On Subjective Well-being and Quality of Life

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Abstract

We integrate the multi-disciplinary fields of quality of life (QoL) and well-being (WB) and appraise the impacts of health factors. Theoretical and methodological limitations are discussed and new conceptual and technical advances identified. These are informed by cross-cultural and community perspectives. Following a definitional review, social inequalities, and links with happiness are examined. Demographic, experiential and personal factors are outlined. Implications for poverty research are addressed. As the concept of SWB recently converged with the longstanding international QoL definition (WHOQOL Group, 1995), we discuss the separate need for SWB. Future collaborative conceptual and pragmatic research is recommended.

Keywords

- culture
- definitions
- health
- poverty
- quality of life
- subjective well-being
Here we review literatures that could improve understandings about the relationship between conceptualizations of quality of life (QoL) and well-being (WB). Although health psychology is a departure point, a multi-disciplinary appraisal is essential. Unusually, cross-cultural research informs our analysis. Acknowledging that both QoL and WB are conceptualized as objective and subjective, this distinction is considered with reference to social inequalities and related economic factors. At this subjective level, dimensions of happiness and life satisfaction (LS) are also important. This analysis is juxtaposed by two established frameworks: one on self-determination, and another on human needs. In better understanding the relationship between WB and QoL in health, an aim is to draw out broader implications (e.g. for studying poverty).

Without definitional and conceptual agreement and in the absence of careful operationalization and statistical modelling, it is not yet possible to conclude with any certainty what the universal relationship between QoL and SWB might be. Several possibilities exist. Is QoL synonymous with SWB or with WB in general? Is the QoL concept subordinate to SWB or could SWB be nested within QoL? If QoL is not the same as SWB how much do these concepts differ semantically and conceptually? If they overlap conceptually, then in what ways and to what extent does this occur? Is it appropriate to use them synonymously as so often happens in the literature and in practice? This debate becomes richer when QoL is viewed as a multi-dimensional rather than unidimensional concept, as many contemporary instruments indicate, because it is then necessary to inquire which dimensions are quintessential to each concept and therefore at an operational level, which should be included in their respective measures. The synthesis becomes more challenging when cross-cultural contrasts need to be taken into consideration.

Pioneering work by Diener (1984) located SWB as central to a person’s experience containing measurable positive aspects and involving a global or overall assessment of that person’s life. Cognitive evaluations or appraisals of LS as a whole, and emotional reactions to life events were later integrated into this definition (Diener & Diener, 1995). Others also focused on the affective dimensions but some see SWB as ‘more than the absence of negative affect or cognition’ (Ratzaflf, Matsumoto, Kouznetsova, Raroque, & Ray, 2000: 37). However international experts recently redefined SWB as: ‘An umbrella term for different valuations that people make regarding their lives, the events happening to them, their bodies and minds, and the circumstances in which they live’ (Diener, 2006: 400).

Life satisfaction is also a salient concept. Although Diener sees LS as a component of SWB and therefore subordinate to it, the relationship of LS to QoL is less clear. Sirgy (1998) claims LS is an ‘accepted’ social indicator of QoL and operationalizes it through specific component domains in a structure similar to those proposed for QoL and SWB. However, LS also appears to be subordinate to QoL. Where ‘bottom-up’ or ‘grass roots’ approaches are used to derive appropriate, meaningful items for QoL measures, questions about ‘satisfaction’ are frequently proposed by users (e.g. WHOQOL). However focus groups from different cultures do not frame all evaluations about QoL solely in terms of satisfaction, as the item stems of the WHOQOL-100 show. They also generate questions about capacity, intensity, frequency and importance (Szabo & the WHOQOL Group, 1996). Questions other than about satisfaction are therefore necessary in creating a comprehensive QoL assessment. From the WHOQOL work we deduce that LS is ‘nested’ within overall QoL, and subordinate to the overall concept.

Quality of life has many definitions but in recent years subjective perspectives have largely replaced objective ones like functional status. In a World Health Organization (WHO) project that conceptualized QoL in cross-cultural terms, QoL was defined as:

An individual’s perception of their position in life, in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns. It is a broad ranging concept, affected in a complex way by the person’s physical health, psychological state, level of independence, social relationships, and their relationship to salient features of their environment. (WHOQOL Group, 1995: 1404)

Recommended by users world-wide, a sixth domain on spirituality, religiousness and personal beliefs was later added to these five domains by the WHOQOL Group (1995). Due to its breadth, this definition has received increasing attention outside health care, for example in international development (Skevington and the WeD group, 2008).

