

A Conceptual Framework of Wellbeing in Some Western Nations (A Review Article)

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Abstract : The aim of this study is to examine and highlight the narrow definition of wellbeing that still exists in some contemporary Western societies. This definition is in keeping with the biomedical model that views the exposure to specific pathogens as the cause of diseases in organisms. Such an approach began during the 130ce to 200ce in Ancient Rome, and despite the efforts of the WHO in 1946 to expand the concept, health in Caribbean societies and in particular Jamaica is still substantially seen as the ‘absence of diseases’ or dysfunctions in the body, which is what is used to indicate wellbeing. Health and wellbeing are multidimensional constructs and so there is a need for academics to begin vociferously working to encapsulate an operational definition of wellbeing that can be used in the images of wellbeing and patient care. This paper presents and examines a conceptual framework on health (or wellbeing) from a biopsychosocial perspective, as well as including an environmental perspective as this is in keeping with an expanded conceptualization of health as forwarded by the WHO in its constitution. Within the discourse, arguments will be presented on both subjective and objective measurements of wellbeing.

Key words: Biomedical model, biopsychosocial model, health, healthy life expectancy, objective wellbeing, quality of life and subjective wellbeing

INTRODUCTION

The traditional view of Western Societies is that health is conceptualized as the ‘absence of diseases’. This approach is both narrow and negative in scope as regards health. According to one school of thought, the aforementioned conceptualization of health emphasizes the absence of some disease-causing pathogens, and not health (Longest, 2002; Brannon and Feist, 2007; Rice, 1998). Such a perspective is in keeping with the traditional biomedical model that views the exposure to specific pathogens as the cause of diseases in organisms. This began during 130ce to 200ce in Ancient Rome and despite the efforts of the WHO as early as 1946 to expand this construct (WHO, 1948), health in Caribbean societies, in particular Jamaica, is still substantially viewed as the ‘absence of diseases’ or dysfunctions, with wellbeing being the opposite of that state. Humans are multifaceted and so any conceptualization of health that seeks to measure an aspect of their existence cannot be uni-directional or bi-directional, as health, wellbeing and wellness are multidimensional, which would be in keeping with the complexities of people. Lynch (2003) opines that everything that we do, feel, think and experience interfaces with our health; hence, wellbeing cannot be operationally defined solely based on functional limitation because of pathogens, as many events affect the quality of life outside of that space. Thus, this paper recognizes the need for the discourse, as it will allow for a better measurement of the concept. In addition to health

measurement, this paper seeks to broaden the scope of the determinants of health, and in the process help policy-makers to understand this concept. In a nationally representative survey of Jamaicans, using observational data on some 2,320 elderly people (ages 65+ years), Bourne (2007) finds 12 factors that determine the wellbeing of elderly Jamaicans. Bourne’s wellbeing model is different to that presented in many other studies, as he uses a combination of physical dysfunctions, income and material possessions to conceptualize wellbeing. Bourne’s overall model explains 40.1% of the variance in wellbeing. Again, wellbeing is influenced by more than just biological conditions. However, one scholar (Bok, 2004) opined that the WHO’s operationalization of health (or wellbeing) is too broad and by extension difficult to measure. This begs the question, why have we reverted to the ancient conceptualization of wellbeing (or health) and its images to guide patient care? Hence, what are the different discourses on wellbeing? Therefore, the paper presents and examines a conceptual framework on health (or wellbeing) from a biopsychosocial perspective, in addition to including the physical environment in the discourse as well as providing other images within the health discourse, with the aim of aiding health outcome research and patient care.

RESULTS AND DISCUSSION

Wellbeing defined: The concept of health according to the WHO is multifaceted. “Health is the state of complete

physical, mental and social wellbeing and not merely the absence of disease or infirmity” (WHO, 1948). From the WHO’s perspective, health status is an indicator of wellbeing (Crisp, 2005). Wellbeing for some, therefore, is a state of happiness – positive feeling status and life satisfaction (Easterlin, 2003; Diener *et al.*, 1985; Diener, 1984) satisfaction of preferences or desires, health or prosperity of an individual (Diener, and Suh, 1997a, b; Jones, 2001; Crisp, 2005; Whang, 2006), or what psychologists refer to as positive effects. Simply put, wellbeing is subjectively what is ‘good’ for each person (Crisp, 2005). It is sometimes connected with good health. Crisp offered an explanation for this, when he said that “When discussing the notion of what makes life good for the individual living that life, it is preferable to use the term ‘wellbeing’ instead of ‘happiness” (Crisp, 2005).

