens caregiver resilience. Multidimensional well-being encompasses physical symptom relief, psychological adaptation, social connectedness, and spiritual meaning-making.

However, measurement challenges persist, particularly regarding culturally sensitive and system-integrated patient-reported outcome tools. A multilevel integration framework is proposed, embedding well-being across patient, family, community, professional, and policy domains.

### **Conclusion:**

Operationalizing well-being as a measurable health system outcome transforms palliative care from a peripheral service into a foundational pillar of equitable and sustainable healthcare. Embedding multidimensional well-being into clinical workflows, public health monitoring, and universal health coverage strategies offers a pragmatic pathway for realizing WHO's constitutional vision in contemporary health systems.

### **Introduction**

In 1948, the World Health Organization (WHO) defined health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). This definition remains one of the most ambitious normative formulations in global health governance. However, despite its visionary scope, contemporary health systems continue to prioritize biomedical treatment over the systematic integration of multidimensional well-being as a measurable outcome (Huber et al., 2011).

The epidemiological transition toward non-communicable diseases, population ageing, and multimorbidity has intensified the relevance of well-being-centered care models. Globally, more than 60 million people experience serious health-related suffering each year, with the vast majority lacking access to adequate palliative services (Knaul et al., 2018; WHO, 2020). These disparities disproportionately affect low- and middle-income countries, where morphine-equivalent opioid access remains critically limited (Berterame et al., 2016).

Palliative care operationalizes WHO's holistic definition by addressing suffering across physical, psychological, social, and spiritual domains (Bulia et al., 2025). Evidence indicates that integrating well-being into structured care planning improves patient-reported outcomes, reduces unnecessary hospitalizations, and enhances care satisfaction (Temel et al., 2010; Smith et al., 2014). Contemporary scholarship emphasizes that well-being must be conceptualized not as an aspirational principle but as a core health system outcome embedded within universal health coverage frameworks (Bulia and colleagues, 2025; Bulia et al., 2026; WHO, 2014).

### **Historical and Conceptual Foundations**

The WHO Constitution established well-being as intrinsic to health, anticipating contemporary biopsychosocial and public health paradigms. Dame Cicely Saunders' theory of “total pain” further expanded this view, recognizing suffering as multidimensional and relational. Subsequent

empirical work confirms that physical pain frequently coexists with psychological distress, social isolation, and existential anxiety, reinforcing the necessity of integrated interventions (Chochinov et al., 2009).

The 2014 World Health Assembly Resolution WHA67.19 formally recognized palliative care as an ethical responsibility of health systems (WHO, 2014). The United Nations 2030 Agenda for Sustainable Development similarly positions well-being at the center of SDG 3 (United Nations, 2015). These global commitments underscore the policy legitimacy of embedding well-being indicators into national health strategies.

The The Lancet Commission on Palliative Care and Pain Relief reframed serious health-related suffering as a global equity crisis, arguing that failure to ensure access to palliative care constitutes structural injustice (Knaul et al., 2018). This framing situates well-being not merely within clinical ethics but within human rights and distributive justice frameworks.

### **Defining Multidimensional Well-Being in Palliative Care**

Well-being in palliative care is inherently multidimensional, encompassing physical symptom relief, psychological resilience, social connectedness, and spiritual meaning-making (Bulia and colleagues, 2025). These domains interact dynamically. For example, untreated depression amplifies pain perception, while strong social support networks are associated with reduced mortality risk and improved coping capacity (Holt-Lunstad et al., 2010).

Empirical evidence from randomized controlled trials demonstrates that early palliative care improves quality of life, reduces depressive symptoms, and may even prolong survival in certain populations (Temel et al., 2010; Bakitas et al., 2015). Interventions such as Dignity Therapy significantly enhance existential well-being and reduce end-of-life distress (Chochinov et al., 2011).

Positive psychological constructs—including hope, gratitude, and meaning—are increasingly recognized as protective factors in serious illness (Breitbart et al., 2015). Integrating meaning-centered interventions strengthens adaptive coping and enhances life satisfaction even when disease progression cannot be reversed (Bulia et al., 2026).

### **Measurement and Operationalization**

The measurement of well-being remains methodologically complex. Traditional clinical metrics fail to capture existential and relational dimensions. Instruments such as the McGill Quality of Life Questionnaire, FACIT-Sp, ICECAP-SCM, and EQ-5D have attempted multidimensional

assessment; however, cross-cultural validation and routine implementation remain limited (Bausewein et al., 2011; Coast et al., 2014).

Recent scholarship emphasizes the integration of patient-reported outcome measures (PROMs) into palliative workflows to ensure systematic monitoring of well-being (Antunes et al., 2014). Embedding such instruments within electronic health systems enables longitudinal evaluation and policy-relevant data generation (Bulia and colleagues, 2025; Bulia et al., 2025).

Robust measurement frameworks would allow governments to quantify serious health-related suffering as a population-level indicator, thereby aligning clinical practice with public health surveillance strategies (Knaul et al., 2018).

### **Multilevel Integration Framework**

At the patient level, early and continuous palliative care reduces symptom burden, improves psychological adjustment, and enhances care satisfaction (Temel et al., 2010; Smith et al., 2014). Multidisciplinary teams addressing complex symptom clusters demonstrate superior outcomes compared to fragmented models.

At the family level, caregiver burden is strongly associated with depression, economic strain, and increased healthcare utilization (Adelman et al., 2014). Structured caregiver interventions reduce burnout and enhance patient home-based symptom control (Bulia et al., 2025).

At the community and system level, integration of palliative services into primary care reduces emergency admissions and improves cost-effectiveness (May et al., 2018). The World Health Organization Global Atlas of Palliative Care documents persistent geographic inequities, emphasizing the need for policy-driven expansion (WHO, 2020). Telemedicine and community volunteer programs demonstrate particular promise in rural settings (Bulia et al., 2026).

### **Professional Well-Being and System Sustainability**

Healthcare professional burnout threatens quality and sustainability. Systematic reviews indicate high prevalence of emotional exhaustion among palliative clinicians (Parola et al., 2017). Institutional support structures, reflective supervision, and resilience training correlate with improved retention and patient-centered care quality (Bulia et al., 2025).

Investing in workforce well-being enhances continuity of care and reduces systemic inefficiencies associated with turnover.

### **Policy Implications**

Embedding well-being within health policy requires alignment with universal health coverage principles and SDG monitoring mechanisms (United Nations, 2015). Cost-effectiveness analyses suggest that early palliative integration reduces hospital expenditure and intensive care utilization (May et al., 2018).

Governments should adopt multidimensional well-being indicators, expand opioid accessibility within safe regulatory frameworks (Berterame et al., 2016), and integrate community-based service models into primary care systems. Such strategies operationalize WHO's constitutional vision through measurable implementation pathways.

## Conclusion

The WHO's 1948 constitutional definition of health remains normatively compelling yet incompletely realized. Palliative care offers a practical, evidence-based mechanism for embedding multidimensional well-being into clinical practice and health systems design.

Evidence from randomized trials, global commissions, and health policy analyses demonstrates that well-being-centered palliative care improves quality of life, reduces inequities, enhances system efficiency, and strengthens social cohesion (Bulia et al., 2025; Bulia and colleagues, 2025; Bulia et al., 2026; Knaul et al., 2018).

Operationalizing well-being as a measurable health system outcome transforms palliative care from a peripheral service into a foundational pillar of equitable, sustainable healthcare. Realizing this vision requires coordinated clinical integration, validated measurement tools, and sustained policy commitment.

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