A comparison of SWB and QoL definitions generates new observations. The recent redefinition of SWB by Diener (2006) shows considerable similarity to QoL. In acknowledging the centrality of ‘value’...
judgements, by including the ‘circumstances in which they live’, and through specifying ‘bodies and minds’, this draws the new definition of SWB closer than ever to the QoL definition published more than 10 years ago by the WHOQOL Group. As with earlier definitions of SWB, positive and negative feelings are typically included in QoL as a psychological domain. It is therefore important to inquire whether this redefinition has effectively made the concept of SWB redundant as the state of subjectivity it describes appears to be addressed by an existing, accepted international definition of subjective QoL. However, we are not currently able to answer this question fully until new empirical information is gathered. These data would be important in resolving the debate about whether a simple, clear but restricted definition of LS is more satisfactory in operationalization terms than an overarching concept of QoL and SWB.

Another conundrum concerns the consistently poor relationship observed between subjective and objective dimensions across all these concepts. Although SWB and QoL studies established that people give fairly accurate reports of their WB (Diener & Suh, 2000; Sandvik, Diener, & Seidtitz, 1993), the question remains as to why objective proxies for SWB or ‘utility’ like income, correlate so poorly with subjective self-reports. This loose relationship between objective life circumstances and perceived QoL is partially explained by several mediating processes of adaptation or ‘response shift’ (Schwartz & Sprangars, 2000), positive cognitive bias, homeostasis, unrealistic optimism, positive illusions and illusion of control. These foundation stones of positive psychology (Snyder & Lopez, 2002) show promise for detailed understandings of good QoL.

One impediment has been the use of self-report measures per se, because shared methodological problems compromise their use. Self-report is influenced by mood (Diener, Suh, Lucas, & Smith, 1999; Schwartz & Strack, 1999), orientation (Skkade & Kahneman, 1998) and timing (Redelmeier & Kahneman, 1996). Social desirability bias arises from cultural norms, for example humility in East Asia (Diener et al., 1995a), self-aggrandisement in the USA (Diener, Suh, Smith, & Shao, 1995b; Diener et al., 1999; Oishi et al., 1999a). However, these influences seem to affect overall SWB measurement more than their component domain scores, which build a more detailed picture of satisfaction with key life areas (Schwartz & Strack, 1999). Furthermore, cognitive psychologists are still uncertain about exactly how the brain integrates SWB components into overall judgements of WB (Kahneman, 2005). We know even less about this process in relation to QoL domains.

A greater challenge to SWB research is cross-cultural applicability. Christopher (1999) and Kitayama and Marcus (2000) argue that SWB cannot be studied cross-culturally as its definitions are culturally rooted in ‘moral visions’. They say that SWB is less relevant to collectivist societies (e.g. Japan) who use group or social judgements, than individualistic societies (e.g. the USA). Features distinguishing these cultural extremes are self-definition, goal structure, greater emphasis on norms than attitudes and on relatedness as opposed to rationality (Triandis, 1996). However this argument is not generally accepted. International investigations continue to show more complex differences in the way SWB judgements are constructed. For example, self-esteem and self-consistency correlate more strongly with LS in individualist than collectivist societies (Diener & Diener, 1995; Suh, 2000). Satisfaction with freedom is less predictive of SWB in collectivist societies, and individualists are more likely to use emotions than norms to judge LS (Suh, Diener, Oishi, & Triandis, 1998). These national differences are paralleled among ethnic groups in the USA (Diener & Suh, 1999), and are not attributed to shortcomings in equivalence between language translations (Ouweneel & Veenhoven, 1991).

Some problems in studying SWB can be attenuated by supplementing self-report with ostensibly less subjective methods like ‘experience sampling’ (Kahneman, 1999, 2000), memories of positive or
negative events (Sandvik et al., 1993), ‘objective’ peer reports or diary records. SWB researchers might draw on mixed-methods techniques like cognitive debriefing, which are useful in QoL research to understand meanings better, and could be helpful in implementing studies in rapidly changing societies, or where ongoing interventions destabilize reporting.