Ergo, the term wellbeing is used interchangeably with words such as ‘happiness’, ‘life satisfaction’, and ‘welfare’ by a number of researchers and/or people in intelligentsia (Diener, 1984; Easterlin, 2003; Veenhoven, 1993). While some scholars argue that happiness and life satisfaction are but a fraction of wellbeing, what is embedded in Diener and Easterlin’s usage of those terminologies instead of wellbeing aptly shows that, within the context of a multidisciplinary global market place in which people must operate, the quality of life that people enjoy (or do not enjoy) must be understood before the goals of policy-planning and decision-making on the desire to improve the welfare, quality of life and/or standard of living of a people can materialize.

Happiness, according to Easterlin (2003) is associated with wellbeing, and also with ill being (for example depression, anxiety, dissatisfaction). Easterlin (2003) argued that material resources have the capacity to improve one’s choices, comfort level, state of happiness and leisure, which militates against static wellbeing within the context that developing countries and developed countries had at some point accepted the economic theory that economic wellbeing should be measured by per capita Gross Domestic Product (GDP) – (i.e. total monetary value of goods and services produced within an economy over a stated period per person). Amartya Sen, who is an economist, writes that a plethora of literature exists showing that life expectancy is positively related to Gross National Product (GNP) per capita (Anand and Ravallion, 1993; Sen, 1998). Such a perspective implies that mortality is lower whenever an economic boom exists within the society and that this is believed to have the potential to increase development, and by extension the standard of living. Sen, however, was quick to offer a rebuttal in that data analyzed have shown that some countries (i.e. Sri Lanka, China and Costa Rica) have had reduced mortality without a corresponding increase in economic growth (Sen, 1998), and that this was attained through other non-income factors such as education, nutrition, immunization, expenditure on public health and poverty removal. The

latter factors undoubtedly require income resources, and so it is clear that income is unavoidably a critical component in welfare and wellbeing. Some scholars believe that economic growth and/or development is a measure of welfare (Becker *et al.*, 2004).

Therefore, those studies on economic wellbeing were able to offer a plethora of answers to national governments on the health status of the people, or the wellbeing and/or illbeing of their citizens. No policy formulation on improving the quality of life of the citizens of a particular space should proceed without firstly unearthing the ‘real’ determinants of wellbeing. From Crisp’s perspective (2005), wellbeing is related to health and the strength of those associations, and secondly planning requires information that is made available by research. Is traditional economists’ operationalization of wellbeing still applicable in contemporary societies, knowing it to be purely objective?

If happiness is a state of wellbeing, then if we were to impute depression, anxiety, stress, and illness and/or physical incapacitation, spirituality and environment within the objective measurement of wellbeing, a more holistic valuation would be reached. With the inclusion of subjectivity conditions in the measurement of wellbeing, we come closer to an understanding of people’s state of wellness, health and quality of life, as better nutrition, efficient disposal of sewage and garbage, and a healthy lifestyle also contribute to health status (i.e. wellbeing). It should be noted that the biomedical model that is objective, conceptualizes health as the absence of diseases. This leads to the question, are any of the following diseases – (i) depression, (ii) stress, (iii) fatigue, and (iv) obsession? Hence, an issue arises, does the lack of objectivity mean it should be accepted with scepticism?

In order to put forward an understanding of what constitutes wellbeing or illbeing, a system must be instituted that will allow us to coalesce a measure that will unearth peoples’ sense of the overall quality of life from either economic-welfarism (Becker *et al.*, 2004) or psychological theories (Diener *et al.*, 1997; Kashdan, 2004; Diener, 2000). This must be done with the general construct of a complex man. Economists like Smith and Kington, and Stutzer and Frey as well as Engel believe that the state of man’s wellbeing is not only influenced by his/her biologic state, but that it is always dependent on his/her environmental, economical and sociological conditions. Some studies and academics have sought to analyze this phenomenon in a subjective manner by way of general personal happiness, self-rated wellbeing, positive moods and emotions, agony, hopelessness, depression, and other psychosocial indicators (Arthaud-Day *et al.*, 2005; Diener *et al.*, 1999; Skevington *et al.*, 1997; Diener, 1984).

