QUALITY OF LIFE, HEALTH AND HAPPINESS
Quality of Life, Health and Happiness

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Preface

The basic work for this book was carried out during the spring of 1989 in Edinburgh, where I had been granted a research position at The Institute for Advanced Studies in the Humanities. I should like to express here my indebtedness to the Institute for the opportunity thus afforded me. I should also like to say how very grateful I am for the stimulating conversations I had there with Professor Timothy Sprigge and Dr Elizabeth Telfer. Dr Telfer's own treatise *Happiness* (1980) has been a major influence on my view of the questions involved.


As in the case of my previous larger projects, I have received a great amount of support and many wise comments from Professor Ingmar Pörn, Helsinki. Three Danish experts - Anton Aggernaes, Erik Ostenfeld and Peter Sandøe - have made valuable comments. Professor Henk ten Have, Nijmegen, has improved my reading of the the philosophy of Jeremy Bentham. I should also like to thank my colleagues at the Department of Health and Society, University of Linköping, for helping me to avoid a number of the pitfalls that one can so easily stumble into when it comes to a treatise like this. Especially I should like to mention Per-Erik Liss, Ingemar Nordin and Bo Petersson, all three of whom have read and commented on the entire manuscript.

A Swedish version of this book, *Livskvalitet och hälsa*, came out in 1991. I have here made quite a number of corrections and additions, one type of addition being replies to critical points made in reviews of the Swedish version.

I should like to thank Malcolm Forbes for valuable help in putting my English into publishable condition.

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Lennart Nordenfelt
Part I

On quality of life and happiness
Introduction

Quality of life is a popular modern subject. The contexts where the term “quality of life” occurs are today frequent. We can observe the term in newspapers and in TV-commercials. It is then often used as an argument for buying a certain product. The commercial claims that the product will raise one's quality of life, a fact which is supposed to be the strongest motive to purchase the product.

Quality of life as a concept is now also common in many serious discourses. To these belong the discourses of social care and medical care. Quality of life is then quite often described as the goal of the professional activities, a goal which is described as being equally as important as the more objective-sounding welfare and health.

But if quality of life is used in these serious contexts, then the dimension of quality of life must be able to be determined and even measured. Personnel from social care, medical care and their politicians need help to become oriented in this new world. They need to know what quality of life in fact is and they need instruments to be able to describe and measure this new dimension. There is a need for specialists on quality of life. A new category of technicians and scientists is required. Theorists of quality of life as well as technicians of quality of life can enter the arena.

So far just a very rough sketch of the subject which I wish to contribute to in this book. There is now reason to ask a number of questions. Who are the experts on this subject? What are its scientific foundations and how could it genuinely help the personnel in health care and social care as well as the decision-makers of health care and social policy? Is it possible to define the concept of quality of life? Can one in any sense measure the quality of life of single individuals or of collectives of people? Is it reasonable that quality of life should obtain the status of being the major goal of health care and social care?

Here are some tremendously big and difficult questions that this book
attempts to treat. The first question, which concerns the very meaning of quality of life, will have a central position in this book. The other questions will be touched upon a number of times but they will not have the same prominent place.

In contrast to many other texts in this area my book will have a philosophical foundation. My sources and my methods will to a great extent be philosophical. I shall collect inspiration from two classical authors dealing with quality of life and happiness. These are Aristotle from the 4th century B.C. and the Englishman Jeremy Bentham from the 18th century. I wish to indicate that the question about the nature of quality of life is as old as human thinking itself. I also wish to indicate that many important conclusions have been drawn long before the time of quality-of-life questionnaires.

There is now a rich literature about quality of life which has a focus that is quite different from the one in this book. First, there is a big psychological and sociological literature. In this literature there is some discussion of the concept of quality of life, but the authors here mostly have a rather practical end in mind, viz. the construction of instruments for the judgment and measurement of quality of life in certain concrete contexts. The medical literature, which has concentrated on the measurement of quality of life in connection with medical intervention, has for natural reasons been even more geared to the construction of instruments. (For an overview of the most important instruments, see McDowell and Newell 1987.) The same holds for the discussions of those health economists who attempt to guide the allocation of economic resources to various sectors of health care.

All these contributions are valuable and in many ways necessary. I have also tried to give an account of some major results of a few of these contributions, in particular in the second part of this book, where I concentrate on quality of life in the medical context. I shall not, however, myself contribute to the technical development of these instruments. My book is therefore not a manual for the measurement of quality of life. For this purpose there are other and more concise texts. Some of these are referred to in my bibliography.

However, there may be a need for a book of this kind also for the person who is involved in practical measurement of quality of life. All measurement requires conceptual clarity. A measurement, however technically sophisticated, can never compensate for unclarity or incompleteness in the conceptual analysis on which it is based. Therefore, the practitioners of measurement of quality of life must, in order to
become credible, seriously consider certain theoretical objections, in particular such as that concerning the question of validity, i.e. the question concerning what is actually measured by their instruments.
This study has two main purposes. First, it attempts to give a theory of quality of life in general. Second, it aims at applying this theory to a medical context. In particular, I wish to point out some conclusions which follow from this theory concerning the contents of so-called “quality-of-life instruments” in the medical setting.

The concept of quality of life to be proposed in this study is a subjective one, in fact identified with the dimension of happiness-unhappiness with life. My basic idea about the nature of happiness can be formulated in the following way. A person P is happy with life, if and only if P wants his or her conditions in life to be as they are. P can be more or less happy with life according to the degree of agreement between the state of the world — as P sees it — and his or her wants. P can be completely happy with life, if P's conditions in life are exactly as P wants them to be. Similarly, P may be completely unhappy with life, if nothing in life is at all as P wants it to be.

These theses constitute the framework of my want-equilibrium theory of happiness. The theory is developed in some detail, whereby a number of concepts and distinctions are introduced. Particular attention is paid to the distinctions between (i) happiness with life and happiness with a fact, (ii) happiness and pleasure, and (iii) being happy and feeling happy. The theory also considers the fact that a person's wants are ranked according to priority. P's want for x may have higher priority to P than his or her want for y. The theory involves an attempt to explicate the relation between the satisfaction of wants of varying priority and happiness.

The want-equilibrium theory is only a part of my theory of happiness. There is a further dimension to happiness, viz. what I call richness of happiness. Want-equilibrium takes care only of the relation between wants and satisfied wants. The richness dimension also deals with the number and nature of the wants. A person P may be happier than Q along the richness dimension because P has a greater number of wants (or more
ambitious wants) which are satisfied than Q has.

Finally, in the theoretical part of the study, the combined want-equilibrium and richness theory of happiness is put to the test through a number of forceful counterarguments.

The second part of the study involves an attempt to apply the proposed theory of happiness to the medical context. As a starting-point I give a condensed presentation of my (elsewhere elaborated) theory of health. According to this theory there is an analytical relation between health and happiness. The most concise way of describing this relation is the following: P is healthy, if and only if, given standard circumstances, P has the ability to realize his or her vital goals. P's vital goals constitute the set of those states of affairs which are necessary and together sufficient for P's minimal happiness. Thus there is a logical relation between the concepts of health and happiness. Health is, however, clearly distinct from happiness. Health is compatible with unhappiness for at least two reasons. (i) P may be healthy but non-standard harsh circumstances may obtain. Thus P cannot realize his or her minimal happiness. (ii) P may be healthy but still abstain from trying to realise his or her vital goals. Thus P may not reach his or her minimal happiness.

Conversely, non-health or illness is compatible with more than minimal happiness. This is the case when P's vital goals are realised without P's bringing it about unassisted. Some of P's nearest and dearest may have helped, either by creating very favourable circumstances, thereby enabling P to realise the goals, or by directly acting so that the goals are realised.

As a second step I introduce the concept of _subjective health_. The notion of subjective health and illness is frequently referred to, and sometimes equated with the notion of quality of life, in the medical literature. My own position is that the two notions should _not_ be equated. There are at least two reasonable senses of subjective health which are quite clearly distinct from quality of life in the sense of happiness. According to sense (i) P is subjectively healthy, if and only if P _believes_ (or knows) that he or she is healthy in the basic sense, whilst according to sense (ii) P is subjectively healthy, if and only if P is in one or more of a specified set of mental states (other than pure cognition) which are associated with health. Roughly, this means that P is subjectively healthy if P _feels_ fit or if P _feels_ strong.

Senses (i) and (ii) of subjective health normally go together but they need not. A child, for instance, may feel fit without believing that it is healthy, because it does not yet grasp the concept of health.
The presented theories of happiness, health and subjective health give us, I believe, tools which are sufficient for analysing some current devices for measuring health-profiles and quality of life in medical contexts. I consider four types of such devices. The first, the Nottingham Health Profile (NHP), is a questionnaire used mainly for measuring degrees of somatic illness. The second, the Kajandi-instrument (KI), has much broader ambitions and tries to analyse quality of life in general, mainly in a psychiatric context. The third kind of instrument is based on the idea of universal human needs. To realise a high degree of quality of life is, according to this type of theory, tantamount to satisfying the basic human needs. The particular theory which is discussed here was constructed by the Danish psychiatrist Anton Aggernaes. The fourth kind of instrument stems from health-economic analyses. This type of instrument is based on the supposition that a particular utility-value can be ascribed to every kind of health state. Given this value and the period of time during which the health state persists, it is possible, according to the advocates of this instrument, to calculate the number of so-called qalys that the subject in question can expect to gain.

The main conclusions regarding these critical studies are the following. The NHP mainly focuses on features of illness and subjective illness in sense (ii) but also introduces certain quality of life features. The NHP thus is a mixed instrument. Its weakness, however, is that it only very partially covers these areas. This holds, in particular, for the quality of life area.

The KI, on the other hand, does not measure health, either in the basic or in the subjective sense. According to my analysis it does two things: (i) it attempts to characterize parts of the happiness-dimension, but also (ii) parts of an objective welfare-dimension. The explanation of this is that the KI-instrument is based on a conception of quality of life which also covers other areas of human welfare than subjective happiness. This "mixed" concept of quality of life is criticised from the point of view of the want-equilibrium theory of happiness proposed in this study.

My critical remarks concerning the need-theories in general and Aggernaes' theory in particular can be summarised in the following way. I find these theories to be insufficient tools for the analysis of the notion of quality of life. Human beings have more goals than what can be sensibly called needs. Human happiness is, I would claim, dependent on the satisfaction of all kinds of goals, not only on the satisfaction of the basic needs described in current psychological theory.
My discussion of the qaly theory is concentrated on the version advocated by the so-called York school of health economics. This theory is based on a particular scale for measuring health-related quality of life, the Distress-Disability Index. This index has its merits and particular complications which are discussed. Particular attention is given to the idea of numerically evaluating the steps in the index. The basis for this evaluation appears to be particularly weak. I try to illustrate that there are serious dangers in applying such a numerical index outside the area of macro-economic calculations.
1 Towards a characterisation of the area

Let me start by sketching some very different life-situations:

Consider, firstly, a young boy who lives in the slums of Sao Paolo. His conditions are very poor. He lives with his parents and several brothers and sisters in a small shed. He does not get the food he needs. His days, however, are full of activities. He has many friends with whom he struggles to improve conditions and to find useful things to do.

Consider, secondly, a man who is a famous scientist. This man is in a prestigious situation but has a life which is full of work and responsibilities. He travels around the globe; he is well received and admired. Such a life-style makes his living rather hectic and results in his family being neglected and his health threatened.

Consider, thirdly, a very particular person, viz. Mother Teresa. This Catholic nun, the founder of the order Missionaries of Charity, has for more than 60 years lived in the slums of Calcutta among the sickest and most rejected of people. She lives herself in a very simple way and in self-chosen poverty. She continuously encounters deep injustice and misery. Her work is not always much appreciated, at least not by the authorities, but all the time she is deeply convinced that she works for good.

Consider, fourthly, a dying elderly woman, a person who does not have many weeks left to live. But she knows and accepts that she has lived a long, active and successful life. She has a big family and she is now pleased to have them with her all the time. She is well treated and she lives her last days without pain and anguish.

What is the quality of life of these persons? Is it good or poor? Is it very different in these individual cases? How do we justify such judgments? Questions such as these seem to every reasonable person vague and open, if not unanswerable. Do they have a precise meaning, and what purpose can one serve by attempting to answer them?

Interestingly enough, and in spite of such difficulties, these questions
are nowadays often raised, and in a variety of contexts. They are raised by politicians but also by scholars from a multitude of disciplines. Within social science over the past 20 years, a whole branch of research called quality of life research has developed. This research has been pursued in such disciplines as sociology, psychology, anthropology, social medicine and nursing. What has prompted this evolution and what has been the purpose of this kind of research? Part of the answer is that there has been a political demand for research into quality of life. The politicians in the rich world have wanted to know about the results of their efforts to create social welfare. They have asked questions such as: What has happened to the populations who have been the objects of our social experiments? What has happened apart from the establishment of schools, hospitals, children's homes, sports arenas and bingo halls? Has the quality of people's lives been raised at all proportionally to these developments?

It has been claimed that the phrase "quality of life" entered upon its present meteoric career during the 1964 presidential campaign in the U.S. No less a person than Lyndon B. Johnson, in a speech at Madison Square Garden, characterised his political goals in the following way:

> These goals cannot be measured by the size of our bank balance. They can only be measured in the quality of the lives that our people lead. (Rescher 1972 p. 65)

The social scientists of the world faced a gigantic task: to define concepts such as welfare and quality of life and at the same time find instruments to characterize and measure these phenomena.

But not only social science has become affected by this trend. Quality of life has become an issue also within medicine and health-care in general. Several factors have contributed to this development. A particularly important one is the technological progress within medicine. It is now technically possible to save or at least to prolong many lives which would previously have immediately terminated. In some cases it has even become possible to achieve a complete restoration to health; in others the therapy has led to a considerable prolongation of life, but the life achieved is one with complications, perhaps a great degree of pain and disability. These cases have prompted the following questions: What value does simple prolongation of life have? Should we opt for prolongation in a case where the quality of life for the person concerned will be very poor?

Within medicine and nursing as well as within the philosophy of
medicine, there is a further discussion which has stimulated an interest in concepts such as "quality of life". I have in mind the continuous critique of the so-called machine-model of a human being. This is the model which is supposed to form the basis of much scientific medicine in its concentration on the human being as a biological mechanism, and its lack of interest in the human being as a social agent. Really effective and humane medicine, the critic emphasises, must understand and care about a person as an integrated, feeling and active being. It is the quality of such an integrated person's life that we should care about, not primarily the person as a biological organism.

Such discussions have had some effect. There is now in medicine an extensive literature dealing with quality-of-life issues. The main bulk of this literature, though, is devoted to rather specific areas of medicine and health care. In some of the clinical specialities, such as cancer care, cardiovascular care and psychiatric care, attempts have been made, at least partially, to define therapeutic success in terms of the patient's quality of life. For this purpose a number of instruments or scales mainly of a questionnaire type have been devised. Some of these scales have been frequently used and are known under such names as: the Nottingham Health Profile, the Sickness Impact Profile and the McGill Pain Questionnaire. (For an overview, see McDowell and Newell 1987.)

In most of the questionnaires which have been used to arrive at a score on these scales, the focus is on quality-of-life consequences of particular diseases/disorders or particular categories of diseases/disorders. Almost all of them, however, contain very broad questions concerning the patient's wellbeing and welfare in general. Thus in the Nottingham Health Profile the patient is, for instance, asked if worries tend to produce insomnia or if he or she finds life worth living. A Swedish questionnaire, used by a group of researchers at Uppsala University Hospital, asks about the patient's self-confidence and self-acceptance as well as if he or she is, in general, happy with life.