However this lack of correlation between subjective and objective well-being (OWB) does not mean that subjective measures are less reliable, as is conventionally assumed. The two are better conceptualized as separate thermometers measuring different processes in the same body, but in related ways. Even if SWB was a distorted perception of reality (as implied in describing discrepancies between SWB and OWB as ‘false consciousness’) it is still an inherently valuable perspective as it improves understanding of how informants perceive and report their world, irrespective of their reasoning (Clark, 2000, pp. 45–48). The reality–illusory dichotomy which is a tenet of Marxist theory has damaged progress because it constrains creative thought (Weatherell, 1999) and impedes the development of new pragmatic solutions through inhibiting direct exploration of the subjective. However, this distrust of the subjective is by no means limited to Marxism.

**Social inequalities in health, economics and well-being**

Health and income are key to understanding the relationship between OWB and SWB and relevant to poverty. Social, psychological and material deficiencies experienced by the poor contribute to explanations of diversity in health status nationally and globally (Marmot & Wilkinson, 1999). A corpus of epidemiological research testifies to a direct relationship between morbidity and mortality with income, and shows how the inequitable availability of material resources within and between societies affects and is affected by health status (Davey-Smith, Gunnell, & Ben Schlomo, 2001; Gwatkin, 2001; Wilkinson, 1996). Poorer groups experience more disability, infectious diseases, chronic illnesses and a shorter life directly resulting from inadequate housing and nutrition, hazardous work environments and problematic lifestyle habits such as smoking (Leon & Walt, 2001; Marmot & Wilkinson, 1999). Furthermore chronic illness and disability related to the major global diseases of heart disease (30% global mortality), diarrhoea, malaria, TB, HIV (WHO, 2001), can seriously damage QoL. Ageing studies indicate this may be cumulative across the lifespan, particularly where illness persists, progresses or is terminal. However the ‘burden of disease’ approach where indicators of morbidity, mortality, income and life-expectancy drive health policy decisions (Murray, Frenk, & Gakidou, 2001), has yet to incorporate a culture-sensitive measure of subjective QoL, and this is overdue (Fox-Rushby, 2002).

Not only do poorer sectors of society have poorer health, they also have less access to the range of quality resources that generate and sustain good health. Where health care is freely available, poorer people who need it most should be its heaviest users. Sen (1990) compared SWB in countries with a similar Gross National Product and showed how income per capita and human capabilities assessed by objective social indicators sometimes diverge. He attributes this to the relative standards of different welfare systems (Sen, 2001). However annual evidence from UN-affiliated organizations shows that even where care is free at the point of use, it is still not delivered to the sectors with the greatest need. Where users pay as they use health services (e.g. India, the USA), the inequalities gradient is steeper, and the poor become further disadvantaged by the system. Furthermore while some economies with high economic growth (e.g. South Korean, Taiwan), have successfully increased both life years and quality, others with similar growth rates such as Brazil, have neither lengthened life, nor improved QoL. Paradoxically Sri Lanka has improved mortality rates and QoL, but has little economic growth (Sen, 2001). These relationships persist even when duration of growth, baseline mortality and inequality are accounted for. Consequently including psychological factors of WB within a behavioural health economics framework (Kahneman, 1999) could provide greater explanatory power by adding variables not formerly of interest to economists, for example competence (Easaw & Ghoshrav, 2004).

**Happiness, QOL and SWB**

While there is considerable research on general QoL and health-related QoL, the relationship of these to happiness remains opaque. Happiness is seen as synonymous with SWB (Ratzlaff et al., 2000), and is used interchangeably with QoL in the UK (Skevington, MacArthur, & Somerset, 1997) and Australia (Herrman, personal communication) but establishing the universality of these findings is
more problematic. Happiness has been defined many times, usually as positive affect (e.g. Layard, 2005), but it can also mean general positive mood, a global evaluation of LS, living a ‘good’ life or the causes of happiness (Diener, 2006). Diener’s definition subsumes LS within happiness, as a subordinate component, implying that happiness is akin to well-being.

These issues are particularly evident in poverty. Considering the material obstacles that may prevent poor people from sustaining what is perceived to be a good QoL, it seems almost frivolous to mention happiness. However independent bodies of work by Diener, and Veenhoven lead to the conclusion that happiness is equally important in all societies, irrespective of differences in wealth or culture. Also Suh et al. (1998) found that happiness was of universal importance, and that only 1 per cent had never considered it. Cross-cultural investigations of subjective QoL in 15 countries world-wide confirm that although happiness is universally important, it only constitutes one important dimension out of 24 that make up the global concept of QoL (WHOQOL Group, 1995). So while happiness undoubtedly has universal currency, the paramount position accorded to it may have been overstated.