An economist (Easterlin, 2001a, b) studying happiness and income, of all social scientists, found an association between the two phenomena, (Stutzer and Frey, 2003). He began with a statement that “the

relationship between happiness and income is puzzling” (Easterlin, 2001a), and found that people with higher incomes were happier than those with lower incomes – he referred to it as a correlation between subjective wellbeing and income (Stutzer, and Frey, 2003). He did not cease at this juncture, but sought to justify this reality, when he said that “those with higher incomes will be better able to fulfil their aspirations, and with other things being equal, on an average, feel better off” (Easterlin, 2001a). Wellbeing, therefore, can be explained outside of the welfare theory and/or purely on objectification-objective utility (Kimball and Willis, 2005; Stutzer, and Frey, 2003).

Whereas Easterlin found a bivariate relationship between subjective wellbeing and income, Stutzer and Frey revealed that the association is a non-linear one. They concretized the position by offering an explanation that “In the data set for Germany, for example, the simple correlation is 0.11 based on 12, 979 observations” (Stutzer and Frey, 2003). Nevertheless, from Stutzer and Frey’s findings, a position association does exist between subjective wellbeing and income despite differences over linearity or non-linearity.

The issue of wellbeing is embodied in three theories – (1) Hedonism, (2) Desire, and (3) Objective List. Using ‘evaluative hedonism’, wellbeing constitutes the greatest balance of pleasure over pain (Crisp, 2005; Whang, 2006). With this theorizing, wellbeing is just personal pleasantness, which postulates that the more pleasantries an individual receives, the better off he/she will be. The very construct of this methodology is the primary reason for a criticism of its approach (i.e. ‘experience machine’), which gave rise to other theories. Crisp (2005), using the work of Thomas Carlyle, described the hedonistic structure of utilitarianism as the ‘philosophy of swine’, because this concept assumes that all pleasure is on par and summarized this adequately by saying that “... whether they [are] the lowest animal pleasures of sex or the highest of aesthetic appreciation” (Crisp, 2005).

The desire approach, on the other hand, is on a continuum of experienced desires. This is popularized by welfare economics, as economists see wellbeing as constituting the satisfaction of preference or desires (Crisp, 2005; Whang, 2006), which makes for the ranking of preferences and assessment by way of money. People are made better off if their current desires are fulfilled. Despite this theory’s strengths, it has a fundamental shortcoming, the issue of addiction. This is exemplified by the possible addictive nature of consuming ‘hard drugs’ because of the summative pleasure it gives to the recipient.

Objective list theory: This approach in measuring wellbeing lists items not merely because of pleasurable experiences, nor on ‘desire-satisfaction’, but states that every good thing should be included, such as knowledge and/or friendship. It is a concept influenced by Aristotle,

and “developed by Thomas Hurka (1993) as perfectionism” (Crisp, 2005). According to this approach, the constituent of wellbeing is an environment of perfecting human nature. What goes on an ‘objective list’ is based on the reflective judgement or intuition of a person. A criticism of this technique is elitism (Crisp, 2005), since an assumption of this approach is that certain things are good for people. Crisp (2005) provided an excellent rationale for this limitation, when he said that “...even if those people will not enjoy them, and do not even want them.”

In the work of Arthaud-Day *et al.* (2005), applying structural modelling to subjective wellbeing was found to constitute “(1) cognitive evaluations of one’s life (i.e., life satisfaction or happiness); (2) positive affect; and (3) negative affect.” Subjective wellbeing, therefore, is the individual’s own viewpoint. If an individual feels his/her life is going well, then we need to accept this as the person’s reality. One of the drawbacks to this measurement is, it is not summative, and it lacks generalizability.

Studies have shown that subjective wellbeing can be measured on a community level (Bobbit *et al.*, 2005; Lau, 2005) or on a household level (Lau, 2005; Diener, 1984), whereas other experts have sought to use empiricism (biomedical indicators - absence of disease symptoms, life expectancy; and an economic component - Gross Domestic Product per capita; welfarism - utility function).