The purpose here is often quite laudable. The quality-of-life questionnaires reflect a serious attempt on behalf of the medical or nursing establishment to assess what medical care in fact does to us, apart from mechanically or chemically affecting the body. It strikes, however, a humanist, particularly perhaps a humanist who takes an interest in conceptual issues, that there is something woolly and potentially dangerous going on here. What is actually measured by these questionnaires? What is the meaning of the phrase "quality of life" in these contexts? To what extent are the social and medical scientists
studying the same kind of phenomenon? Let me illustrate what I mean by returning to the examples in my introduction and ask: What are the principal difficulties in trying to assess these people's quality of life?

First, we have of course the trivial fact that the pictures are so far only fragmentary and partial. We must know much more about the people involved. Our image of the young Brazilian's life would be quite different had we known that he had just entered on a prestigious education in Rio de Janeiro. Our picture of the scientist's life would be very different had we known that he had just fallen terminally ill. Likewise would our image of the lives of Mother Teresa and the dying elderly woman be very different, were we to know that some of their loved-ones had been imprisoned for some serious crime. But the theoretically more important answer is that we are not at all clear about the question: What is the "quality of life" of these people? The phrase is semantically so general that it allows of a multitude of different interpretations. Without qualification it includes the following: What is the moral quality of X's life? What are its intellectually interesting qualities? What religious qualities does it have? What is its degree of happiness or wellbeing?

I think that there is a point in noticing this potential multiplicity of meaning, while at the same time admitting that most quality-of-life assessors implicitly have had something more specific in mind. The point is precisely that what they have in mind is almost always implicit, and has therefore not been given a thorough treatment.

The more specific interpretation that most researchers in the field appear to have had in mind can in a preliminary way be covered by the concept of welfare. Terms often employed are "welfare" itself, "wellbeing", "subjective health", "harmony", "security", "satisfaction" and "happiness". Although this delimits the issue considerably, it immediately calls for further clarification. Particularly crucial questions which arise are: (1) Are we only to consider welfare in relation to the subject under scrutiny, i.e. are we only investigating the subject's so-called subjective welfare, or are we also trying to study his or her welfare in some objective sense? (2) Who is making the normative evaluations of a particular person's welfare? Is it the assessor or is it the subject?

In many current psychological and sociological discussions it has been claimed that an adequate measurement of a person's quality of life must contain both so-called objective and subjective parameters. Among objective parameters are included such things as the person's somatic health-status, his or her economic situation, housing conditions, and occupational and family situation. Among the person's subjective
properties are included *his or her experiences* of the external situation, as well as his or her more general moods and emotional states.

The theoretically important question is however: why is it important to include both objective and subjective factors? Is it because we want to measure two different kinds of things, the objective and subjective welfare? Or is it because we want to measure one kind of thing — say, the subjective welfare — and need different types of data to measure it?

One might, for instance, argue that subjective welfare is difficult to get access to and hard to describe and assess. Not only is it difficult for an external assessor to get access to it; even the subject, although having privileged access to his or her own subjective welfare, can find it hard to give a balanced evaluation of it. Therefore in a particular assessment of a person's quality of life a considerable amount of data from various sources may be required. Certain data about the person's objective situation may be needed to correct and qualify some of the person's own statements about his or her subjective welfare.

In a case like this there is a *methodological* motivation for including the objective data. The ultimate purpose of the assessment is not to collect and describe these. The objective data are wanted as one of our means for judging a particular subject's state of subjective welfare.

But the great and interesting question then is: which are those external states and affairs in the life of a human being that have such a connection to the person's subjective wellbeing that we can use them in a scientific context as indicators of wellbeing? What is the rational basis for including data concerning, for instance, health, professional life and family life, and for excluding other kinds of data?

One can of course here refer to various empirical investigations. There is a very ambitious overview of such investigations in a book written by a Dutch author, Ruth Veenhoven. Veenhoven has in his book, *Conditions of Happiness* (1984), presented and analysed no less than 245 studies where researchers, mainly psychologists, have investigated the importance of various background conditions for human happiness and satisfaction. After many reservations — Veenhoven has had great difficulty in interpreting and above all comparing the studies — he presents the following main conclusions.

Financial strength has a strong positive correlation to happiness (in particular in the developing countries). The same holds for having a job, having a partner and children. Deep friendship relations are also important for happiness. Health also has a strong correlation to happiness, in particular the health which has been assessed by the subject. Less
strong, but still evident, is the correlation between happiness and such factors as education, intelligence and general activity.

Veenhoven points out that the comparisons have been very difficult to make. The investigations have very different quality and depth. The researchers use different terminologies and concepts. It is often also very difficult to determine the direction of the causal link. Is it, for instance, the case that an active life creates a happy disposition, or is it the happy disposition that creates the happy life?

Veenhoven's work is admirable and gives us many important pieces of knowledge. But at the same time it calls for other kinds of studies, not least of a terminological or conceptual kind. Just by studying the logic of such concepts as wellbeing and happiness one can, as far as I can see, get rather far in the understanding of these phenomena and also in the understanding of their relation to various kinds of background factors. My own analysis of the concept of happiness in chapter 4 will be an investigation of the logical grammar of happiness. But let us first be inspired by some classic studies.
Some main points in Aristotle's theory of eudaimonia

The ultimate good in life was called eudaimonia by Aristotle. Literally this means “being blessed with a good daimon”. The latter in its turn means “a divine guard” (Aristotle 1982, p. 48). The literal translation can give one the impression that Aristotle by eudaimonia means that that person who is favoured and guarded by the gods and who in general lives in good circumstances, lives the best life. Such an interpretation, however, would give a misleading picture of Aristotle's theory.

It is difficult to translate eudaimonia into the Western languages of today. The traditional translation in English, however, is “happiness”. It is then immediately important to realise that Aristotle by happiness means something quite different from (although partly connected with) what we today mean by happiness.

A first important difference between the eudaimonia of Aristotle and the happiness of today is that eudaimonia is not a state of a person but an activity. Aristotle does not regard happiness as a state that one is in possession of. Nor is happiness an experience. Instead happiness consists in a certain type of active life.

On the other hand, there is also an important similarity between Aristotle's eudaimonia and the kind of happiness that, for instance, the utilitarian ethics of our time speaks about. Both concepts have an equally central place in ethics. Eudaimonia and happiness are the things to be achieved, both for oneself and for others. Eudaimonia and happiness are both the goals of human activity. We must then, however, bear in mind that eudaimonia is in itself an activity.

But what is the activity that Aristotle considers to be the meaning and goal of life? What should one pursue in order to live the best conceivable
life? In order to answer these questions one has to presuppose certain other important parts of Aristotle's theoretical philosophy. Aristotle believed, and tries to persuade the reader, that his theory of happiness follows logically from his basic metaphysics. The commentators of our time are perhaps not so convinced that this is so. One major difficulty is that Aristotle's ideas in this area are expressed in slightly different ways in his two major ethical works the *Nicomachean Ethics* and the *Eudemian Ethics*. Let me here in spite of this try to reconstruct the main steps in Aristotle's reasoning. (I shall here exclusively refer to the *Nicomachean Ethics* (NE).)

An important ingredient in Aristotle's theoretical philosophy is that all entities in the world have a *function*. When we deal with artefacts this idea is rather simple and understandable. A knife has the function to cut things; an axe has the function to split wood; a sewing-machine the function to sew etc. But Aristotle's idea is quite general. All entities, be they living or dead, have some function. With a modern terminology we might express this thought more vividly by talking about the function of animals and plants in the ecological equilibrium. Plants and animals are preconditions of each other. Plants constitute by their photosynthesis and their production of oxygen a general precondition of animal life. Small animals, like insects, constitute food in particular for birds. These in their turn are food for predators, and so on.

The function of an object, Aristotle says, is a part of its *essence*. The ability to split wood belongs to the essence of the axe. According to the modern way of speaking we might say that it belongs to the very definition of the concept of axe that it is an object by means of which one can split wood. Could the object not split wood, then it wouldn't be an axe. In the same way could we reason concerning other objects, including animals and human beings. (NE, Book I, vii, 10-16.)

The functions are hereby distinguishing features. The function of the axe is distinct from the function of the stone. The function of the anemone is at least partly distinct from the function of the orchid; similarly with the functions of the buzzard, the chimpanzee and the human being.

Another important thought behind Aristotle's view of the good life is that the purpose of every object is to exercise its function. It is therefore important that the inanimate object is used for its purpose or that the living being realises itself. Here we have an important premise in Aristotle's reasoning: it is better for an object to exercise its function than to be inactive. Therefore it is better for a human being to actively exercise his or her function than live in a passive state. Therefore
eudaimonia, the best thing in life, must be an activity and not a static state.

The purpose of the existence of a human being therefore must be to exercise the function of a human being. It is then easy to add that the good life is to exercise the function well. The best conceivable life then is to exercise one's function in the best conceivable way. Thus a human being has eudaimonia, i.e. is happy in Aristotle's sense, when he or she exercises his or her specific function in the best conceivable way.

But what is the function in the case of the human being? Are we only dealing with one function? Here we enter controversial territory, but certain things seem to be clear. That or those functions which constitute the essence of the human being must be distinct from the functions which apply to other living beings. Otherwise we wouldn't be able to separate human beings from these other living beings. The function of the human being cannot, for instance, be the intake of nutrients. This activity we have in common with both plants and other animals. Nor can the human function be just to breathe, move about or be sexually active. This we have in common with all other animals. We must find something which is specific for Homo Sapiens, the "sage" man. (NE, I, xiii, 5-20.)

What Aristotle focuses on is that human beings, in contradistinction to the animals, can act according to rational principles, which he takes to be equivalent to acting according to the norms of virtue. To live virtuously is the same as exercising the human function. A virtuous human being, in the sense that he or she is also active and continuously practising his or her virtue, thus lives a life in eudaimonia and is happy.

This is not Aristotle's complete answer, however. He also thinks that there are different degrees of virtuous life and that there can be different degrees of eudaimonia. This grading of eudaimonia is not just dependent on how often or to what extent one performs virtuous actions. No, the degree of eudaimonia also depends on the nature of the virtues exercised.

Aristotle in fact proposes a hierarchy of virtues in the following sense: those virtues which are predominantly of a spiritual character, or those which are mainly performed by the soul, have a higher position in the hierarchy than those which are mainly of a bodily kind. To perform well with one's body is something good, but it is even better to perform well with one's soul, i.e. with that part of the person that distinguishes him or her from the animals. In fact this is the best conceivable kind of activity. The complete eudaimonia therefore consists in contemplation, in particular the contemplation of abstract ideas. (NE, X, vii.)

To this we can add a matter concerning time. In order for real
eudaimonia to occur such a contemplation should apply to a complete lifetime. Strictly speaking, it is only the completed life which can be referred to as happy in the Aristotelian sense. (NE, I, vii, 16.) So much for the general framework of Aristotle's philosophy.

One may think that Aristotle's theory of happiness is almost absurdly unrealistic. One cannot conceive of a human being who can contemplate supernatural truths throughout life. Is it then reasonable to propose such a theory? Aristotle's answer to such an objection would probably be that the continuous contemplation only applies to the highest degree of eudaimonia. He does not mean that all other lives completely lack eudaimonia. On the contrary, many people can, according to Aristotle, reach a high degree of happiness without approaching the utopian ideal. In fact, all philosophies of happiness would need a similar thesis. No human being can in practice be completely happy. But this does not preclude us from giving a theoretical characterization of the notion of complete happiness. (NE, X, vii, 9.)

Aristotle is also careful in reminding us that there exists not just an abstract description of human eudaimonia in general. There are also concrete descriptions of the eudaimonia of every specific individual. Different individuals have different degrees of potential eudaimonia. Some people have very small intellectual capabilities and therefore have little possibility of exercising intellectual virtues. Their competence to exercise other virtues can, on the other hand, be much greater. Conversely, one can say that an intellectual who is bedridden has little competence to live such a virtuous life as presupposes bodily activity. On the other hand, his or her opportunity for living a contemplative life is the greater. These two different extremes of human beings have through their constitution completely different potentials for eudaimonia. But in both cases they would probably be rather far from the highest conceivable eudaimonia.

In all realistic discussion, whether it deals with morals or with the prudent planning of a human life, these basic presuppositions have to be considered. For each individual one has to try to characterise that degree and kind of eudaimonia that is at all attainable for him or her. The important thing then, according to Aristotle, is not that one shall exploit as many of one's potential activities as possible and thereby act in a bad or unvirtuous way. The important thing is that the activities which are actually performed are performed well. It is better to be a skilful carpenter than a mediocre author. It is better to be a skilful soldier than a scarcely competent prime minister. These are some of the conclusions to be drawn
from the theory of Aristotle.

But it is not only the constitution of a person that confines his or her ability to reach eudaimonia. Also external circumstances do this to a high degree. It is clear that the person who lives in impoverished and appalling circumstances does not have the same opportunity to live a virtuous life as that rich person who lives in a peaceable and creative society. It is not possible to be generous if there is nothing to give; it is not possible to be a contemplative person if one is a parent of a great number of hungry children who continuously crave food. Thus it is not only happiness in our modern sense that is confined by negative circumstances. This holds equally well for Aristotle's eudaimonia. (NE, I, viii, 15-17.)

Aristotle was quite clear — in fact much clearer than many contemporary debaters — about the difference between the conditions for eudaimonia and eudaimonia itself. Many conditions, both external and internal, must be fulfilled in order for a person to reach a high degree of eudaimonia. Among these conditions are a certain minimal degree of health, a minimum of physical protection and a minimal economic platform. Perhaps one should add a minimum of social life. But these necessary conditions are not together sufficient for eudaimonia. In order for a person to have eudaimonia he or she must act; the person must be active, and be active according to a rational and virtuous principle.

Thus I can repeat the thesis that I proposed in the beginning of this section. To have external and internal welfare is not the same as having eudaimonia. The happy person must also act on the basis of this welfare.

We still need to answer a further question. What exactly is the relation between eudaimonia and the modern Western concept of happiness? If happiness in the modern sense is a kind of experience or disposition towards experience, then eudaimonia is something completely different. Our modern version of happiness is a mental state and not an activity.

In some of our modern concepts of happiness sensual pleasure is a species of happiness. That is the case with Jeremy Bentham's concept of happiness. This is very far from Aristotle's view. There is a specific argument for excluding pleasure from eudaimonia. To feel pleasure is not anything specifically human. Many other animals have the capacity to do so. Thus pleasure cannot be a part (or species) of the specifically human function. Thus pleasure cannot be a part or species of eudaimonia which is the function of man.

Nor does it follow per definition from Aristotle's concept of eudaimonia that a person who is very happy, in the modern sense, must also have a high degree of eudaimonia; or the converse: from a high
degree of *eudaimonia* does not follow logically a high degree of experiential happiness. On the other hand, Aristotle seems to have meant that the virtuous and active person has normally as a matter of fact a high degree of experiential happiness. If one happens to be interested in the latter kind of happiness — which, in a sense, we should not be, according to Aristotle — it is a very good recipe to opt for *eudaimonia* in order to attain it. The virtuous person is normally a very happy person in our sense. The happiest person is the contemplative philosopher, who is continuously in contact with the supernatural facts.

**What can we learn from Aristotle’s theory of *eudaimonia***?

Several features of Aristotle’s theory of *eudaimonia* seem alien to modern thinking. We do not share his metaphysics. We do not regard the world as a teleological structure in the way he does. We do not say that all objects have functions which belong to their essence. We also distinguish, at least conceptually, between morals and happiness. Our concept of happiness, which we to a great extent seem to share with the utilitarians of the 19th century, refers to a mental state, which need not be the result of a moral life and can apply both to the good and the evil among us.

In spite of this there are several important observations made by Aristotle which are also relevant to a modern discussion of quality of life. The most important one is that of the distinction between the conditions for *eudaimonia* and *eudaimonia* itself. In the modern discussion we must make a completely parallel distinction, between happiness and the conditions for happiness, and between quality of life and the conditions for quality of life. Many conditions, indeed many necessary conditions, for *eudaimonia* or happiness may be fulfilled without the *eudaimonia* or happiness being the case. Aristotle also makes the fruitful distinction between external and internal conditions for *eudaimonia*. The happiness of human beings is dependent on both inner constitutional and health factors, on the one hand, and external environmental and cultural factors, on the other hand.