Since Aristotle, happiness has been seen as a universal goal that is appropriate and attainable. Yet in USA—arguably the most privileged society in the world—greater material prosperity has not matched rising levels of happiness over the same period, so the number of people describing themselves as happy remained relatively constant. Paradoxically, increasing US divorce and suicide rates provide recognized indices of societal unhappiness. Diener and Diener (1996) noted that individualist nations reported higher LS alongside higher suicide rates, possibly due to greater personal helplessness. Schwartz (2000) connects disparities between overwhelming levels of choice and unrealistic perceptions of environmental control to recent explosive growth in the US incidence of depression.

Perhaps this disjunction arises from defining happiness in purely hedonic and idiosyncratic terms, which may be a mistranslation of Aristotle’s original ‘eudaimonia’. In its fullest sense, eudaimonism integrates actualized potential, or recognizing and realizing one’s true nature or self, into WB. It embodies a life worth having/desiring with intense qualities of harmony, fulfilment and engagement (Waterman, 1993). At this point it shares commonalities with QoL. However SWB includes not just affect but also LS with meaning. This brings it closer both to the concept of QoL, and the eudaimonic definitions of happiness proposed by and Ryan and Deci (2001) and Ryff and Singer (1998). They point out that psychological WB—a normative measurement comprising positive mental health and absence of distress—is as important as SWB, and that the two correlate only moderately (Compton, Smith, Cornish, & Qualls, 1996; McGregor & Little, 1998). It is unclear how distinctive these two concepts are and whether they are tautological. Ryan and Deci (2000) use this definition as the basis of their self-determination theory (SDT) of psychological need, seeing autonomy, competence and relatedness as essential to needs fulfilment and psychological growth. Here WB is more closely associated with pursuing intrinsic goals, like close relationships, personal growth and bettering the community, than extrinsic goals, like wealth and materialism. Attributing positive events to internal or personal factors also enhances WB.

This eudaimonic orientation and autonomy drawn from SDT provide a conceptual bridge to Doyal and Gough’s (1991) Theory of Human Need (THN). Here autonomy is one of two basic universal needs, co-equal with health. Both theories share a deductive, universalist approach. Drawn from social policy and Maslow’s theory of need satisfaction, the THN has received less attention and field-testing in psychological research compared to SDT; both are central to this debate about QoL. While the universality of QoL is supported globally (Skevington, Sartorius, Amir, & the WHOQOL Group, 2004), there is limited support for universality in the other two theories. Unpublished reports from Venezuela and Hong Kong support the THN, and national data from Bulgaria (Deci et al., 2001), Japan (Hayamizu, 1997) and Russia (Chirkov & Ryan, 2001) support SDT. Although not included in the original WHOQOL, autonomy was confirmed as important to QoL in older adults (23 countries) (WHOQOL-Old Group, 2005).

Of additional theoretical interest are changes relating to goals that affect SWB. Goals are central to the way people conceptualize their QoL (see WHO definition on first page). They are embedded in the THN where need satisfaction can be equated to goal achievement (Doyal & Gough, 1991). In SDT, SWB is explained by the progress made towards salient life goals (Cantor & Sanderson, 1999; Carver & Scheier, 1999; Diener, Sapyta, & Suh, 1998; McGregor & Little, 1998; Oishi et al.,
1999b) and is important cross-culturally (Ryan et al., 1999). However, these goals need to be intrinsic, attractive and approachable, not extrinsic, unattractive and avoidant (Elliot & Sheldon, 1997). They should be optimally challenging (Csikszentmihalyi & Csikszentmihalyi, 1988), pursued autonomously (Ryan & Deci, 2000) and with reasonable expectation of success (Emmons, 1996). However while need satisfaction for autonomy, competence and relatedness (Reis, Sheldon, Gable, Roscoe, & Ryan, 2000; Ryan & Deci, 2000) are important globally, the weight given to them may differ culturally. In some collectivist societies, autonomy correlates poorly with SWB but relatedness is important to collectivists and individualists (Oishi, 2000; Oishi & Diener, 2001; Oishi, Schimmack, Diener, & Suh, 1998).