Powell (1997) in a paper entitled ‘Measures of quality of life and subjective wellbeing’ argued that psychological wellbeing is a component of quality of life. He believed that this measurement, in particular for older people, must include Life Satisfaction Index, as this approach constitutes a number of items based on “cognitively based attitudes toward life in general and more emotion-based judgment” (Powell, 1997). Powell addressed this in two dimensions. Where those means are relatively constant over time, and while seeking to unearth changes in the short-run, ‘for example an intervention’, procedures that mirror changed states may be preferable. This can be assessed by way of a twenty-item Positive and Negative Affect Schedule or a ten-item Philadelphia Geriatric Centre Positive Affect and Negative Affect Scale (Powell, 1997).

In a reading entitled ‘Objective measures of wellbeing and the cooperation production problem’; Gaspart (1998) provided arguments that support the rationale behind the objectification of wellbeing. His premise for objective quality of life is embedded within the difficulty as it relates to consistency of measurement when subjectivity is the construct of operationalization. This approach takes precedence because an objective measurement of concept is of exactness as non-objectification; therefore, the former receives priority over any subjective preferences. He claimed that for wellbeing to be comparable across individuals, population and communities, there is a need for empiricism.

Gaspart discussed a number of economic theorizings (Equal Income Walrasian equilibria, objective egalitarianism, Pareto efficiency; Welfarism), which saw the paper expounding on a number of mathematical theorems in order to quantify quality of life. Such a stance proposes a human predictable, rational form, from which we are able to objectify plans. The very axioms cited by Gaspart emphasized a particular set of assumptions that he used in finalizing a measurement for wellbeing for man who is a complex social animal. The researcher points to a sentence that was written by Gaspart that speaks to the difficulty of objective quality of life; he wrote, "So its objectivism is already contaminated by post-welfarism, opening the door to a mixed approach, in which preferences matter as well as objective wellbeing" (Gaspart, 1998). Another group of scholars emphasized the importance of measuring wellbeing outside of welfarism and/or purely objectification, when they said that "Although GDP per capita is usually used as a proxy for the quality of life in different countries, material gain is obviously only one of many aspects of life that enhances economic wellbeing" (Becker *et al.*, 2004), and that wellbeing depends on both the quality and the quantity of life lived by the individual (Easterlin, 2001). This is affirmed in a study carried out by Lima and Nova (2006), which found that happiness, general life satisfaction, social acceptance and actualizations are all directly related to the GDP per capita for a geographic location (Lima and Nova, 2006). Even though in Europe these were found not to be causal, income provides some predictability of subjective wellbeing, and more so in poor countries than in wealthy nations. (Lima and Nova, 2006)

It should be understood that GDP per capita speaks to the market economic resources, which are produced domestically within a particular geographic space. So increased production in goods and/or services may generate excess, which can then be exported, and vital products (such as vaccination, sanitary products, vitamins, iron and other commodities) can be purchased, which are able to improve the standard of living and quality of the life of the same people compared to the previous period. One scholar (Caldwell, 1999) has shown that life expectancies are usually higher in countries with high GDP per capita, which means that income is able to purchase better quality products, which indirectly affects the length of years lived by people. This reality could explain why in economic recession, war and violence, when economic growth is lower (or even non-existent) there is a lower life expectancy. Some of the reasons for these justifications are government's failure to provide for an extensive population in the form of nutritional care, public health and health-care services. Good health is, therefore, linked to economic growth, which further justifies why economists use GDP per capita as an objective valuation of standard of living; and why income should definitely be a component in the analysis of health status. There is another twist to this discourse as a

country's GDP per capita may be low, but the life expectancy is high because health care is free for the population. Despite this fact, material living standards undoubtedly affect the health status and wellbeing of a people, as well as the level of females' educational attainment.