Another important Aristotelian insight is more indirect. It concerns the role of activity with regard to human welfare. Even if we do not believe today that happiness consists in a certain kind of activity, we must realise the role of many activities and the role of an active life in general as conditions for happiness. In order to experience happiness it is not enough to be strong and healthy. Nor is it enough to live in a peaceable society,
to have a good job and a good economic situation. We must also do something about it. We must use our strength and health, we must go to our job and we must make use of our economic situation. Sheer passivity, the static state, is completely insufficient for a happy life also according to our modern way of thinking.

Perhaps we are also inclined to agree with Aristotle that living a rational and virtuous life is an effective means of attaining happiness, at least when we have long-term happiness in mind. Let us remember that Aristotle did not speak about temporary pleasures but about lifelong happiness.

Jeremy Bentham and the utilitarians

That activity-oriented theory of the good life which was advocated by Aristotle has not much influenced the welfare philosophers of our time. I have in mind primarily the utilitarians who have been the leading figures in the Anglo-Saxon countries and Scandinavia.

The modern forefather of utilitarianism is Jeremy Bentham (1748-1832). He presented his main ideas on moral and legal matters in the great work *An Introduction to the Principles of Morals and Legislation* from 1789. I shall here present some of his main thoughts.

According to Bentham our life is governed by two main principles, the principle of pleasure and the principle of pain. We all have a natural tendency to aim for pleasure and avoid pain. In fact, says Bentham, all our voluntary actions are ultimately motivated by our desire to seek pleasure and avoid pain. This does not entail that such a desire has to be the immediate motive behind all actions. (I shall shortly exemplify that.) What Bentham intends is that ultimately in that chain of causes which results in an action there must be either a desire for pleasure or a desire to avoid pain. By stating this Bentham shows that he is an extreme representative of the school of *psychological hedonism*.

So far, however, I have only talked in psychological terms. I have said that there is a human tendency to behave in certain ways. But what has this to do with morals or with the ideal human life? Does the biological natural tendency have to be the morally correct one? Should we aim for pleasure and avoid pain?

Yes, in a way this is what Bentham and the other utilitarians mean. We ought to follow our psychological inclination and let it constitute the
foundation of our morals. Bentham does try to argue for this. He says that it is both unnecessary and impossible to prove that this thesis is true. The thesis that we ought to aim for pleasure and avoid pain is a thesis that resembles the axioms in mathematics. It is used to prove other things, but it cannot itself be proved. (Bentham's famous pupil John Stuart Mill tried to prove the utilitarian principle. Most commentators agree however that he failed in this attempt. See Mill 1979.)

But what is the utilitarian ethical principle? So far I have not proposed any precise formulation. Whose pleasure should we aim at and what kind of pleasure? Bentham formulates his principle, which he calls the principle of utility, in the following way:

By the principle of utility is meant that principle which approves or disapproves of every action whatsoever, according to the tendency which it appears to have to augment or diminish the happiness of the party whose interest is in question; or what is the same thing in other words, to promote or to oppose that happiness. I say of every action whatsoever; and therefore not only of every action of a private individual, but of every measure of government.

By utility is meant that property in any object, whereby it tends to produce benefit, advantage, pleasure, good, or happiness (all this in the present case comes to the same thing) or (what comes again to the same thing) to prevent the happening of mischief, pain, evil, or unhappiness to the party whose interest is considered: if that party be the community in general, then the happiness is that of the community; if a particular individual, then the happiness of that individual. (Bentham 1982, pp.11-12)

According to Bentham's principle of utility we should recommend the action which raises the pleasure or happiness of an individual or group of individuals, if the alternative is to abstain from this action or to perform some other action which does not have the same good consequences. But who is the individual or what is the group of individuals that should be the target of this action? Bentham uses himself the expression "the party whose interest is considered". He does not present any further rules for deciding which are the relevant interests and thereby which are the relevant groups. (Here Bentham is in a way less clear than he is in his earliest work A Fragment on Government, first published in 1776; the edition to be quoted here is the one by J.H. Burns and H.L.A. Hart 1977. In this work Bentham refers to the utility principle as the greatest happiness principle and explains it as "the principle which lays down, as
the only right and justifiable end of Government, the greatest happiness of the greatest number”. Thus, basically, the parties, whose interests are affected could be the whole of mankind (op.cit. p. 59). The idea of considering the utility of the whole of mankind was to be explored to a great extent by Bentham's pupil Mill (1979). For a scholarly commentary, see Harrison 1983, p. 168.)

There is now an important theoretical question which is unresolved: how can we defend the transition from psychological hedonism to an ethical utilitarianism of the type that Bentham advocates? When Bentham says that we all have a natural tendency to seek pleasure and avoid pain, he must be referring to the subject's own pleasure and his or her own pain, i.e. some kind of egoism. But the ethical doctrine advocated both by Bentham and Mill talks about how we should act towards the whole of mankind. The self is not excluded but it does not have a privileged position. One must not make a preference for one's own self in relation to one's fellow human beings.

According to authoritative interpretations (for instance Hart 1982, pp. xlvi-xlviii) Bentham reasons in the following way: a rational person realises that his or her own long-term interests will most probably benefit most if he or she subscribes to a moral code such as the utilitarian. Admittedly this will now and again entail that the person's short-term interests have to give way to the interests of others. But succumbing to these restrictions is a precondition for motivating other people to embrace the same moral code. And a universal support for this code is in its turn a precondition for a harmonious society, which in its turn forms a basis for the subject's satisfaction. According to Bentham a rational person will accept a utilitarian ethics by performing this reasoning which has psychological hedonism as its starting point.

So far a few words about utilitarianism as an ethical theory. I shall now, however, focus on Bentham's views on the nature of pleasure or happiness and of the various kinds of pleasure and happiness that he acknowledges. I shall also briefly comment on his ideas on measuring pleasure or happiness. These are in a way the classic forerunners of the measurements of quality of life today.

Bentham is interesting because he is almost unique in his careful analysis and classification of the fundamental concepts of utilitarianism. His attempts to classify different kinds of pleasure and pain remind us to some extent of Linnaeus' classifications in biology. Admittedly, one can be sceptical about many details in Bentham's system. It is valuable, however, to get somewhat acquainted with these details. One can thereby
better understand what variety of things Bentham had in mind when he talked about pleasure and pain.

First some remarks about terminology. It is notable that Bentham does not make a clear distinction between pleasure and happiness. On many occasions he talks about “pleasure or happiness” as if the two terms were almost synonymous. This means that pleasure with Bentham is something extremely general, referring to all kinds of positive sensations, moods and emotions. This general use of the term is not common today. Moreover, I shall myself make a rather sharp distinction between pleasure and happiness in my own theory. Let me, however, in this section follow Bentham’s way of speaking and talk about pleasure in a very general sense. Let me for similar reasons keep his term “pain” for the negative counterpart, although pain today almost exclusively refers to a bodily sensation. With Bentham this is also a very general term referring to all kinds of human suffering.

The characterisation and measurement of pleasure and pain in Bentham’s theory

For Bentham as well as for all other utilitarians it is important to have good tools for the characterisation and measurement of pleasure and pain. If a good ethics should consist in the creation of pleasure and the avoidance of pain, then we must have criteria for the existence and the degree of these properties. Bentham is very conscious of this and takes at least certain careful steps to realise this purpose.

First he specifies a number of dimensions according to which a measurement should be made. An experience of pleasure or pain should be characterised with regard to its position along the following scales:

a. intensity
b. duration
c. certainty or uncertainty
d. propinquity or remoteness
e. fecundity (i.e. ability to generate new sensations of the same kind)
f. purity
g. extension.

Unfortunately, Bentham offers rather few comments on these dimensions. It is sometimes, therefore, rather unclear how to interpret them. The
unclarity concerns primarily the dimensions certainty and proximity. Does the certainty of an experience of pleasure refer to whether the experience is precisely an experience of pleasure? Or does the certainty have to do with the stability of the experience, i.e. whether it will last for some time? Should we by proximity mean whether the experience is close to one's consciousness, i.e. is more or less present in one's consciousness? Or does Bentham refer to the possibility that it is easy to recall the feeling in one's consciousness?

The dimensions of purity and extension are, however, given a clear interpretation by Bentham. An experience of pleasure is pure if it is not mixed with pain or if it is not (with high probability) going to be immediately followed by pain. By “extension” is meant the number of people who are affected by the experience. The dimension of extension then entails that aspect which is so important for latter-day utilitarians, viz. that the number of people who are affected is of great importance for the ethical quality of an action.

We can note that “extension” could very well have referred to another dimension that Bentham does not say anything about. An experience could be described as extended in the sense that it affects a great deal of a person's mental life. It is easiest to illustrate what I mean in the case of bodily sensation. A person who is injured all over the body can be said to have a pain that has a greater extension than that of a person who has an injury at only one place. (Observe that I am here not talking about the intensity of the pain. The one who has an extended pain in this latter sense would most probably, but not necessarily, have an intenser pain.)

I shall not here further analyse or criticise Bentham's choice of dimensions. Let me just note that it is perhaps only one of them which tries to catch the very “quality” of the pleasure or pain in contradistinction to its spatial, temporal and causal properties. This is the intensity of the experience. A significant omission in Bentham's list of properties is a dimension of evaluation. Bentham does not indicate that certain kinds of pleasure are more valuable than others. It seems as if Bentham believes that the “value” of his pleasures and pains can be objectively measured along the scales that his dimensions suggest. If this is a correct interpretation Bentham clearly distinguishes himself from his pupil Mill, who explicitly talked about more valuable or less valuable experiences. Mill's distinction between “happiness” (the more highly valued experience) and “content” (the less highly valued experience) is an important addition to the utilitarian philosophy.

According to Bentham the “value” of an experience of pleasure should
be measured objectively, by assessing the experience according to the scales (referred to above), which are at least in principle given cardinal values.

After having introduced the dimensions of quality of life Bentham presents in an abstract way the basics of his famous “felicific calculus”. Hereby he refers to the method by which one should be able to assess whether one piece of happiness is greater than another one. I quote Bentham 1982, p.39:

To take an exact account then of the general tendency of any act, by which the interests of a community are affected, proceed as follows. Begin with any one person of those whose interests seem most immediately to be affected by it: and take an account,

1. Of the value of each distinguishable pleasure which appears to be produced by it in the first instance.
2. Of the value of each pain which appears to be produced by it in the first instance.
3. Of the value of each pleasure which appears to be produced by it after the first. This constitutes the fecundity of the first pleasure and the impurity of the first pain.
4. Of the value of each pain which appears to be produced by it after the first. This constitutes the fecundity of the first pain and the impurity of the first pleasure.
5. Sum up all the values of all the pleasures on the one side and those of all the pains on the other. The balance, if it be on the side of the pleasure, will give the good tendency of the act upon the whole, with respect to the interests of that individual person; if on the side of the pain, the bad tendency of it upon the whole.
6. Take an account of the number of persons whose interests appear to be concerned; and repeat the above process with respect to each. Sum up the numbers expressive of the degrees of the good tendency, which the act has, with respect to each individual, in regard to whom the tendency of it is good upon the whole: do this again with respect to each individual, in regard to whom the tendency of it is bad upon the whole. Take the balance; which, if on the side of pleasure, will give the general good tendency of the act, with respect to the total number or community of individuals concerned; if on the side of the pain, the general evil tendency, with respect to the same community.

Such is the classic formulation where Bentham sets forth the calculus by which the moral value of an action should be judged. It is striking how this idea resembles the attempts of today to make measurements of quality of life for the purpose of medical or social decision-making.
What kinds of pleasure or happiness are there?

Bentham then proceeds to making a detailed analysis and classification of the species of pleasure or happiness. This taxonomic enterprise gives a good picture of the very broad area that Bentham has in mind. He first makes the distinction between simple and complex experiences. A single experience can be composed of experiences of different kinds. We have already above noted the dimension of purity-impurity. Pleasure and pain can both be impure in the sense that they can include elements of the opposite kind of experience. Here Bentham observes that an experience of pleasure can be composed of different kinds of pleasure, and an experience of pain can be composed of different kinds of pain. Here I list his main categories of pleasure.

1. The pleasures of sense
2. The pleasures of wealth
3. The pleasures of skill
4. The pleasures of amity
5. The pleasures of a good name
6. The pleasures of power
7. The pleasures of piety
8. The pleasures of benevolence
9. The pleasures of malevolence
10. The pleasures of memory
11. The pleasures of imagination
12. The pleasures of expectation
13. The pleasures dependent on association
14. The pleasures of relief.

The first group, the pleasures of sensation, is a large category which has no less than nine subsections. Some of them are rather trivial and refer simply to the different senses. Others are more interesting, some are even surprising. Among the expected ones we find the pleasures of sexuality and the pleasure associated with health. More unexpected in this category is the pleasure of satisfied curiosity, or as Bentham himself defines the category: “the pleasures derived from the gratification of the appetite of curiosity, by the application of new objects to any of the senses” (Bentham 1982, p.43).

Some of the other categories require explication. By the pleasures of
amity Bentham refers to such pleasure or happiness as a consequence of one's conviction that one has a good relation to one's friends. It is surprising, however, that love is not explicitly mentioned as a subcategory of this or any other of the categories of pleasure.

The pleasure of benevolence is at first sight somewhat ambiguous. What Bentham has in mind, however, is that species of happiness which follows from the conviction that all is well with a person that one loves. (This might be a part of the pleasure of love, but it far from exhausts it.) It is only if we have this interpretation that we can realise the meaning of the pleasure of malevolence. Hereby is simply meant malice.

The pleasures of memory and imagination are some kind of second-order entities. Bentham reminds us here how we can be happy not only about such phenomena as are directly presented to us but also about such things as we can only remember or just imagine. All these pleasures can then in their turn be divided into most of the other categories.

The pleasures of association are also indirect but in another way. Here we deal with a certain phenomenon, for instance a piece of music, which can give pleasure (not just by itself, that would be a pleasure of sensation) by being associated with a period or moment of happiness in the past. Here it is not just a question of a pleasure of memory. The source of association, the execution of a piece of music, is something real, which is presented at a particular moment and creates an experience of pleasure in the listener.

The pains are given a similarly complicated taxonomy in Bentham's system. This on the whole corresponds to the taxonomy of happiness. One only needs to imagine the opposites of the various kinds of happiness or pleasure. Consider, for instance, the following categories: the pains of the senses, the pains of awkwardness, the pains of enmity, the pains of an ill name, the pains of malevolence and benevolence, i.e. the pains associated with the success of an enemy and with the failure of a friend. In the same way there are the pains of memory, imagination, association and expectation.

As a real asymmetry in Bentham's system appears one category among the pains, i.e. the pains of privation. Bentham notes that we often feel pain because we lack a person or an object that we associate with pleasure. Knowledge about the existence of a pleasure that one does not have, can give pain. Bentham distinguishes between three main categories of such pain: the case when the pleasure in question is strongly desired; the case when it is both strongly desired and expected and the subject therefore has become disappointed; the case of sorrow or despair when
the lack is associated with the knowledge that one will never more reach the desired person or object.

A commentary on Bentham's system

Bentham has a well-developed sense for details and an admirable ambition to attain completeness when he maps this difficult and abstract area. He is well aware that this is a vast and complex territory and he is sensitive to many distinctions. At the same time one must note that his classification is not really well constructed. It is easy to object to details in his system both on logical and factual grounds. One observes not only the omission of the happiness of love. The happiness of artistic creativity or artistic contemplation is hardly mentioned. And on the negative side there is no treatment of such anguish and despair as lacks an object, for instance existential anguish or such depression as is not connected with being deprived of a dear friend or object.