Demographic, experiential and personal factors

Here we review demographic, experiential and personal factors relating to SWB and QoL. Most research was completed in Europe and North America but stars (*) indicate where developing countries are included. Personal income is important to SWB but shows a curvilinear relationship. Diener, Sandvik, Seidtlnz and Diener (1993*) observed a steep reduction in SWB when annual household income fell below US$10,000. This may be due to income’s positive relationship with other external resources, and internal resources like personal control (Lussier et al., 1997), self-esteem (Carpenter, 1997; Tran, Wright, & Chatters, 1991) and optimism (Eckelersley, 1997). Furthermore, income can protect people from situations that might compromise their homeostasis (Ahuvia & Friedman, 1998), so that a buffering mechanism maintains SWB at a level of 75 per cent or higher (Cummins & Nistico, 2002). This psychological homeostasis is akin to the human body’s temperature regulation mechanism. However, once ‘subsistence’ level was exceeded, increases in income did not coincide with improved SWB (Biswas-Diener & Diener, 2001*; Cummins, 2000; Diener et al., 1993*), possibly due to adaptation. On the contrary, SWB can be reduced, as higher income is associated with more divorce (Clydesdale, 1997), and reduced pleasure in small activities (Kahneman, 1999; Parducci, 1995).

Furthermore income is not the only factor, as financial needs are important. People who strongly desire wealth are more unhappy than others (Kasser, 2002*). In SDT terms, this is due to an extrinsic, less healthy goal. The limited role of personal income is evidenced in a study of Calcutta slum dwellers who despite their poverty, reported high satisfaction across all domains:

In the case of Calcutta, much of our attention remains focused on the image of poverty and its related ills. However, broader examination reveals a richer picture with positive life aspects. The participants in this study do not report the kind of suffering we expect. Rather they believe that they are good (moral) people, they often are religious […]; they have satisfactory social lives and enjoy their food. […]. So the complete picture requires not just a focus on the deficits of poverty and poor health but includes the positive aspects of the respondents’ lives. (Biswas-Diener & Diener, 2001, pp. 347–348)

Biswas-Diener et al. (2001*) attributed this to a ‘focusing illusion’ whereby people ‘judge the standards of the lives of others based on a few focal attributes, such as a personal deficit or material wealth’ (Schkade & Kahneman, 1998).

Studies show that national wealth has greater influence on SWB than personal income (Veenhoven, 1991*; Diener & Diener, 1995*; Diener & Suh, 1999*), but even here there are diminishing returns. Not all poor countries report low SWB (Diener & Suh, 2000*), suggesting that culture mediates. Using Maslow (1954), Inglehardt & Klingemann (2000*) and Veenhoven (1991*) indicate that once basic needs are met, people move to a post-materialist phase, focusing on self-fulfilment. Studies of low income populations (Mercier, Peladeau, & Tempier, 1998), and students in 31 countries (Diener & Diener, 1995*) support this view. Political and personal freedoms in poor countries are not related to SWB in the same way as richer nations (Veenhoven, 2000*), so any satisfactory solution must account for these complexities.

Annual data on international inequalities show that not all those living in poor countries are poor (and vice versa) so assumptions that poorer nations focus on basic, physical needs, and richer ones on complex, cerebral ones are over-simplified (Clark, 2002). Where inequality decreases (national income distribution), average SWB tends to increase (Hagerty, 2000). Assessing inequalities may be more important to health psychology than baseline measures like standard of living, and links back to Runciman’s work on relative deprivation. Furthermore although political freedom and participation influence SWB in richer countries (Diener et al., 1995a; Frey & Stutzer
2002), they affect poorer nations too (Moller, 1995*, 1996). At individual levels, civil participation and social trust are strongly linked with subjective health (Poortinger, 2006). Political instability dramatically reduces SWB (Inglehardt & Klingemann, 2000*). This deserves further investigation.

As a consequence of focusing on individual stressful life events, psychologists have been slow to study the impact of major environmental disasters, such as famine or tsunami, on community SWB. Such events can affect the nation’s development and economy, and exacerbate poverty where few surplus resources exist to buffer deleterious effects. Furthermore while responses to stressful events can have a major, prolonged impact on SWB, for example bereavement (Stroebe & Stroebe, 1996), adaptation to other events is swift (Cummins & Nisticò, 2002; Suh, Diener, & Fujita, 1996*; Winter, 1999). Adaptation to poor QoL is partly explained by the ‘response shift’ model (Schwartz & Sprangers, 1999, 2000; Schwartz et al., 2006).

Community studies of SWB provide a broader context. Inequality from socio-economic deprivation negatively affects people’s environmental QoL (Drukker, Ferou, & van Os, 2004). Related to socioeconomic status, neighbourhood status has an impact on SWB (Drukker, Gunther, & van Os, 2007), being associated with subjective health, even after adjustment for age, gender and ethnicity (Wen, Hawkley, & Cacioppo, 2006). As this is only partly explained by individual factors like loneliness, hostility and stress, we conclude that community factors should also be addressed to understand health, WB and QoL better.