Ringen (1995) in a paper entitled 'Wellbeing, measurement, and preferences' argued that non-welfarist approaches to measuring wellbeing are possible despite its subjectivity. The direct approach for wellbeing computation through the utility function according to Ringen is not a better quantification as against the indirect method (i.e. using social indicators). The stance taken was purely from the vantage point that utility is a function 'not of goods and preferences' but of products and 'taste'. The constitution of wellbeing is based on choices. Choices are a function of individual assets and options. With this premise, Ringen put forward arguments showing that people's choices are sometimes 'irrational', which is the make for the departure from empiricism.

Wellbeing can be computed from either the direct (i.e. consumption expenditure) or the indirect (i.e. disposable income) approach (Ringen, 1995). The former is calculated using consumption expenditure, whereas the latter uses disposable income. Ringen noted that in order to use income as a proxy for wellbeing, we must assume that (1) income is the only resource, and (2) all persons operate in identical market places. On the other hand, the direct approach has two key assumptions. These are (1) what we can buy is what we can consume and (2) what we can consume is an expression of wellbeing. From Ringen's monograph, the assumptions are limitations.

In presenting potent arguments in favour of non-empiricism in the computation of wellbeing, Ringen highlighted a number of drawbacks to welfarism. According to Ringen:

- Utility is not a particularly good criterion for wellbeing since it is a function not only of circumstances and preferences, but also of expectation. In the measurement of wellbeing, respect for personal preferences is best sought in non-welfarist approaches that have the quality of preference neutrality; ...As soon as preferences are brought into the concept of wellbeing, it cannot but be subjective. (Ringen, 1995)

The difficulties of using empiricism to quantify wellbeing have not only been put forward by Ringen, as O'Donnell and Tait (2003) were equally forthright in arguing that there were challenges in measuring quality of life quantitatively. O'Donnell and Tait believed that health is a primary indicator of wellbeing. Hence, self-rated health status is a highly reliable proxy of health, which "successfully crosses cultural lines" (O'Donnell and Tait, 2003). They argued that self-reported health status could be used, as they found that all the respondents

of chronic diseases indicated that their health was very poor.

To capture the state of the quality of life of humans, we are continuously and increasingly seeking to ascertain more advanced methods that will allow us to encapsulate a quantification of wellbeing that is multidimensional and multifaceted (Pacione, 2003). Therefore, an operational definition of wellbeing that sees the phenomenon in a single dimension such as physical health, medical perspective (Farquhar, 1995), material (Lipsey, 1999) and would have excluded indicators such as crime, education, leisure facilities, housing, social exclusion and the environment (Pacione, 2003; Campbell *et al.*, 1976) as well as subjective indicators, cannot be an acceptable holistic measurement of this construct. This suggests that wellbeing is not simply a single space; and so, the traditional biomedical conceptual definitions of wellbeing exclude many individual satisfactions and in the process reduce the tenets of a superior coverage of quality of life.

One writer noted that the environment positively influenced quality of life (Pacione, 2003) of people; in order to establish the validity and reliability of wellbeing, empirical data must include issues relating to the environment. The quality of the environment is a utilized condition in explaining the elements of people's quality of life. Air and water quality through industrial fumes, toxic waste, gases and other pollutants, affect environmental quality. This is directly related to the maintenance or lack thereof of societal and personal wellbeing (Pacione, 2003).

Studies have conclusively shown that environmental issues such as industrial fumes and gases, poor solid waste management, mosquito infestation and poor housing are likely to result in physiological conditions like respiratory track infections (for example lung infection) and asthma.

According to Langlois and Anderson (2002), approximately 30 years ago, a seminal study conducted by Smith (1973) "proposed that wellbeing be used to refer to conditions that apply to a population generally, while quality of life should be limited to individuals' subjective assessments of their lives ...". They argue that a distinction between the two variables has been lost with time. From Langlois and Anderson's monograph, during the 1960s and 1970s, wellbeing was approached from a quantitative assessment by the use of GDP or GNP (Becker *et al.*, 2004), and unemployment rates; this they refer to as a "rigid approach to the (enquiry of the subject matter) subject." According to Langlois and Anderson (2002), the positivism approach to the methodology of wellbeing was objectification, an assessment that was highly favoured by Campbell *et al.* (1976), Andrews and Withley (1976).

In measuring quality of life, some writers have thought it fitting to use Gross Domestic Product per capita (i.e. GDP per capita) to which they referred as standard of living (Lipsey, 1999; Summers and Heston, 1995).