From a logical point of view one can note that Bentham puts some categories on the same level of abstraction, or in the same hierarchy, when it seems to be obvious that this is not a correct procedure. The pleasures of memory, imagination, association and expectation, for instance, seem to be categories of pleasure given another ground of division than most of the other categories mentioned by Bentham.

There is one important distinction that Bentham does not make. I think that it is very crucial because it is a powerful tool for mapping the whole area of happiness and pleasure. I shall return to it in a more systematic way when I introduce my own notion of happiness.

A first step in understanding this distinction is to think in terms of direct and indirect happiness or pleasure. What Bentham calls the pleasure of the senses is the paradigm of direct pleasure. By "direct" I here mean that a person perceives an experience as pleasant without having to reflect upon the quality of the experience, upon its sources or upon its conceivable consequences. The pleasure of taste or the pleasure of sexual orgasm are direct in this sense. But we must also include that kind of bodily wellbeing which is a direct consequence of physical activity, and the direct experience of beauty that can accompany listening to a piece of music or looking at a work of visual art.

Most of the other species of happiness or pleasure mentioned by Bentham, or in general most of the other kinds that there are, are indirect in the sense that they are based on a belief or a conviction of their bearer.
The pleasure of wealth is dependent on the belief that one is well-off. The same is true of the pleasures of friendship, benevolence and malevolence. One must be convinced that certain things are true in the world, for instance that one's friends are well or that one's relations with one's friends are good, in order for the unhappiness or pleasure to occur.

The pleasure of taste or sexuality has a different character. These pleasures directly penetrate our minds and are almost completely independent of what beliefs or convictions we have. (This thesis is consistent with the fact that certain convictions about negative states of affairs can disturb these direct pleasures. But then there is a complex experience, consisting partly of the sensual pleasure and partly of a reflected experience of unhappiness.)

My reasoning can be completely parallel concerning pain — apart from sensual or direct physical pain, which, depending on the nature of the object, can be called sorrow, despair or disappointment. These emotions occur as a consequence of the fact that their bearer believes or knows that something is the case.

The pleasure or pain of imagination is an interesting special case. Here it is not a case of belief or knowledge in the ordinary sense. Most often the imaginative person is conscious of the fact that he or she is imagining. This does not prevent there being a feeling of satisfaction at things which go well in the world of imagination. We can here only note that we have the ability during short periods to suspend our daily life and indulge in another life, in which the psychological laws of the daily life are to a greater or lesser extent valid.

Instead of using the terms "direct" and "indirect" happiness we can now more adequately talk about sensual and cognitive pleasure. From now on I shall mark this distinction terminologically. I shall call the former "pleasure" and the latter "happiness". Why, then, is this demarcation important? The important thing lies in the conception of the "cognitive" happiness. We then realise in a moment the enormous scope of this concept. We then also realise that it is rather pointless to create categories of the kind that Bentham visualised. The great risk in his kind of endeavour is that the result will always turn out to be incomplete. There is always a new category that one would have liked to include. Moreover, Bentham misses the possibility that there may be individual variations. There may be important categories of happiness which are relevant for one person but not for another one.

In my own systematic approach I shall try to explicate, in some detail, how the idea of cognitive happiness solves this problem. Let me here just
indicate the answer in a swift fashion. A human being is happy about such things as he or she finds supportive of his or her own interests, i.e. such things as are conducive to the realisation of his or her wants in life. People have, at least partly, different ideals and wants in life. Therefore it is partly different phenomena in the world which constitute preconditions for human happiness.

What can be learnt from Bentham?

Bentham's greatness is mainly in his capacity as a theoretician in morals and law. He was the first person in modern times to formulate the principles of utilitarianism and he did it more carefully than many of his successors in the field. He introduced the "felicity calculus" as a necessary precondition for the application of the moral principles. Thereby he laid the foundations for the attempts today to measure quality of life. Unfortunately, the modern makers of instruments for measuring quality of life have seemingly been ignorant of the existence of Bentham. This has often been apparent in their treatment of the concept of quality of life.

Bentham's strength in the treatment of the concept of happiness or pleasure lies in his systematic method and his very admirable aspiration to understand and specify all kinds of human positive experience. In looking at Bentham's taxonomic system one thereby gets a fair impression of the most important species that there are. The system is, however, not good enough, for the reasons that I have just cited above.

The difference between the theories of Bentham and Aristotle is enormous. Can we at all compare them and can we say that they at all deal with the same thing? Is it not the case that Aristotle's theory of eudaimonia and Bentham's theory of happiness or pleasure are as distant from each other as a theory about shipbuilding and a theory about bridgebuilding in technological science? Is it not a very superficial fact that eudaimonia conventionally has been translated into English as "happiness", i.e. the same word as the one that Bentham used in his theory about something else?

In a way the answer is obvious. The two theories are very different. I have had good reason to emphasise this during my presentation. On the other hand they have one thing in common. They both try to characterise the supreme human value. Eudaimonia is what all people ought to attain both for themselves and for others, according to Aristotle. Likewise,
pleasure or happiness is what everybody ought to desire, according to Bentham. In this sense their theories are competitive. They both try to construct a theory of the supreme human value. Both theories are in a sense totalitarian. Thus, both theories cannot be completely true theories of the supreme human value.

How do we then explain that the premises and conclusions of these two thinkers were so different? Only a historian of ideas can give a satisfactory answer to this question. There is however one type of answer that I shall suggest. Aristotle and Bentham emphasise different elements of moral life. In a way Aristotle includes much more in morals than Bentham does. Aristotle investigates what an ideal human life should look like in all its aspects. He then also considers aspects that many modern moral philosophers would consider to fall outside morals. To Aristotle it was important to live a life of virtue and moderation even if no other human being could benefit from this moderate and virtuous life.

Bentham's whole focus however is on a person's interaction with other human beings and on the effects this person's life has on others. When pleasure becomes the key notion in utilitarian moral philosophy it is normally not the ego's pleasure that is at issue. It is the pleasure of others that is in focus, even if the pleasure of the self can also have a place in moral argument. When, on the other hand, Aristotle talks about our duty to develop our *eudaimonia* it is primarily the *eudaimonia* of the self that is at stake.

In this book I shall not take a stand on the issue of the supreme human value. On the other hand I shall take a pragmatic stand in making a choice for my own analysis. I am going to analyse concepts of happiness and pleasure which have more similarities with Bentham's central concepts than with Aristotle's *eudaimonia*.
In the first chapter of this book I made a preliminary survey of the field of quality of life as it is normally conceived in the literature. I said that by quality of life is normally meant something that has to do with the values of welfare or wellbeing. I then also pointed out the distinction between external welfare, i.e. those phenomena which surround us and continuously affect us, and, on the other hand, our inner wellbeing, i.e. our reactions to the external world and our experiences in general. In this chapter I shall make a more penetrating presentation of these concepts.

As a starting point for the distinction between welfare and wellbeing I shall use the observations which I have made several times already, both in the introduction and in my treatments of Aristotle and Bentham. I mentioned in the introduction objective and subjective forms of quality of life and, in particular in my analysis of Aristotle’s eudaimonia, I pointed out the difference between the conditions for eudaimonia and the eudaimonia itself. Let me now develop these observations.

A human being always lives in some kind of environment. This environment has many parts. First, there is a physical environment, a landscape with its natural resources and its climate. Second, there is a cultural environment, a society with its laws and regulations, with its political system, its customs and other cultural expressions. Third, there is a psychological close environment consisting of relatives, friends and workmates.

This environment influences our lives in many different ways, also when seen from a logical point of view. The environment is the platform for our actions, it gives us the opportunity to indulge in various activities. It is obvious that these opportunities vary enormously in different parts of the world. Greenland, for instance, provides the opportunity to go out hunting and fishing but it gives very little opportunity for doing agriculture. The climate of southern Europe makes it possible to cultivate grapes and citrus fruits, but it is not suitable for having reindeer. British
society gives the opportunity to express one's opinions and found political parties. This is currently (1993) not the case in Cuba and North Korea. We can easily multiply this type of examples within many sectors of human life.

While being a platform for action the environment also sets the limits for our goals in life. We cannot want to achieve anything in every environment. We cannot create a fleet in Hungary, we cannot build a capital on the slopes of Mount Everest etc. We cannot change our fellow human beings unlimitedly. We can probably not make a Nobel Prize winner of our son or daughter.

The environment then is both a platform for action and a basis for our goalsetting. These are two principal ways in which a human being can be influenced. His or her platform can be transformed, and upon realising this he or she must change the goals previously set up. But the environment can also influence in a direct way. This is very obvious when we talk about the physical aspect of the environment. We are directly influenced by wetness and cold and by the chemicals of the water and the air. There is also a kind of direct influence from our cultural and psychic environment in terms of stimulation and stress.

This whole many-faceted environment influences us physically and mentally, both in the short and the long run. It affects in particular our wellbeing. It is an extremely important, although not the only, condition of our degree of wellbeing or illbeing.

Thus I make a distinction between the external conditions of wellbeing and the wellbeing itself. (By a condition of wellbeing I mean so far a condition which in general contributes to a person's wellbeing. I shall later on make the distinction between contributing and necessary conditions.) A state of wellbeing is created, affected and annihilated by different combinations of external conditions. To the extent that such a combination of external states contributes positively to a person's wellbeing I call it a state of welfare. To the extent that it contributes negatively to the wellbeing of a person or even creates illbeing, I call it illfare. In the following I shall mostly refer to the positive variant.

Welfare then corresponds quite well to what I in the introduction called the conditions of quality of life or what constituted the conditions of Aristotle's eudaimonia.

Now I must immediately make an addition to the characterisation of welfare. There is an important area between welfare, as I have so far described it, and wellbeing. There are not only external conditions of wellbeing but also a series of internal conditions. It is not only the
external world that affects our wellbeing. We are also to a great degree influenced by our own physical and mental constitution, how we are constituted of physical and mental elements — by our physical and mental strength, our character, as well as our inclinations and interests. Our inner properties are certainly continuously affected by the external environment, but there is an important constitutional platform that the environment cannot affect in any other sense than that it can annihilate it.

Let us coin the expression inner welfare for that combination of inner properties which lead to or positively affect our wellbeing. The opposite could then be called inner illfare.

Still this is not sufficient. There is an area which in a sense is a product of the outer and inner environment, and which to a great degree affects our wellbeing. This is the human activity itself. If we reflect for a moment we can see that the most typical way in which the outer and inner environment influence us is through our activity. In order to be affected by the environment we must normally act upon the environment.

In order for economic resources to lead to wellbeing they must be utilised. We must go out and cultivate the earth in order to be able to grow plants. In order for a tool to be appreciated it must be used. We must use our weapons or fishing rods in order to get meat and fish. In short we must work in order to get food, and in today’s monetarian society we must work in order to get hold of almost all kinds of objects. In all these cases the external world influences us through our utilising it. It is only in rather special cases that the external world affects our wellbeing directly, for instance through the purely physical influence on our senses, in terms of wetness, coldness or chemicals.

One can perhaps also say that the external world can affect us simply by our realising that it is there. One can simply be happy about the fact that one has £100,000. One can feel grief at the famine in Africa. Neither of these facts need directly or physically influence us. In spite of this we can feel both happiness and grief because of them. Perhaps it can also here be said that this is a case of influence without the involvement of human activity. This, however, is a qualified truth. In order for some influence to occur in this case it is needed that the subject reflects upon certain facts. It is as a result of this kind of reflection that one feels happiness or sorrow.

I can sum up in the following way. To human welfare belongs both the external environment of a human being, and his or her inner constitution, and the person's activities. All these things can affect his or her wellbeing or illbeing. In addition to this there is a series of both logical and
empirical connections between these main categories. I shall not, however, here explore these in any detail.

I shall however make an observation concerning the relation between the concepts of welfare and wellbeing. By the welfare of a particular person I shall mean the compound of things in the person's external and internal environment which together with the person's activities influence his or her wellbeing. A presupposition for an entity's belonging to the welfare of P is thus that it as a matter of fact contributes to the wellbeing of P. Thus it is not the case that P's welfare has been defined once and for all in some independent way, and that one thereafter empirically studies whether it also results in some wellbeing in P. The relation between the concepts of welfare and wellbeing is thereby logical and not empirical.

An immediate consequence of this is that the welfare of P need not be identical with the welfare of Q. The conditions for P's having a good time can be distinct from the conditions for Q's having one. Those things which make life good to a banker in New York are at least partly different from the things that make life good to a housewife in Helsinki.

The welfare-classes of different people are thus partly different. But it is also clear that all of them have a common kernel. The conditions for pure survival are necessary elements among the conditions for wellbeing. Thus such conditions belong to the welfare of all people. Most probably some further conditions belong to the common kernel of welfare. Perhaps a certain minimum of social relations belong there.

The relatively big difference between the welfare-sets of different individuals poses a difficult and interesting problem when we wish to talk about welfare as a social concept. What does it mean when we say that we wish to raise the welfare in society? Are we speaking about the welfare of the complete population or about the welfare of a certain proportion of the population? Or, alternatively, are we speaking about the common platform for all individuals, i.e. some basic welfare?

The latter seems to be the most promising suggestion if we are to enter into a discussion of general policy. If there is a set of conditions which is common to all people in a population in the sense that it contributes to the wellbeing of all of them, then as politicians we ought to concentrate on realising these conditions. To this platform belongs first the external material conditions which I have just exemplified. But certain inner phenomena also belong here, in particular health and knowledge. Other essential features of the inner life also belong to the common platform but they are more difficult to influence politically. Among these we find
intelligence and good traits of character.

Let me now make two additions to our list of concepts. I introduce the minimal common platform of welfare and the minimal common realisable platform of welfare.

The minimal common platform of welfare need not constitute the final ambition for political action. Above this platform there are many things which constitute important conditions for many people's wellbeing, and which are indifferent or only mildly disturbing to the minority. A striking example of such a thing is the range of sports programmes on radio and TV. These are important elements in most people's lives. The minority are mostly indifferent. If they are not interested in sports they can abstain from watching such programmes.

Observe that there is also another minimality concerning welfare. Every individual can be said to have a set of minimal welfare conditions which is such that these conditions have to be fulfilled in order for him or her to experience a minimal wellbeing, i.e. be minimally satisfied. Below this level the individual does not have any wellbeing at all. How this minimal set is related to the common minimal platform is an empirical question which does not, it seems to me, have an obvious answer.

In order to answer this question some logical matters have to be settled first. So far I have not strictly differentiated between necessary conditions for wellbeing and contributing, but not strictly necessary, conditions. Moreover, it is necessary to distinguish between such conditions as are necessary for minimal wellbeing and such as are necessary for a certain higher degree of wellbeing.

It may be the case that the smallest common platform does not contain everything that is necessary for anybody's minimal wellbeing. It is even more plausible that the smallest common platform does not contain everything that is necessary for everybody's minimal wellbeing. The smallest common platform may also contain things which are not necessary for anybody's wellbeing but which when they are realised will contribute to everybody's wellbeing. It is possible that we can find such conditions among simple entertainments. Some of these may be considered pleasant by everybody, without being necessary for anybody's minimal wellbeing.

From minimal sets of welfare we can now proceed to a maximal set. By a maximal welfare set we can mean the set of all types of phenomena which contribute to the wellbeing of at least one individual in the population. We can quickly convince ourselves that this set — being in practice impossible to specify — is completely impracticable for policy
decisions. Among other things it must contain a lot of incompatible elements. What is a necessary element in a certain person's welfare must be excluded in another person's. President Jeltsin is considered to be an extremely important person for Russian welfare by some citizens. Others however consider that he must immediately be replaced. Similarly, snow and ice are important things for certain winter sports enthusiasts. For others it is an environment to be avoided.

One complication is also that the maximal welfare set contains big exchangeable alternative sets. (How big these are depends in part on the level of abstraction on which they are described.) A particular person can take pleasure in a holiday trip either to the Bahamas, Mallorca or the Maldivian islands. He or she may not however be particularly interested in (or have the strength for) making all three journeys. In a specification of the maximal welfare set all three things would, however, be included.