Resources from social capital and social cohesion have formed a focus of recent investigations (Berger-Schmitt, 2002). Social capital is ‘The set of cooperative relationships between social actors that facilitate collective action’ (Requena, 2003: 331). However it represents more than social relationships alone, so definitions are contentious (Navarro, 2002). In a survey of 173,236 US adults, social capital level made 11 per cent difference to the odds of self-rated health (Kim & Kawachi, 2007). More social capital was associated with fewer problems (days), physical and mental activities. Age, ethnicity and state income predicted its relationship with QoL. Low social capital has also been linked with poor social QoL in older adults living in rural Bangladesh (Nilsson, Rana, & Kabir, 2005); higher age and poor household economic status were factors. Therefore it is possible that income inequalities and health-related QoL are mediated by social capital. This implies that where social capital could be promoted in communities, health and QoL may improve.

Socio-demographic studies show that gender (Cummins, 1995) and age (Carstensen, 1998; Diener & Lucas, 2000; Mroczek & Kolarz, 1998) are indirectly related to SWB. However the pattern is more complex in Europe and North America where age correlates positively with LS, despite declines in physical health (Okun & Stock, 1984). This disjunction demonstrates the importance of obtaining information about subjective meanings of physical change, instead of assuming their relationship with WB. Education has limited effect, and its link with income could be confounding (Judge & Locke, 1993; Tran et al., 1991).

Heredity accounts for half the variance in SWB expression (DeNeve, 1999; Newman et al., 1998). Extraversion correlates positively with SWB (DeNeve & Cooper, 1998*) cross-culturally (Lucas, Diener, Grob, Suh, & Shao, 2000*). Personality explains SWB stability (Magnus, Diener, Fujita, & Payot, 1993), and because LS is stable (Schimmack, Diener, & Oishi, 2002), could account for the stability of QoL.

**Conclusion**

We considered the relationship between SWB and QoL through definitions of concepts. Initially we observed that the SWB field showed more theoretical progress than methodological development when compared with QoL, where the reverse seemed true. However, closer scrutiny showed that the new definition of SWB derived by an expert panel now displays high convergence with an international definition of QoL (WHOQOL Group, 1995). The revised definition of SWB embraces values and life circumstances that are also embedded within the WHOQOL definition which was agreed a decade ahead of the SWB guidelines (Diener, 2006). Earlier assumptions about the paucity of conceptual work in QoL research are therefore mistaken. On the basis of available evidence drawn from cross-cultural research, we suggest that SWB and subjective QoL are virtually synonymous with each other, and question whether SWB may now be superfluous to definitional requirements. In addition, cross-cultural evidence showed that SWB and QoL contained a substantial component of LS but this was insufficient to explain either. This research
imply that LS is a subordinate component in SWB and QoL. While patient satisfaction is a useful outcome indicator in certain situations (e.g. treatment response), this limited concept might be better replaced by a comprehensive QoL assessment (US Food & Drugs Administration, NICE). In resolving some conceptual opaqueness, this could ease practice for health professionals, as high performance QoL measures are readily available for use in many settings and populations. However we recognize that future research may show that all these concepts (and their associated measures) may still have pragmatic value in specified contexts within and beyond health care. Consequently continued research collaboration between these fields is desirable.

In distinguishing between ‘objective’ and subjective factors in WB and QoL we conclude that increased material resources do not directly lead to improvements in SWB, despite continued interest by policy-makers (Layard, 2005). Furthermore, where inequalities exist, this damages QoL as expected, and furthermore, inequality provides a more useful explanatory variable for health and WB than standard baseline indices (e.g. wealth). Consequently, researchers may seek to revisit relative deprivation within this context. Furthermore we saw how social capital acts as a buffer to poor QoL and SWB in poorer communities, although social relationships in QoL have only been partly assessed. Despite the individual focus we also note that QoL assessment might add a new dimension to understanding social cohesion, for example through interventions to improve social capital in deprived circumstances. This growing area demonstrates the importance of obtaining community, as well as individual assessments, because they tap into different but complementary levels of experience to provide a comprehensive perspective. While demographic, experiential and personality factors will still need to be accounted for, given their demonstrable value to cross-cultural research, a multilevel approach in this ‘post-disciplinary’ area seems likely to be the most productive way forward.

Note

1. The authors differ on this point.

References


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