According to Summers and Heston (1995), "The index most commonly used until now to compare countries' material wellbeing is their GDP_{POP}." The United Nations Development Programme has expanded on the material wellbeing definition put forward primarily by economists, and has included life expectancy and educational attainment (UNDP, 2005) as well as other social indicators (Diener, 1984; Diener and Suh, 1997). This operational definition of wellbeing has become increasingly popular in the last twenty-five years, but given the expanded definition of health as cited by the WHO, wellbeing must be measured in a more comprehensive manner than merely using material wellbeing as seen by economists.

Despite the fact that quality of life extends beyond the number of years of schooling and material wellbeing, generally wellbeing is substantially construed as an economic phenomenon. Embedded within this construct of a measure is the emphasis on economic resources, and we have already established that man's wellbeing is multifaceted. Hence, any definition of the quality of life of people cannot simply analyze spending or the creation of goods and/or services that are economically exchangeable, the number of years of schooling and life expectancy, but it must include the psychosocial conditions of the people within their natural environment.

GDP is the coalesced sum of all the economic resources of people within certain topography, so this does not capture the psychosocial state of man in attaining the valued GDP. By this approach, we may arrive at a value that is higher than in previous periods, making it seem as though people are doing very well. However, with an increase in GDP, this single component is insufficient to determine wellbeing, as the increase in GDP may be from (1) more working hours, (2) higher rates of pollution and environmental conditions, (3) psychological fatigue, (4) social exclusion, (5) human 'burn out', (6) reduction in freedom, (7) unhappiness, (8) chronic and acute diseases and so forth. Summers and Heston (1995) note that "However, GDP_{POP} is an inadequate measure of countries' immediate material wellbeing, even apart from the general practical and conceptual problems of measuring countries' national outputs." Generally, from that perspective, the measurement of quality of life is therefore highly economic and excludes the psychosocial factors, and whether quality of life extends beyond monetary objectification.

In developing countries, Camfield (2003), in looking at wellbeing from a subjective vantage point, notes that Diener (1984) argues that subjective wellbeing constitutes the existence of positive emotions and the absence of negative ones within a space of general satisfaction with life. According to Camfield (2003) and Cummins (1997a, b), this perspective subsumed 'subjective and objective measures of material wellbeing' along with the absence of illnesses, efficiency, social closeness, security,

place in community, and emotional wellbeing, which implies that “life’s satisfaction” comprehensively envelopes subjective wellbeing.

Diener (2000) in an article entitled ‘Subjective Wellbeing: The Science of Happiness and a Proposal for a National Index’ theorizes that the objectification of wellbeing is embodied within satisfaction of life. His points to a construct of wellbeing called happiness. He cited that:

- People's moods and emotions reflect on-line reactions to events happening to them. Each individual also makes broader judgments about his or her life as a whole, as well as about domains such as marriage and work. Thus, there are a number of separable components of SWB [subjective wellbeing]: life satisfaction (global judgments of one's life), satisfaction with important domains (e.g., work satisfaction), positive affect (experiencing many pleasant emotions and moods), and low levels of negative affect (experiencing few unpleasant emotions and moods). In the early research on SWB, researchers studying the facets of happiness usually relied on only a single self-reported item to measure each construct (Diener, 2000).

Diener’s theorizing on wellbeing encapsulates more than the marginalized stance of other academics and researchers who enlightened the discourse with economic, psychosocial, or subjective indicators. He shows that quality of life is multifaceted, and coalescing economic, social, psychological and subjective indicators is more far-reaching in ultimately measuring wellbeing. This work shows a construct that can be used to operationalize a more multidimensional variable, wellbeing, which widens the tenet of previous operational definition on the subject. From the theorizing of various writers, it is clear that wellbeing is multidimensional, multidisciplinary and multispatial. Some writers emphasize the environmental components of subject matter (Pacione, 1984; Smith, 1973), from the psychosocial aspect (Clarke *et al.*, 2000) and from a social capital vantage point (Glaeser, 2001; Putnam, 1995; Woolcock, 2001).