We can see that there is a set of interesting questions to explore here. We can also further complicate our collection of distinctions among welfare sets, from the necessary conditions for a particular person's minimal wellbeing to the set of all those things which may at least once contribute to one person's wellbeing. I shall here abstain from continuing this exercise and instead analyse what I take to be the kernel of quality of life: human happiness.
Towards an analysis of the notion of happiness

Introduction

Welfare is the foundation for quality of life but is not the same as quality of life as it is to be defined in this book. First, there are so many species of welfare. The collective welfare, viz. the welfare that gives a majority of people wellbeing, probably contains much which does not lead to wellbeing for a particular subject, for instance myself.

But even if we were to talk about my individual welfare, i.e. all the things in my surroundings that provide me with wellbeing, it is hardly those things in themselves which are interesting. They are important to me through their property of creating wellbeing; it is the final wellbeing that constitutes the ultimate criterion of their importance.

I shall now concentrate on wellbeing and try to find the kernel of quality of life there. I shall almost exclusively then concentrate on one of the species of wellbeing, viz. happiness.

I envisage that wellbeing covers the whole area of positive human experiences, from sensations to emotions and moods. It is customary in modern philosophical psychology to differentiate between these three categories. It is significant for sensations that they are located in a specific part of the body. They are normally physically well-defined. Itch and pain are typical instances of sensations. One feels pain in one’s knee, for instance, or one’s nose itches. Emotions and moods do not have this physical demarcation. The feeling of love is not located in one’s stomach, and anguish does not reside in the legs. What is significant for emotions, in contradistinction from the pure moods, is that they are directed towards objects, which are normally outside one’s own self. There are many examples of such emotions: love, hatred, gladness, sorrow, hope, despair etc. All of them have objects. One loves somebody, one hates somebody,
one is glad about something, one is sorry about something etc. (For a closer analysis of the concept of emotion, see Kenny 1963, pp. 52-75. See also Nordenfelt 1987, pp. 82-83.)

As examples of moods, on the other hand, we find calmness, and (certain instances of) depression and anguish. These lack objects and they are not located in any specific part of the body. They are feelings, which, if at all locatable in the body, are properties of the body as a whole. (In order to avoid misunderstandings I must here underline that these theses about the location of emotions and moods are not meant as theses concerning the neurophysiology or biology of feelings. They concern the phenomenology of feelings, they concern how we as ordinary human beings look upon our feelings and how we as a result of this use the words of feelings in our language. To say, for instance, that we do not locate a feeling of harmony in a particular part of the body is therefore completely compatible with a scientific hypothesis to the effect that there are certain locatable neurophysiological and endocrine processes which constitute preconditions of a feeling of harmony.)

What is interesting about the objects of emotions is that they can normally be quite clearly defined. I mean in the following way. One can normally give an abstract description of those entities that a person can, for conceptual reasons, hate, despise or hope for. One can, for instance, not despise a person unless one is at the same time convinced that this person has behaved in a cowardly or otherwise morally disgraceful way. It would be an abuse of the logical grammar of this concept to talk about contempt in such a situation. One can have some other negative emotion towards the person, but it can only be contempt if certain conditions are fulfilled.

With these distinctions as a background we can now return to the different species of wellbeing. How should they be characterised according to this division? As a candidate for a sensation we can find at least one, viz. pleasure. The receptors of the senses, such as smell, taste and tactual feeling, can give us sensations of pleasure. In our consciousness we also locate these sensations of pleasure in the relevant parts of the body — in the nose, the mouth, or the skin.

Among the moods we can find several kinds of wellbeing. To these belong for instance calmness, peace of mind and harmony. These feelings have no particular physical place. We feel neither peace nor harmony in the legs, the stomach, the heart or the brain.

Neither happiness nor gladness are locatable feelings, but they can be distinguished from the ones just mentioned by being directed at objects.
Thus they are emotions. One can be happy or glad about an achievement, or in general, about some success. Moreover these feelings can be directed at some external event, the beautiful weather, a positive change on the stock market or the fact that one's wife has given birth to a child. In the next section I shall study in more detail the nature of these objects of happiness or gladness.

Happiness or gladness has, apart from the fact just mentioned, a special place among the species of wellbeing. The concepts of happiness and gladness are in one sense the most general of the concepts of wellbeing. In a way they can be said to incorporate the other species. Through their position of being emotions — i.e. directed feelings — they can be directed at other parts of one's wellbeing as well. One can be glad or happy about being at ease; one can be happy about an experience of pleasure or can have a feeling of gladness at living a life in security.

Another way of expressing this is to say that happiness and gladness are species of wellbeing of the second order. Happiness and gladness are consequences of one's reflecting upon one's life. One observes and reflects upon some phenomenon in life and as a result one feels happy about it. In the extreme case one can reflect upon one's whole life and be happy about it. In short, one can be happy about existence as a whole as well as all its parts.

(Observe that we must distinguish between the objects and the causes of feelings. All feelings, including sensations and moods, have causes. An external situation can create peace and quiet. This does not entail, however, that the resulting ease is directed at this external situation.)

Are happiness and gladness the same thing or should they be distinguished? It is clear that happiness and gladness are very similar emotions and that they can often be exchanged in ordinary language. This does not prevent that more subtle analyses can demonstrate differences between the two. Happiness is more often connected with a stronger feeling of wellbeing. The term “happiness” is also more preferred as a general description of the state of a human being. This holds in particular when one says that a person is happy with life as a whole. (For deeper analyses of possible distinctions within the area of emotions, see Broad 1954 and Pörn 1986.)

In this book I shall, however, make the simplification that I collapse the two concepts and exclusively use the term “happiness”, mainly because it has the longest tradition in the history of the theory of welfare. I shall therefore suggest a characterisation of the concept of happiness which corresponds to the “happiness” of ordinary language but which is also in
many ways applicable to the "gladness" of ordinary language. What I shall characterise is therefore a partly reconstructed, technical, concept. I hope, however, that it can function in a clarifying way for the purposes of this book.

The fundamental idea

Is there then an abstract way of characterising the object in the logical grammar of happiness? What can we be happy about? In many investigations the following facts are noticed. Happiness is conceptually connected to the wants and goals of human beings. One is happy about the fact that one's wishes and goals are realised or are becoming realised. One is happy about being able to do what one intends to do; one can be happy about an academic achievement or an achievement in sports; or one can be happy about some external event which contributes to the realisation of some wish one has. One may inherit a fortune which makes a journey to Australia possible. If one's life as a whole is characterised by the fact that one's most important goals are fulfilled or are in the process of being fulfilled, then this life is with great probability a life in happiness or harmony. It is important to emphasize that the goals talked about here need neither be conscious to the individual nor be the result of a personal achievement or even constitute a change. It belongs to our most important goals to maintain the status quo, to keep our nearest and dearest with us, to keep our jobs and in general maintain our most fundamental conditions in life.

This observation about the relation between happiness and the realisation of our conscious or unconscious life-plan gives us immediately a fruitful suggestion for judging the role of external conditions in the measurement of quality of life. Let us first look at the matter from an individual point of view. The external states of affairs which have directly to do with my happiness are those which contribute to — or prevent — the realisation of my goals. If I have a profession which entails freedom of action and gives me great resources, I am quite likely to enjoy a very high degree of happiness. On the other hand, if I experience a crisis in the family which threatens my fundamental security and binds all my energy, many goals in my life plan are threatened and my happiness will be reduced.

Now, different people partly have different life-plans. Some have very
ambitious and expansive goals; others, the more careful ones, require much less from their life. Some wish to develop certain aspects of their personality; others, completely different aspects. The conditions for happiness can therefore differ enormously; let us compare some extreme pairs: a monk and a disc-jockey, a mathematician and an athlete, a university president and a photographer's model, an alpinist and a farmer.

What does an observation like this tell us? It says among other things that we can never try to map the happiness of a person — on the individual plane — by describing certain parts of this person's life-situation, unless we know about the relation this situation has to the person's life-plan or to his or her wishes in general. When it comes to the measurement of quality of life, therefore, there can be no general and workable instrument, which lacks the connection to the wants of persons and at the same time has the ambition to describe their happiness.

With this reasoning as a background I now give a preliminary characterisation of the concept of happiness:

P is happy with his or her life as a whole, if and only if P wants his or her conditions in life to be just as he or she finds them to be.

A more formal and abstract way of expressing this thought is the following:

P is completely happy with his or her life as a whole, if and only if,

(i) P wants at t that (x1...xn) shall be the case at t,
(ii) (x1...xn) constitutes the totality of P's wants at t,
(iii) P finds at t that (x1...xn) is the case.

Another more general way of expressing this intuition is to say that there is an equilibrium between P's wants and reality as P finds it to be. The concept of happiness which I try to characterise here could therefore be called happiness as equilibrium.

According to this thought happiness is connected to the fact that life is shaped in the way that one wants. The ideas of happiness and satisfaction of wants are therefore quite similar, according to this way of thinking. It must however be emphasized that the notion of want used here is a very abstract one. The wants need not be egoistic or connected to a person's very narrow interests. One can very well want to do one's duty towards a fellow human being, and one can be happy about the fact that one has
fulfilled this duty.

It is a consequence of this characterisation that happiness must be a *dimension* and not an absolute state. One can be either more or less happy, and this is dependent on the degree to which the states of affairs in the world correspond to one's wants. One is completely happy only if there is a complete agreement between the factual state (as one finds it to be) and the wanted state of the world.

A conceivable negative extreme case is that nothing in the world is as one wants it to be. If this holds, the subject is completely *unhappy*. Thereby we can see that there is a continuum of states between complete happiness and complete unhappiness. Happiness as a dimension must be distinguished from every specific state of happiness and unhappiness.

But what about the transition between happiness and unhappiness? Are they contrary or contradictory concepts? Is there a middle region between the two which is constituted neither by happiness nor by unhappiness? In such a case the concepts are contrary. Or is there a sharp dividing line between the two? In such a case the concepts are contradictory.

I do not think that conceptual analysis can give us an unequivocal answer to this question. In a reconstruction like this one we shall have to make a choice. I regard happiness and unhappiness as contradictory. I shall among other things introduce a notion of minimal happiness, which corresponds to the lowest degree of happiness. A person who has not reached this state is at least to some degree unhappy.

To the idea of happiness with life as a whole we must now add the important concept of happiness with a *single fact*. That is the concept with which we are more acquainted in ordinary life. We are happy with something that has happened to us, for instance that we have taken an exam, that we have found a partner in life, that we have got children or grandchildren, or simply that the sun is shining and the spring is approaching. What are we then happy about? What do all these objects of happiness have in common so that they create this kind of wellbeing? Here my answer is analogous to the general answer to the question of the nature of happiness: the exam, the partner in life, the child and the beautiful weather have in common that they satisfy a want in the subject. I am happy about the fact that I have found a partner since an old want of mine has become satisfied. I am happy about the beautiful weather because we have had many days of rain and we have longed for sun and a blue sky.

What then is the relation between the happiness with single facts and happiness with life as a whole? It is easy to believe that the latter is a kind
of sum of single "happinesses". One is happy with life as a whole if one is happy with every single fact with which one is acquainted.

A moment's reflection however shows that happiness with life as a whole is not a simple sum of the single "happinesses". The collected happiness or unhappiness with life that one has is instead dependent on the nature of the wants which have been satisfied, in particular if such things as one has found important have been realised. To most of us it is more important to become a parent than to enjoy a beautiful day. The happiness with the child then affects the collected happiness much more than the happiness with the weather. In a later section on wants of different priorities I shall return to the discussion of this point.

Observe also that every state of happiness which is not complete happiness is compatible with unhappiness with certain facts. Conversely, a basically unhappy person can be happy with certain facts. These are certainly the realistic situations. Most of us are most of the time either moderately happy or moderately unhappy.

The reference of happiness to different points in time: the two aspects of the basic idea

Let me return to my initial characterisation of happiness and scrutinize the expression: wanting the conditions in life to be as they are. It can be analysed into two components (i) having now what one wants to have now, and (ii) wanting to hold on to what one has now. Let me elaborate a little on both conditions.

At a particular moment in time a person P has a variety of wants. Some of these refer to the present time, others refer to some time in the future. P may now want X to be the case now, and P may now want Y to be the case in five years time. It is crucially important for P's happiness now that his or her wants which refer to the present time are satisfied. P may, for instance, want his or her children to be now in good health and do well at school. P is happy (or at least it contributes to P's happiness) if P sees that this is true of his or her children now.

For obvious reasons those of P's wants which relate to the distant future need not (or sometimes should not) be satisfied now. P may want to become the Prime Minister of Sweden in five years' time. P does not want this to be realised now. Thus it will not, given the premisses, contribute to P's happiness, should he or she by any chance get this position now.
There is, however, an important indirect way in which future-related wants also affect present happiness. If the present conditions are such that they don't favour the realisation of P's future-related wants, or if they even prevent this, then P's happiness will be affected negatively. P is happy now, only if P believes that the prospects of the realisation of his or her future-related wants are good. These prospects can be viewed as conditions existing now, which P wants to be the case.

It can justifiably be argued that P may also want his or her past to have been different than it was. P may, for instance, be unhappy now because of never having established a close relationship with his or her father. Since P's father is dead, this is a state of affairs that cannot be improved. Unhappiness related to an unalterable past can therefore only be removed by a change in the importance which P attaches to this past. For a discussion of the notion of importance and high priority, see pp. 57-60.

Consider the second component of the initial characterisation of happiness: (1) P may in the past have had a number of wants which may either have been satisfied or not. If they were satisfied they must then have contributed positively to P's past happiness. The satisfaction of some of these wants entailed the creation of stable states which continue to exist now. P may have got a job which he or she still has. Or P may have got married, which he or she still is. It need not be true that P wants these states to continue; P may not want to hold on to them, because he or she is bored, disappointed or even hurt by them. If that is the case and there is no prospect of a quick termination of them, P will not be completely happy.

(2) Not everything that affects P has been wanted by P or has been created by P. Many other people, as well as natural events, affect P's wellbeing. P has been given by nature a particular bodily and mental constitution. P is continuously experiencing a number of events over which he or she has no control. P has (normally by his or her parents) been placed in a particular country and a particular neighbourhood. All such externally given states or events can affect P positively or negatively. P may want to hold on to them; or P may want to get rid of them. In the first but not in the latter case these states contribute to his or her happiness.

By making these clarifications of the locution "wanting one's conditions to be as they are" I wish to separate my theory from a superficially similar theory of happiness in terms of want-satisfaction, which has often been cited and criticised. According to this theory P is happy only if all of P's wants have become realised. Given such a
formulation it is unclear whether P wants to hold on to what he or she has thus acquired. It is also unclear how to treat those things which P had not wanted, but which have happened and continue to affect him or her.

Happiness as a cognitive state

In order to be able to want something one must at least be a minimally intelligent being. If P wants to get a car, P must believe that there are such things as cars and that they are available. If P wants to travel abroad he or she must be able to envisage such a journey. To want something, then, presupposes the existence of knowledge, or at least some conception of that which is wanted.

This truth has immediate consequences for the concept of happiness that I am trying to reconstruct here. P cannot be happy about something unless P believes that this something exists. The sources of this belief can, however, be of different kinds and of different value. They can be direct or indirect, they can be consequences of direct perception or of reading; they can be rational or irrational, they can be sophisticated or primitive, they can be true or false.

The knowledge or belief of the happy person can now be described more precisely. In order for a person to be happy about something (including life itself) it is required that he or she at least believes that this object constitutes the realisation of a want that he or she has. As I have already said, this belief need not correspond with reality. A person’s happiness is in this sense completely dependent on his or her own perception of reality.

But what if a person’s perception is completely false? Can we then say that the person has “true” happiness? Consider the following case. A Swedish man has been imprisoned in Saddam Hussein’s Bagdad. One day his mother receives the message that he will shortly be released and sent to Sweden. As a result she becomes very happy. Assume now that the message is false, but that the mother is unaware of this fact for more than a day.

Is the falsity of the message any reason to deny the status of the mother's happiness (during the time when she was unaware of this fact)? My answer is no. In ordinary language we have an expression which is very adequate for this case, viz. happy ignorance. It is clear that the mother is genuinely happy during the day when she believes that her son will be coming home. In the same way it is clear that her happiness is
transformed into an equally strong unhappiness when the negative message arrives.

I think that it would only theoretically confusing to deny the mother's happiness during the day when she believed the world to be better than it was. On the other hand there is reason to point out how vulnerable her happiness is. And certainly when we talk about recommendations for the raising of people's levels of happiness there is every good reason to warn against false information as a simple recipe. The risk of a many times greater unhappy reaction is in most cases very great.

To repeat my general conclusion: To be happy with life one must have a certain set of beliefs (or possibly some stronger cognitive states, such as conviction or knowledge). This does not imply that the beliefs involved must be sophisticated. The beliefs can be very simple and related only to immediately present persons and things. Thus the theory allows that small children and mentally retarded people can be happy. (The theory would indeed by very defective if this were not true.)

Happiness and pleasure

I shall now face a classic question. What is the relation between happiness and pleasure? Let me do that by asking for the reasons for our wanting a condition to be the case.

Why does P want X? There are two principal cases. Either P wants X for its own sake or P wants X as a means for attaining some Y. When P wants X for its own sake it is typically because P finds X immediately gratifying; X gives P pleasure. In the case where X is seen to be a means for attaining Y, X need not be believed to give pleasure, nor need Y be. Y may in its turn be a means for attaining some further end.

It is a part of the celebrated and much criticised theory called psychological hedonism that such a chain of means-to-end-relations must finally conclude in a state of affairs which is believed by P to give P pleasure. I do not adhere to this view. P may find it important and therefore want that a state of affairs S occurs, without believing that S or any of its causal consequences will give P pleasure. P may want S since it is his or her duty to realise S.

The anticipation or perception of pleasure is, however, a typical reason for wanting. Thus I have also indicated what I take to be the logical relation between pleasure and happiness. Let me illustrate by considering two species of pleasure, viz. enjoying an activity and having a pleasant
sensation. Assume that P wants to play golf because he or she enjoys it; or that P wants to have a meal of seafood because he or she finds the taste of seafood delicious. If these wants are satisfied it follows from our conception of happiness, that the level of P's happiness has been raised. At the same time it is true that P is experiencing pleasure.

The two, happiness and pleasure, are however quite different things. Neither of them is part of the other. The relation should be construed in the following way: since P wants to experience pleasure, P is now happy with his or her pleasure. The pleasure is the object of P's happiness.

In general, it is a feature of the conception of happiness developed here that happiness is not a container of whatever positive mental states there are in the world. Happiness is rather a state of the second order. One is happy about or happy with certain facts; some of these facts may involve the possession of certain mental states.

Unhappiness and pain

The relation between pleasure and happiness has a counterpart in the relation between pain and suffering on the one hand and unhappiness on the other. Pain and suffering are typically not only not wanted states, but also states which one wants to get rid of. Thus when P is in pain he or she is typically unhappy about this fact.

This does not mean that all pain or suffering must in the end be unwanted, or that all pleasure must in the end be wanted. The main reason for this is that the bearer of the pain might realise that the pain (or its source) is a necessary prerequisite for an important desired end. The person sees that he or she must go through the agony to reach what is aimed for. A typical case of this is the medical situation where the patient understands that he or she must undergo a painful operation in order to be restored to health. The person must want the operation and thereby, in a sense, the pain, if he or she decides to undergo the operation.

It is easy to find parallel cases exemplifying that a person does not want to hold on to a particular pleasure because the pleasure or some necessary concomitant prevents a highly desired state from coming about. Consider, for instance, the man who does not want to hold on to the pleasure of drinking the night before he is due to take his exams.
Being happy and feeling happy

In my introduction above I referred to happiness as an emotion, or more generally as a *feeling*. So far, however, I have said very little about this aspect of happiness.

My omission is conscious and stems from the observation that happiness, like most other emotions, can occur without at every instant entailing some experience on the part of the subject. In order to convince ourselves consider the following reasoning.

A happy woman often has many things to be happy about. She can be happy about some personal success, about the general wellbeing of the family and about an approaching journey. This, however, does not entail that she at every moment has three distinct experiences corresponding to each of these facts. The woman need not at a particular moment have any experience of the happiness kind at all. There can be long periods when she does not at all pay attention to the objects of happiness. She can be completely engaged with other matters, with paying bills, talking to the neighbour or making the dinner. During these moments she need not experience the happiness at all. If, however, somebody were to remind her about the journey abroad, and she actively began to think about it, then the probability is great that she would also have a *feeling* of happiness.

The absence of a feeling of happiness does not however indicate that the person has ceased to be happy about the journey or any of the other things I mentioned. The term “happiness”, as I see it, does not stand for an experience that can come and go from one moment to the other. Happiness is defined as an equilibrium between wants and the belief that these wants are satisfied. This equilibrium can exist without the occurrence of any experience. On the other hand we can say that the equilibrium constitutes a *disposition* for an experience. During all the time when P is happy he or she is disposed to experience a feeling of happiness. This disposition is typically released at the moment that P pays attention to the object of happiness.

I do not wish, however, to exclude the possibility that a person can feel happy without consciously knowing why. In order for this emotion to qualify as happiness, and not as some other form of wellbeing, I presuppose, however, all the time that there is some fact that P (perhaps unconsciously) finds to be satisfying, and that this understanding is the cause of P's wellbeing.
We can reason completely analogously concerning being unhappy and feeling unhappy. The former is a state which is defined by the fact that there is a disagreement between wants and their realisation. It is also, however, a state which disposes to a negative experience, which can, but need not, be released.

Let me sum up. Feeling happy is not exactly the same as being happy. The two are analytically connected but not identical. Feeling happy entails being happy but the reverse does not hold. To be happy is only to be disposed to feel happy. This is a disposition which is particularly likely to be released when the subject pays attention to those conditions which constitute the realisation of his or her wants.

A controversial issue is whether P can be happy throughout a whole period t to t₁₀, without ever feeling happy. There is nothing in my conception which excludes this. Nor do I think that it is implausible to allow for it. Everything can be as P wants it to be for some period of time and P knows it, without consciously reflecting on it and feeling anything in particular. Thus P would qualify as being happy during this period without ever feeling happy. It should perhaps be emphasised here that the cognitive acts associated with wanting and happiness need not be conscious acts. P need not consciously know or believe that his or her wants have been realised.

(It could be argued that the converse case is more implausible. Can we imagine a person who is unhappy without ever feeling unhappy? The relation here is admittedly closer. One can give some kind of teleological explanation why this is so. Unhappiness is a sign that something in one's life ought to be changed. Such a change normally presupposes an action on one's own part. In order for an action to be performed the agent must be conscious of the undesired state of affairs. Thus he or she must feel unhappiness.)

The relation between happiness as a feeling and pleasure

*Feeling* happy or *feeling* pleased is sometimes referred to as a species of pleasure. If we adopt this view there is a need in our system to distinguish between pleasure in a *narrow sense* and pleasure in a wider sense. By pleasure in the narrow sense I mean the kinds exemplified above, viz. the enjoyment of activities and the pleasure of physical sensations. These should be distinguished from feeling happy or feeling pleased, which are second-order kinds of pleasure that can take the first-order ones as
objects. One can feel happy or feel pleased about many kinds of facts, as many as one can be happy about, and one of these things that one can feel happy about is one's experience of pleasure.

Happiness and time

Does the concept of happiness with life have some time-restrictions built into it? Can one be happy with life just for a moment or is there some minimal timespan required? Some theorists (e.g. Tatarkiewicz 1976) claim that happiness requires some minimal, however unspecified, duration. I cannot find this to be a plausible requirement.

The conceptual requirement that happiness shall have some duration should be distinguished from the pragmatic considerations to be found in certain empirical studies. There is (normally) very little point in establishing or assessing such happiness as only has a moment's duration. When a study of happiness is related to some kind of intervention (whether it be medical, social or self-administered) the interventionist certainly is interested in seeing whether the measure has resulted in any lasting change. After all, the goal of health and social policy (as well as of general utilitarian ethics) is an *enduring* state of happiness of the members of the population.

The actual *period of measurement* must often be long for further reasons. Certain interventions are such that they do not cause the desired result until after some time, and a temporary rising of the level of happiness before that time may be due to some other short-lived circumstances.

It seems to me odd, however, to deny that one can be very happy or very unhappy for a very short period of time. As long as it is true during this period that one wants the conditions in life to be as they are, then one is happy. And as long as it is true during a short period that one wants the conditions in life to be otherwise, then one is unhappy with these conditions.
On degrees of happiness

On the possibility of counting wants

I have said that one can be more or less happy with life. Along the want-equilibrium continuum one can be completely happy with life, meaning that one wants all conditions which are affecting one's life to be exactly as they are. One is less happy if some conditions are not as one wants them to be, and one is completely unhappy if nothing is as one wants it to be.

It is here tempting to try to arithmetically measure the dimension of happiness by counting the conditions or by counting the wants which are satisfied, in the following way:

P, who has 90 out of 100 wants satisfied, is happier than Q, who has 70 out of 100 wants satisfied; Q is in turn happier than R who has 30 out of 100 wants satisfied. If P and Q have different numbers of wants, the difference in their happiness can be calculated by the simple operation:

\[
\frac{\text{number of satisfied wants}}{\text{number of wants}}
\]

Thus P who has 9 out of 10 wants satisfied must be happier than Q who has 20 out of 30 wants satisfied.

It is easy to see that this is a caricature of assessing happiness. First, the notion of one want or one condition as distinguished from several wants or several conditions has to be explicated. Second, even if this can be done satisfactorily, it is obvious that different wants have different weight to their bearer. P's want to have children and want to get a decent job have a higher priority to P than his or her want to have a good evening meal or to spend a nice holiday in Scotland. As a result P becomes more happy if the former are realised than if the latter are. I shall shortly analyse this crucial notion of priority. But let us first get a clearer idea of the basic notion of a want as a unit for quantification.

(i) The problem of a hierarchy of wants. Many of our wants are logically related in hierarchies. One may want to have F in order to get G. G in turn may be wanted for a further end, until we reach an ultimate end wanted for its own sake.

How are the wants to be counted here? Shall we say that we have just
one basic want? Or is every member of the hierarchy a separate want? Both alternatives involve difficulties. If we were to count only the basic abstract wants, we might end up with quite few entities (for instance, a want to have a long and successful working life, a want to live in one's own country together with one's family) which may not differ so much between individuals.

The other alternative — of counting all elements in every chain leading up to the fulfilment of the basic wants — is, at least in practice, an impossible alternative. For one thing such a chain is infinitely divisible. If one wants to walk to the supermarket, then — it may be claimed — one wants also to walk to each point on the way to the supermarket. There are infinitely many of these points.

It could seem natural here to opt for one's conscious wants. They are clearly not infinitely many. When one wants to walk to the supermarket one does not (normally) consciously want to walk to every point on the way there. The case for just considering conscious wants is, however, not strong, given other considerations that have been set forth in this study.

Consider a further difficulty.

(ii) On complex and atomic wants. The two wants, to want $F$ and to want $G$, can always be construed as the single want, to want $F$ and $G$. Thus any number of contemporaneous wants can always be reduced to one. (Observe that the wants need not refer to the same time. One can have the single want of fulfilling $F$ at $t_1$ and $G$ at $t_2$.)

In order to avoid the mentioned unwanted reductions and expansions certain pragmatic decisions must be made. I shall here just sketch what I mean by this. I think one has to distinguish between certain areas of life, such as work, household activities, family life, political life, religious life, sports activities, other recreational life. In comparing one person's want structure at different times or two persons' want-structures, one would have to go through all these areas and ask whether the person in question has any wants in each of them. The answers must be given on the same level of abstraction, and all goals which are obviously subservient to or parts of goals already mentioned must be dismissed. Example: If P declares that he or she wants to spend 4 hours a week playing golf, P cannot add as a separate want that he or she wants to play golf between 1 and 2 p.m. on Thursdays (if the latter is a part of the former).
The notion of a high-priority want

Assume that P has 20 wants at both \( t_1 \) and \( t_2 \). At each time eight different wants are satisfied. Yet P claims with good reason that he or she is happier at \( t_1 \) than at \( t_2 \). P does so because the satisfaction of the first eight wants had higher priority to him or her than the satisfaction of the eight latter ones.

I think that we have here an intuitively very strong idea. Certain of our wants are of vital importance to us. It is of major importance to us that the members of our family are in good health and have their lives organised; to most of us it is also of great importance that our own health is in order, that the political situation is tolerable and that our working situation is all right. We say that the realisation of these wants has a much higher priority than the realisation of a number of other wants that we may have at a particular moment. They all have a higher priority than, say, the realisation of our want to go abroad for our next holiday or our want to get an honorary degree at the University of Nevada.

But what does the notion of high priority mean more precisely? What does it mean to say that P's want for X has a higher priority than P's want for Y? Does it simply mean that the satisfaction of the want for X gives P more happiness than the satisfaction of the want for Y? If that is so we are simply moving in the following circle: we are trying to clarify the dimensionality of the concept of happiness in terms of degrees of priority of wants. We can then not explain the degree of priority in terms of degrees of happiness.

I shall suggest the following explication of priority: P's want for X at \( t \) has a higher priority than P's want for Y at \( t \), if and only if P, in a situation of choice at \( t \), where P can choose either X or Y but not both, would choose X, unless prevented by external or internal force. (Observe here that X and Y need not be actions actually performable by P. The situation of choice must have the character of an intellectual experiment where the items to choose from can be any kinds of states of affairs.)

With this formulation I can keep the connection to my basic analysis of the concept of happiness. I said that P is happy about his or her life, if and only if P wants the conditions in life to be just as he or she finds them to be. I can now say that P is happier about a situation which contains X than about another situation which contains Y and explain it by saying that P prefers the situation with X to the situation with Y.

Thus when a mother says that she is happier now than before she got
her first child this has the following easy interpretation. She prefers that
total situation in which she has her baby to the previous total situation.
For the sake of simplicity we presuppose here that her preference order
has remained constant over time. (The situation becomes more complex if
the mother at the earlier time did not have any wishes concerning
children. I shall introduce that complication in a subsequent section when
I introduce the richness dimension of happiness.)
Through the idea of an order of priority for a person's wants we now
seem to have an instrument for intrapersonal comparison of states of
happiness. But do we hereby also have an instrument for a comparison
between different people? How shall we be able to say that Smith is
happier than Brown or, for that matter, that Brown is equally as happy as
Smith?
The analysis that I have so far made permits me to do this only under
very special conditions. Let us assume that P and Q have exactly the same
profile of wants; they have exactly the same wants and also the same
order of priority among the wants. Thus we know that both of them
prefer X to Y (where X and Y are total situations). Assume then that P is
in X and Q is in Y. From here it follows that P is happier than Q.
A comparison can however also be made where the presupposition is
slightly weaker. We need not assume a total agreement between the
profiles of goals. It may be the case that P's and Q's different profiles still
entail that both prefer X to Y. Then if P is in X and Q in Y, P must be
happier than Q.
A pragmatic criterion for a comparison between two people as to their
happiness would then be to describe (in the utmost detail) the two
situations to them both and see which they would prefer. Before entering
upon such a project one must, however, bear in mind that “preference” in
our discussion is a theoretical term. We are talking about some kind of
ideal situation for decision, where the individual has complete self-
knowledge, and where he or she can foresee such things as risks of
disappointment, boredom etc. In many real decision situations people lack
this insight.
It is also important to bear in mind that we have to compare total
situations in order for the preference to say anything about happiness. P
who is in X need not be happier than Q who is in Y (even if both prefer X
to Y) if X and Y do not cover total life-situations. If X and Y only
concern some part of their lives, for instance their working life or their
health, then it is always possible that P has been struck by some
misfortune within another sphere of life. P may have lost a near relative,
a fact which leaves him or her in the deepest misery despite the existence of other favourable circumstances.