Smith and Kington (1997), using $H_t = f(H_{t-1}, P_m, G_o, B_t, MC_t, ED, \bar{A}_t)$, to conceptualise a theoretical framework for “stock of health,” noted that health in period t , H_t , is the result of health preceding this period (H_{t-1}), medical care (MC_t), good personal health (G_o), the price of medical care (P_m), and bad medical care (B_t), along with a vector of family education (ED), and all sources of household income (\bar{A}_t). Embedded in this function is the wellbeing that an individual enjoys (or does not enjoy) (Smith and Kington, 1997).

In seeking to operationalize wellbeing, the United Nations Development Programme (UNDP) in the Human Development Reports (1998, 2001) conceptualized human development as a “process of widening people’s choice as

well as the level of achieved wellbeing”. Embedded within this definition is the emphasis on materialism in interpreting quality of life. From the UNDP’s Human Development (1994), the human development index (HDI) “...is a normative measure of a desirable standard of living or a measure of the level of living”, which speaks to the subjectivity of this valuation irrespective of the inclusion of welfarism (i.e. gross domestic product (GDP) per capita). The HDI constitutes adjusted educational achievement ($E = a_1 * \text{literacy} + a_2 * \text{years of schooling}$, where $a_1 = 2/3$ and $a_2 = 1/3$), life expectancy (demographic modelling) and income ($W(y) = 1/(1 - e) * y^{1-e}$). The function $W(y)$ denotes “utility or wellbeing derived from income”. This income component of the HDI is a national average (i.e. GDP per capita, which is then adjusted for income distribution ($W^*(y) = W(y) \{1 - G\}$), where $G = \text{Gini coefficient}$). In wanting to disaggregate the HDI within a country, the UNDP (1994) noted that data are not available for many countries, which limits the possibility.

An economist writing on ‘objective wellbeing’ summarized the matter simply by stating that “...one can adopt a mixed approach, in which the satisfaction of subjective preferences is taken as valuable too” (Gaspard, 1998; Cummins, 1997a, b), which is the premise to which this paper will adhere in keeping with this multidimensional construct, wellbeing. Wellbeing, therefore, in the context of this paper, will be the overall health status of people, which includes access to and control over material resources, environmental and psychosocial conditions, and per capita consumption.

New Focus: Healthy Life Expectancy

One of the drawbacks to the use of life expectancy is the absence of capturing ‘healthy’ years of life. Traditionally, when life expectancy is measured it uses mortality data to predetermine the number of years of life that are yet to be lived by an individual, assuming that he/she subscribes to the same mortality patterns of the group. The emphasis on this approach is on length of life, not on the quality of those lived years. The rationale why healthy life expectancy is important in ageing comes against the background that age means increased dysfunction and the unavoidable degeneration of the human body. Hence, we must seek to examine more than just the number of years that an individual is likely to survive, and we should be concerned about the quality of those years. Therefore, in attempt to capture ‘quality of lived years’, the WHO in 1999 introduced an approach that will allow us to evaluate this, ‘disability adjusted life expectancy’ (DALE). DALE is not only concerned with length of years to indicate the health and wellbeing status of an individual or a nation, but the number of years without disabilities and the severity of their influence by reducing the quality of lived years.

DALE is a modification of the traditional ‘life expectancy’ approach in assessing health. It uses the

number of years lived as an equivalent to 'full health'. In calculating DALE, the number of years of ill health is weighted based on severity. This is then subtracted from the expected overall life expectancy to give what is referred to as years of healthy life. Embedded in this approach is reduction in years because of numbers, and severity of dysfunctions and HIV experienced by the individual or people within a particular socio-political geography.

Having arrived at 'healthy life expectancy', the WHO has found that poorer countries lost more from their 'traditional life expectancy' than developed nations. The reasons put forward by the WHO are the plethora of dysfunctions and the devastating effects of some tropical diseases like malaria that tend to strike children and young adults. The institution found that these account for a 14 percent reduction in life expectancy in poorer countries and 9 percent in more developed nations (WHO, 2000). This system is in keeping with a more holistic approach to the measure of health and wellbeing, which this study seeks to capture. By using the biopsychosocial model in the evaluation of the wellbeing of aged Jamaicans, we will begin to understand the factors that are likely to influence the quality of lived years of the elderly, and not be satisfied with the increased length of life of the populace. The rationale behind this study is that it will assist policy-making on health and social services, long term care and pension scheme planning, and will aid in the understanding of future health needs and the evaluation of future health programmes.