Thus it is easy to go wrong when one dreams about another person's life-situation and prefers that one to one's own. It is easy to prefer Prince Charles's existence to one's own. But one must then remember that to his situation belong not only his royal status and his prosperity; to his life also belong his illnesses, marriage problems and other misfortunes.

But how do we then tackle the cases when the profiles of goals are different and when a comparison between the situations of two persons does not give as a result that they both agree as to which is the preferable situation? Can we then ever say that one of the two is happier than the other?

My general conclusion must be that there are many cases when the happiness states of people are incommensurable. In such cases we can simply not say — not only for practical but also for theoretical reasons — that one is happier than the other.

There is, however, one important situation which is not uncommon and which is an exception to this incommensurability. This is the case when a person P finds his or her situation in life unacceptable, whereas Q finds his or her acceptable. In this case Q is clearly happier than P. And we can say this even if Q were to prefer P's situation, and even if P were to prefer his or hers to Q's. (This is then also an exception to the general rule for comparison given above.)

I hereby indicate the important borderline on the scale of happiness between happiness and unhappiness. I assume then that there is a level on the scale of happiness which marks a transition from happiness to unhappiness. Under this level the situation is so far from satisfactory that it is not acceptable; the person is unhappy. Just on the level or just above it the situation is acceptable; he or she is minimally happy.

In order for a person to be minimally happy in this sense a certain set of his or her wants have to be satisfied. I shall call this set the set of wants which have a high priority (in an absolute sense of the word) for the person. (Observe that we have previously only characterised the comparative relation higher priority than.)

Thus we have the following theoretical way of characterising a level of minimal happiness:

P is minimally happy with life, if and only if everything which is of high priority to P is the way he or she wants it to be.
The position of the borderline between happiness and unhappiness varies a lot between different people. The character traits and temperaments of people here play a major role. The impatient and spoilt person is such that he or she very easily becomes unhappy and refuses to accept life. To him or her practically all wants have a high priority. The patient and stoic person, on the other hand, can meet most adversities without falling below the borderline. To him or her very few conditions in life have a high priority.

I have here observed that happiness depends on how we assign priorities among wants. This observation provides an important key to happiness that I have not so far paid attention to. To influence the happiness of a person does not only entail the realisation of certain conditions in his or her life. It equally much entails influencing the profile of wants of this person. In particular, it may involve the reduction of the number of wants which have a high priority. That person who has a low profile, the human being with the lowest number of high-priority wants, has, in a certain sense, the greatest chance of becoming happy.

I think many people would accept that there is a good portion of truth in this dictum. At the same time there is something paradoxical — and even politically dangerous — about it. Shall our strategy for attaining quality of life entail the reduction of people's ambitions? Shall we aim for some kind of a minimal life? Is this the happiest life?

I do not in general intend this, as may be seen from some of my points in the next chapter.

A critical analysis of the decision-theoretic sense of “higher priority than”

I explained the nature of a person's ranking of priorities in terms of what he or she would choose given two alternatives and where he or she could not choose both. At the same time not all conceivable decision situations are realistic in the sense that the subject can actually perform actions of the kind envisaged. For instance, a woman may prefer having two babies to making a career as a lawyer. There are no concrete action sequences corresponding to these compared alternatives. Hence the comparison made by the subject must be in terms of an intellectual experiment.

Such an intellectual experiment, however, faces familiar difficulties when we discuss the epistemic question. How do we test that having X has a higher priority to P than having Y? In the case envisaged above we
cannot test the woman's preferences by inviting her to act. The standard way to test must instead be to ask: Which would you choose, if you had the choice between these two things, and if you were unhindered by any external or internal disturbances or forces?

Although this is the standard and practicable way of testing we must keep the connection with the real situation of agency. This is so because our theory must allow for the existence of unconscious wants. Per definition, an unconscious want does not reveal itself in a simple interview; it may reveal itself in a more complicated and cleverly designed intellectual experiment but it is not ultimately revealed until acted upon. Thus the test situation that we need is in a way an idealised intellectual experiment.

This idea can be problematised by means of the following case of a drug-addict. P is on amphetamines and continuously craves the tablets. All day P is busy getting hold of enough money, by whatever means, to purchase the daily dose of the drug. Does this not prove that having the daily dose of amphetamines has an extremely high priority for P and, consequently, that if P continuously gets it, he or she must be a very happy person? On the other hand, as we know, most drug-addicts are deeply unhappy persons.

In order to solve this paradox it can first be pointed out that there are many moments in the drug-addict's life when he or she consciously wants to get out of the whole situation of dependency. If we were to interview the addict in one of his or her clear periods the annihilation of the drug-addiction would prove to be at the top of his or her list of preferences. P is unhappy because of being a drug-addict with all its devastating consequences, and wants to get rid of this state of affairs.

This answer, however, is not sufficient. P seems constantly to refute this claim, acting against his or her declared wants. Does this then mean that P unconsciously and deep down prefers the drugs to a different life?

I do not think that we would describe the situation in this way. My answer is the following. The action test for priority is valid only if there is no external or internal force preventing an expected action from being performed. I can be prevented from doing what I deeply want to do if somebody at gunpoint forces me to rob a bank and disappear with the money. Likewise, I can be prevented from doing what I deeply want to do if I am in great pain and cannot do anything whatsoever and must lie down in bed. The case of the drug-addict has to do with the latter kind of internal force. The truth about the addict is that he or she is most of the time in a state of terrible tension and unbearable anguish. In this state he
or she is unable to do anything useful at all, knowing from experience that the only thing that can restore him or her to a state which is at least minimally human is the daily dose of drugs. Thus by choosing this life the addict does not reject his or her basic want. The addict chooses the drugs because he or she is, or believes that he or she is, forced to do so.

**Degrees of feeling happy v. degrees of being happy**

I have already noted that not only “being happy” but also “feeling happy” is a dimensional concept. The latter is moreover multidimensional. A feeling of happiness can be more or less *intense*, it can be more or less *frequent* and it can be more or less *enduring*. (According to Tatarkiewicz 1976 there are even further dimensions, e.g. the dimension of depth.) Along all these dimensions it could be true to say of P that he or she feels more happy now than before.

As has been said, there is an analytical relation between being happy and feeling happy. If P is happy, P is disposed to feel happy. This is shown also in the dimensionality of being happy. If P is very happy, then P is disposed to feel very happy, i.e. P is likely to have an intense feeling of happiness and it is likely to be frequent.

We cannot, however, use a person’s *degree* of feeling happiness as the ultimate criterion of his or her *degree* of happiness. A person may be very happy without feeling happy at all. Moreover, a person's frequency and intensity of feeling is partly due to other factors than his or her basic happiness.

Observe first the distinction between feeling happy with life and feeling happy with a particular fact. P can feel intensely happy with the fact that he or she has found a valuable object that has been lost for some time. This intense feeling may be due to the fact that the object has a high priority to P and that P is therefore also much happier than before. But the degree of intensity may also be influenced by a quite different factor, viz. the fact that the discovery was *unexpected*. P feels very happy at the moment of discovery; the feeling, however, gradually fades away and may soon disappear, when he or she no longer thinks of the object.

It would be misleading, though, to say that P’s degree of happiness is adequately mirrored by the fading away of the feeling. P is still happy with having the object, and his or her happiness with life is affected by the possession of this object according to the degree of its importance.

Thus the unexpectedness either of a positive or a negative event is a
confounder; it "blows up" one's feeling of happiness or unhappiness out of its "real" proportion. When something unexpected has happened it is therefore especially difficult to rely on a feeling in order to determine a person's degree of happiness with life.

Another confounder which particularly disturbs attempts to make inter-human comparisons concerning happiness is the following: People have very different emotional sensitivity and very different capacities and tendencies to feel happy. Being happy requires only the capacity to want and believe. Feeling happy also requires an emotional sensitivity. Moreover, this sensitivity exists in degrees.

A person with a very high emotional sensitivity can feel intensely happy (as well as intensely unhappy) for much less reason than somebody else who does not feel anything at all.

The problem of low levels of want-equilibrium happiness

Can one not have too low aspirations, or too small a set of wants? Can the want-equilibrium criterion work in the minimal case? Is it reasonable to say of a person who doesn't want to do anything else than to lie on a sofa licking a lollipop, that he or she is happy, now that this want is satisfied?

Given some necessary specifications of the example I shall say that this person can be happy in the want-equilibrium sense and that it is also reasonable to say so. What we must presuppose in the example is, of course, that this person now and again wants to eat, drink and sleep, and that these wants are satisfied. We must also assume that the person does not frequently get bored, that he or she doesn't in fact quite often wish to be somewhere else doing something useful.

Most lollipop-people on sofas don't fulfil the second requirement. They are terribly bored with life in general, and they want desperately to do something else. They may be unable to change their situation for various psychological or circumstantial reasons. They may be very weak, unimaginative or have few opportunities to act upon their wants.

Having said this we must allow for the extreme case of a person who is not bored and who genuinely does not want to do anything else. This would presumably be a person with a very low degree of intelligence and emotional sensitivity. But it would be wrong to deny that such a person has happiness.
A further dimension of happiness: the dimension of richness

The strong case

Consider a boy who has lived all his life in simple and unpretentious circumstances in the Highlands of Scotland. He has been entirely content with his lot; he gets along well with his family, he appreciates the wild countryside and he enjoys the sometimes hard struggle for life up there. Thus he has been completely happy in our want-equilibrium sense.

One day he and his family are visited by a tourist who happens to be a famous musician. The tourist is attracted by the place and settles there permanently. Partly to earn his living he starts teaching the young boy to play the violin. He then discovers that the boy has a remarkable talent for music and that he very soon develops a proficiency in playing. This completely changes the boy's life. A whole new world has been opened up to him.

The intuitive picture of the boy is that he is now highly involved and enmeshed in his musical activities. He is more active than before, he enjoys playing and he very much enjoys listening to music. His moments of pleasure have become much more frequent and therefore he has much more often reason to feel happy. To put it in our technical terms, he has acquired a multitude of wants which he didn't have before, and he is in the process of satisfying them.

The boy was, as said before, completely happy with life before the musician arrived. But how should we then express the positive change that has now happened to him? Let us here presuppose that it really is a positive change. One can, of course, imagine the case where the appearance of the musician disturbs the idyll in the family. The boy's parents may become envious or even jealous; they may want to get rid of the musician and thereby ruin the whole enjoyment for the boy.

But the case we shall consider is instead the following: the boy has all his previous wants satisfied; in addition he now has a number of further wants; some of these, or even all of these, are being satisfied. In quasi-numerical terms, the boy may now have 20 out of 20 wants satisfied, instead of 10 out of 10 wants satisfied.

I shall here acknowledge this as a further and genuine dimension of happiness, which I shall call the dimension of richness of happiness. The Scottish boy is now happier than he was before in the richness sense,
although he is equally as happy as he was before along the want-equilibrium continuum.

I shall identify richness of happiness not only in this quasi-numerical sense but also in the sense of acquiring qualitatively richer wants. This can quite well be illustrated by the case of acquiring higher ambitions. Consider the person P who starts off having modest ambitions in life. Let us say that P is a man who intends to become a bank clerk like his father and settle in the local branch of the bank. He is then persuaded by a friend to set a higher target; he enters upon an education in bank-managing and aims for a top position in the bank, which he finally gets. In his new position he is engaged in more varied and more prestigious activities. He may enjoy the power attached to the job, as well as the variety of duties and the opportunities for travelling. His moments of pleasure are now more frequent than before, and so are his feelings of happiness.

In this case it need not be the case that P's actual number of wants has become greater; the essential difference is that he has replaced a less ambitious set of wants with a more ambitious set of wants in the professional sector of his life. (Observe here that ambition is not an objective concept. It need not at all correspond to a conventional idea of a career. What is important is that the subject considers the transition as more ambitious and more desirable.)

Even if the described increase in happiness cannot be explained in terms of the relation between the number of wants and the number of satisfied wants, it can still be understood within the framework of our fundamental conception. When the Scottish boy has become a musician we let him compare his present life with his previous life. He then finds that he prefers the new life to the old life. In the same way P prefers his life as a bank-manager to the old one as a clerk. Ex post facto they can both say that the new life is more in agreement with how they now want their life to be. We could perhaps say that every human being has a set of potential wants which he or she would embrace had he or she been ideally informed. It is from among this set of wants that the person has picked when his or her happiness in the richness sense has been raised.

In order to be able to claim that P is happier now than before we must, however, add another presupposition to our reasoning. We must presuppose that the order of preference does not change over time. P can at $t_1$ prefer the life he or she has now to the one that he or she had at $t_0$. This does not necessarily entail that P is happier at $t_1$ than at $t_0$. P's order of preference at $t_0$ can have been different than at $t_1$, so that P at $t_0$ in fact
would have preferred the life at \( t_0 \) to the one that he or she was going to have at \( t_1 \). The simple \textit{ex post facto} judgment can therefore be illusory.

Some properties of the richness dimension

(i) \textit{The upper limit of richness}. Can there be anything such as complete happiness in the richness sense? As we can immediately see, there is no equivalent to the simple mathematical algorithm that can be used in the want-equilibrium case. The richness of happiness can therefore \textit{in principle} be extended infinitely.

The limit that there must be is of an empirical kind. There is a physical and psychological limit to what people can grasp intellectually; as a consequence there is a limit to what they can take an interest in and form wants about; moreover, and what is more confining, there is a limit to what they can do and achieve.

A consequence of what is indicated by these observations is that the limit varies with \textit{individuals}. Different human beings have very different abilities to grasp reality, to take an interest in reality and to realise advanced plans in life. There is a personal upper limit for how happy \( P \) can become in the richness sense, which is different from what \( Q \) can achieve. In contrast to the want-equilibrium sense, according to which everybody can become equally happy, there is a constitutional difference in people's ability to become happy in the richness sense.

(ii) \textit{Does richness of happiness require want-equilibrium happiness?} Siri Naess (1979, p. 20) says in a criticism of the simple want-equilibrium theory:

\begin{quote}
A person who has 90 out of 100 wants satisfied can have a much better time than the person who has all his 10 wants satisfied.
\end{quote}

We must first observe that the person who has 90 out of 100 wants satisfied can be, and perhaps typically is, unhappy than the one with all his or her 10 wants satisfied. There is a great risk that among the ten which are not satisfied is some high-priority want, for instance the want to remain healthy. Thus this person is, per definition, unhappy with life.

Assume, however, that all the ten unsatisfied wants are minor. The person is then, also according to the want-equilibrium criterion a very happy person. We can imagine him or her to be an extremely vital and active person who has a great number of projects and aspirations,
concerning both work and leisure time. In fact, this person wants to do so many things that he or she has no time to realise everything. Moreover, some of the person's aspirations may be so far-reaching that he or she doesn't have the capacity to realise them.

We shall now recognise that with an additional — and psychologically plausible — assumption this person can be completely happy also in the want-equilibrium sense. The person may simply want life to be an adventure, to be a struggle, in general to be slightly unpredictable. This means that this person may have a want of higher order which is such that he or she does not want all the first-order wants to be satisfied; the person may, for instance, want some of them not to be satisfied, in order to keep him or her alert in the struggle. This second-order want may have a very high priority. If the wants which are not satisfied among the hundred wants are within the scope of this second-order want, then, slightly paradoxically, our vital person can achieve even complete happiness in the want-equilibrium sense.