CONCLUSION

The discourse on health began centuries ago, but today the issues have a changed focus because of new information, and a modification in epistemology about health. In this discourse some scholarships have used the 'absence of diseases' or dysfunctions as a conceptual definition of health, and in so doing they work substantially to see health from a mechanistic approach. Such an approach treats patient care from a biomedical science standpoint, and the emphasis is on the biology of the organism. The biomedical model as a study of health fails to appreciate that long before any ailments (or dysfunctions) appear within an organism, the socio-physical, cultural and psychological milieu would have had an impact on the quality of that organism. Thus, the use of symptomology as the identification of ill-health, and using the opposite of this to indicate health, is one-dimensional, and fails in its bid to encapsulate all the possible aspects that influence the quality of life, wellbeing, and health of people.

Following the clear limitations with the construct of health from the perspective of the biomedical sciences [model], in 1946 the WHO conceptualized a definition of wellbeing that was composite and far reaching, and one scholar (Crisp, 2005) refers to this as an elusive dream,

which is difficult to operationalize. Although the debate continued for years, George Engel was the first scholar and psychiatrist to map out a conceptual framework for the WHO's new construct for health as a working definition that guides how he approached patient care. Engel, in the 1950s, began using what he called the biopsychosocial model in treating psychiatric patients. He believed that when a patient goes to a doctor, the individual's ailment is a complex apparatus of different tenets, and not merely the outward appearance, which is the identified symptomology. Engel proposed that the medical fraternity should commence approaching patient care from the vantage point of mind, body, and social conditions. Although some scholars and practitioners concurred with Engel's beliefs, and practiced this new model (biopsychosocial), and he (Engel, 1978; 1977a, b; 1960) got Rochester Medical School to institute this approach in the curriculum of medical training, substantially the biomedical approach was widely practiced.

Traditionally, people were socialized to use symptomology to identify ill health and the reverse of this meant 'health', so much so that scientists still continue to research in this tradition. Some scholarships argue that Engel's biopsychosocial model is but an 'abstraction' (or a theoretical construct), and so with the objective realities of patient care, the use of morbidity is still the best indicator of the extent of wellbeing. Gradually, the culturalized tradition of the supremacy of the biomedical model began to be seriously challenged in the 20th century.

A group of authors claim that the United States, in the 20th century, expanded their operational definition of health from the traditional 'absence of diseases' to the biopsychosocial approach argued by Engel (Brannon and Feist, 2007; Engel, 1960). It was not until the 1970s that a scholar, using empirical data, finally provided an econometric model that encapsulates what Engel was arguing some 2 decades before (Grossman). Using data, Grossman (1972) showed that the health status of people in the world is influenced by both biological, and a plethora of other social conditions. He laid the foundation that has shaped the present landscape of social science research on health, wellbeing and quality of life, so much so that a group of scholars have used the advanced quantitative method to model happiness, which was conceptual to measuring wellbeing.

Today Grossman's model with some modifications, is being used by some Caribbean scholars (Bourne, 2007; Hambleton *et al.*, 2005). Using data from Barbados, Hambleton *et al.* (2005) showed that health (proxy physical functioning) is a function of biological, cultural and social conditions. Bourne (2007), using data from Jamaica, expanded on the operational definition of health (or wellbeing) from physical functionality used by Grossman (1972) and Hambleton *et al.* (2005) to that of a composite index which captures physical, functional and

economic wellbeing (material possessions). Bourne's work did not only add to the operational definition of health, but he showed that environmental and psychological conditions in addition to social factors do influence health.

In sum, only a few studies in the Caribbean have sought to expand the narrow definition of health in spite of the WHO's efforts as well as others. The narrow definition of health is still dominant in contemporary Jamaica as well as other Caribbean nations, and this primarily accounts for the image of health that is held by many peoples. It is this narrow definition of health that fashions the health care system, patient care, data collected on health and peoples' image of health, health care and lifestyle practices. This is not only a challenge for public health specialists, but for the general populace as one image of health influences his/her perception of health care, lifestyle and views on preventative health.

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