But, even without this assumption, the person who has realised 90 out of 100 wants, where the 10 remaining are minor, is a very happy person in the want-equilibrium sense. His or her happiness is also much richer than that of the person who has satisfied all his or her 10 wants.

(iii) Is the person who is rich in happiness more vulnerable than the poorer one? Is there, in general, a greater risk that such a person will lose his or her happiness? It could be maintained that the happiness of the rich person — in our sense — is more vulnerable than the happiness of the poor person. If one has many wants to satisfy there is a greater probability that something will go wrong; moreover, if one has many wants with high priority the probability of direct unhappiness with life is great.

From a purely mathematical point of view this seems to be true. On the other hand, the real threat to happiness must lie in the nature of the wants. We may assume that P, who has many wants, has wants which are quite realistic and easily realisable; Q, who has few wants, may want to have or to do something which is hardly attainable. Here, of course, Q must in practice be the more vulnerable.

The relation between a person's ambitions, whether this relates to multiplicity or degree, and the realism in these ambitions, which is dependent on the probability of a particular course of events and the person's own abilities, determines his or her degree of vulnerability.
The recipe for happiness, then, seems to be to place one’s ambitions at a realistic level. The Stoics were particularly aware of this and consequently recommended the reduction of human ambitions to a minimum. In contrast, Aristotle was an expansionist. Human beings should develop their potential; they should take an interest in all that for which Nature had supplied them with endowment. For the Stoic want-equilibrium happiness at a very low level of richness is what we should aim for. For Aristotle we should aim for the highest possible — but still realistic — level of richness.

The weak cases: the cases where “richness” does not entail higher degrees of happiness

Is it always plausible to say that a person who has satisfied a greater number of wants or satisfied wants that are more ambitious, is in general happier than the one with fewer or less ambitious wants satisfied? Does this not contradict some important insights that we have about human psychology, for instance that the satisfied greedy person is not happier than the person who has satisfied very moderate wishes?

To illustrate this point best we must choose examples which are different from the strong cases. The strong cases entailed the development of human potential: the Scottish boy could develop his musical talent; the bank-clerk could develop his talent for advanced bank-managing.

The weak cases that I have in mind are the cases of pure consumption. (1) Boy A wishes to have 100 sweets and gets them; boy B confines his wishes to 10 and gets these 10 sweets. Is boy A necessarily happier than boy B? (2) Family C in Scotland wish to have a five-room flat and get it; family D in Bangladesh, who have not even heard of five-room flats, want to have a single room for themselves and get it. Is family C necessarily happier than family D?

The case of the sweets. First, we must keep in mind what time-span we are discussing. There is a risk that, in analysing this case, we are influenced by what are the possible consequences of eating 100 sweets. It is, of course, in the long run dangerous to have a daily dose of 100 sweets. The boy’s teeth will be ruined and the balance of his diet will be negatively affected. He is, in fact, likely to have his future happiness lowered. Thus, as counsellors, we would never advise a person to eat 100 sweets.
But this is a question different from the one dealing with boy A's happiness at the time when he is eating the 100 sweets. Assume instead that boy A derives equally much pleasure from each sweet that he eats and feels happy about each sweet. Assume that boy B does not derive more pleasure from each sweet, and does not attach more importance to any of them, than A does. Then, all else being equal, it is not at all implausible to say that A is happier than B.

Most probably, however, our assumptions are not true and all else is not equal. First, it is very unlikely that A derives equally much pleasure from all sweets. He may enjoy the first four or five, but then may hardly notice the rest. Moreover, he may even feel slightly sick during the intake of the last 20 sweets. Why does he then eat them all? Does he not want them?

There are two ways of describing the situation. One is that he picks the sweets from their bag in a semi-automatic way without even reflecting on it. The other way is to say that he picks them because he is obsessed; he is like a drug-addict who is by inner forces compelled to take the sweets which he deep down does not want to take. In both cases we have denied that the assumption of a high degree of happiness is true.

A further plausible interpretation of the situation is that B uses the time that A spends eating sweets, to do something useful from which he derives much more pleasure than having sweets. Thus B may be happier than A, because all else is not equal; the life of B differs from the life of A in some important respects.

What I have given here are some plausible interpretations of a situation where A has had 100 sweets which he, at least initially, wanted to have, and B has had 10, but where A is still not happier than B. I have been able to give these interpretations within my theoretical framework. They do not constitute arguments against the idea of richness of happiness based on the satisfaction of highly ambitious wants or a great number of wants.

The case of the flats. The problematic thesis to tackle here would be the following: The Scots who have managed to get a five-room flat need not be happier than the poor Bangladeshi who gets a single room for his family.

Consider first some cases where it is indeed more plausible to say that the Scots are happier. First, housing has a very high priority to most Scots. It is important to most of them to have spacious accommodation. A decent house is a matter of status; the house is the place where the Scots
spend most of their free time, as well as possibly some of their working time.

Moreover, it is not difficult to visualise that the Bangladeshi family can be unhappy. Although they do not expect a bigger flat than the one they have got, they can still be discontent. If the family is big there is a great likelihood that the members of the family cannot do everything that they would like to do in their room. They may not be able to work, to play, or to manage the household in the way they would like. In such a case there is some unhappiness in this family. Admittedly they may not have a conscious want for bigger accommodation if such a thing is unheard of in their neighbourhood; still, it is true that they in general want to live under different conditions.

The strong case in favour of the thesis under debate is the following. The Bangladeshi family have lived completely without decent accommodation for a long time. Unexpectedly, they get an opportunity to acquire this room to have on their own. Their happiness with this development is great.

The Scots, on the other hand, expect to get their five-room flat and have no difficulty in acquiring it. They pay little attention to the flat and spend, as it happens, very little time in it.

First, it is clear in this case that the Bangladeshi family would feel much happier than the Scots for some considerable time. They are faced with an extremely positive surprise, whereas the Scots get something completely expected and subsequently pay very little attention to it. But it is also true that they are much happier, and this can be explained within our framework in terms of the importance they attach to their new accommodation. The room has to the Bangladeshi family the highest priority. It signifies for them the difference between an unbearable and a tolerable life. The five-room flat to the Scots has much less importance. Although they wanted to have a five-room flat, they do not need more than two rooms. Thus having at least two rooms has a high priority for them. The surplus, however, has a low priority.

The general conclusion to be drawn is the following: The cases of "pure consumption" do not, as far as can be seen, constitute arguments against the general idea of happiness in the richness sense. It can be agreed, of course, that people who consume more need not be happier than people who consume less. This can, however, as I have indicated, be explained in terms of other features of the theory.
A reply to my critics

The Danish philosophers Sandøe and Kappel have taken issue with my analysis of richness in their paper “Changing Preferences: Conceptual Problems in Comparing Health-Related Quality of Life” in Nordenfelt 1994. According to their view richness is not an independent dimension of happiness. The intuitive plausibility of the case of the Scottish boy, they say, can be handled within the general framework of the want-equilibrium notion of happiness:

The increase in wellbeing is not caused by the fact that the boy now satisfies a desire which he did not have before. Rather he becomes aware of new and better ways of satisfying preferences that he has all along had, e.g. the desire to do admirable things, and this improves his life.

The kind of case that Sandøe and Kappel describe is a possible case, but it is not the case of richness that I envisage. In fact, Sandøe and Kappel presuppose something which I did not intend to presuppose. They seem to maintain that every human being from birth to old age has a fixed set of abstract wants which does not change over time. The only thing that changes is the subject's awareness of different opportunities for realising these wants. A change in the environment may present new opportunities for such a realisation.

This is a very strong and rather implausible assumption since it denies the possibility of a genuine change in a person's psychology. Moreover, it relies on a notion not only of unconscious wants (which I think that we must accept) but also of such unconscious wants as could not have been discovered but for the appearance of a particular fact, viz. in this case the musician. Observe that Sandøe and Kappel presuppose that there is a general want operating here, for instance of the kind that the boy wishes to do admirable things. I claim that this need not at all be the case. There can arise for the first time a genuine love of music in the boy's mind. It is very implausible to maintain that the boy had had the love of music all along, even when he knew nothing about music. The strongest thing that we can say is what I say above: the boy had had a potential want for playing music all along.

Sandøe and Kappel, however, make a further, and I think more important, critical remark. They wonder about the reverse case, i.e. the case when a person moves from a state of having many and ambitious wants to a state of having few and less ambitious wants. This is indeed
what often happens when people get older, and it happens particularly dramatically when people are stricken with dementia. The question could then be asked: Does it follow from my idea of richness that such a person must become less happy when he or she starts living a poorer life?

Let me first sketch a psychologically very plausible scenario where a person who lives a very rich life can become happier when he or she becomes older and loses a number of aspirations and ambitions. I envisage a man who looks forward to retirement. He can do this although his present life is in many ways interesting and also satisfying. There are many challenges and there is a lot to do in his life. He has many plans regarding both his private life and his working life, and he has reasonable success in most of what he tries to do. However, there is one very important thing that he has difficulty in achieving, viz. peace of mind. The stress and worries connected with many of the challenges often pain him and even keep him awake at night.

When this person considers the time of retirement he can very well envisage that this will be a happier time. In fact, he may even long for the peace and quiet of the days when the requirements of today will disappear. That time will not have the same pleasures of excitement as the present time, but even given this he would prefer the life of retirement to the life that he lives today. In a way he would then prefer the poorer life to the richer life.

Is this case a counterargument to what I have said about the richness dimension of happiness? No, it is not. We must observe that the man was not maximally happy on the want-equilibrium scale during the years when he was still working. In fact, at times he was not even minimally happy, i.e. when he could not realise the peace of mind which he considered to be something very important. He envisaged that this was something that he could get when the very tough challenges in his present life disappeared. Thus the life of retirement, if it were to become as he hoped, would be a happier time.

It seems to me clear that a rich life in itself is not happier than a poorer life, unless, at the very least, everything that the subject considers to be important in the rich life is as he or she wants it to be. This is exactly in line with my theoretical description.

What then about the following case? P lives a very rich life and is maximally happy on the want-equilibrium scale. He or she envisages a much poorer future life but one which still entails want-equilibrium happiness. Can P not prefer the latter life to the former one? Is this just a psychological impossibility or is it a logical one?
I shall tentatively argue that this is a logical impossibility. If P has everything that he or she wants, then unless P acquires new wants or drops some of the ones he or she has, P cannot want to have a poorer life. The latter becomes plausible only if we tacitly assume that there is something in P's rich life with which he or she is not totally satisfied in the way I described above. But then we have begged the question. We have denied the postulated premise of the reasoning.

But what about a person who has already entered upon the poorer life and judges him or herself to be completely happy? Can this person not judge his or her present happiness to be greater than the former one? Yes, his or her psychology can be changed to the extent that this is possible. The person may find that the things that he or she previously wanted are unimportant and be completely content with his or her present lot.

From this, however, it does not follow that the person is happier than he or she was before. The only thing that follows is that the states before and after the psychological change are incommensurable.

Some test cases

In this concluding section I shall discuss some cases which in one way or the other throw doubt on my theory of wellbeing in terms of happiness-with-life.

In case 1 the thesis is that the only real happiness is constant and intense pleasure. In case 2 it is argued that there is a further dimension of subjective wellbeing, distinct from happiness with life, which might be called experience of meaningfulness. In case 3 it is argued that the engrossment in a sublime activity, such as religious contemplation and worship, is the real essence of wellbeing.

Case 1. Happiness as constant pleasure. Not so long ago a young Swedish boy was interviewed about what he considered to be happiness in life. His answer was blunt and arrogant: "Happiness to me would be to lie down on a beach in the Canary Islands and have a continuous sexual orgasm". However unimaginative and appalling this answer is, there is something typical about it, and there are some more refined versions of it appearing in philosophical literature; therefore, it is worth being considered.

First a minor point of order. Given the framework of our theory the
boy has not answered the question properly. As a candidate for happiness he has produced a sensation. Happiness, as I have explained it, is not just a sequence of sensations. That fault can, however, easily be remedied. He can instead claim that in order for him to be happy he must satisfy his want to acquire the sensation involved in sexual orgasm.

Our first reply to the boy is that he cannot be sincere. A second's reflection would show to him that it would be hell to lie on that beach for more than half an hour. He would soon become thirsty and hungry; soon his mates would be calling to him, reminding him of the tennis time or of the excursion they had planned to make to Africa; soon he would get completely exhausted by his energy-consuming orgasm.

Therefore, realistically, he cannot want to hold on to this state of affairs. Given the nature of the world, and in particular his own nature with its needs and interests, he cannot want this eternal orgasm. Therefore, having it — *per impossibile* — could not constitute even want-equilibrium happiness, however small his set of wants happens to be.

Now it is time to present the sophisticated version of the puzzling idea. Assume that we are not talking about any so far known sensation connected with a particular bodily function. Assume instead that we invent a machine which can induce in us an extremely pleasant feeling of a completely new kind. Assume also that the whole scenario of our world and our nature is changed to the extent that we will have no other needs to satisfy, that there is nothing else that we want but this pleasant feeling. Assume further that a particular person constantly has this sensation. Would this person not be extremely happy? (For a classic discussion of this kind of case, see Nozick (1974), pp. 42-45.)

Yes, this creature would satisfy our criteria of being happy, but would do so at the expense of no longer being human. This can be said without any particular evaluation put into the notion of being human. The example is so artificial and so emptied of content from the world as it is, and from persons as they are, that it cannot have any force for our judgement about the conditions of human happiness.

**Case 2. Wellbeing in a further sense. Experience of meaningfulness?** A famous Swedish journalist got cancer and had a long and extremely painful period of illness. She afterwards appeared before the public in a TV programme. She was completely transformed as a person. She had great difficulty in speaking. In spite of this she made some fantastic and astonishing remarks. She said that although this period had been the most painful in her life — sometimes the pain had been completely unbearable
— she was extremely grateful for having had this experience. It had been the most important period in her life, which she now wouldn't have wanted to be without. It had given her a deep insight into the conditions of life; she could now clearly see the value and meaning of her own life.

Do we here have to do with quality of life in a completely new sense? The woman was in extreme pain, which *prima facie* indicates great unhappiness. On the other hand something extremely positive had happened to her. She had acquired the deepest insight into the meaning of her life.

Without denying the peculiar nature of this case I wish to argue that it can be handled within our framework and that it would be reasonable to call the journalist quite a happy person. Let us try to explicate the situation.

She realises that the pain and the illness in general have been and still are necessary means for attaining the very gratifying state in which she now is. Thus, although her pain was *prima facie* unwanted, it is now seen to be highly desirable. In our terminology her wellbeing is then to be classified as happiness.

The journalist got a painful disease, which in the beginning must have caused a great deal of unhappiness. She then gradually realises that her pain and her general situation give her an insight which she finds extremely important and which she very much wants to hold on to.

This does not mean to say that she is completely happy. She is still continuously prevented from performing most minor things in life. That must constitute a considerable stress and frustration. But, if we are to believe her, this stress and frustration is tolerable, because she is fundamentally happy.

**Case 3. The bliss of religious life.** It could be maintained that the theory presented in this study — purporting to be a theory of happiness-with-life — is only a theory of simple satisfaction. Happiness is in fact equated with the satisfaction of wants. This, it may be said, is a very crude and simple theory. Happiness, and human wellbeing in general, is something much more complicated and profound.

Consider a devout Christian who argues along the following lines: The happiest life is not a life of want-satisfaction; it is the life which is in the vicinity of God, in the Mass, in Holy Communion or in prayer. Analogously — but perhaps not with equal force — a scientist or an artist can claim that the really happy life is the life of science or the life of artistic creativity. Such lives have qualities which make them more than
worth living, in comparison with the bureaucratic and grey lives that most of us have to live.

There is first a preliminary answer to this: The religious, scientific or artistic lives are happy lives for those who have the interest and inclination for such lives. To a devout Christian the religious life is splendid, to an intellectual the scientific life may be splendid etc. But having introduced the notion of interest we have in fact reintroduced the notion of want. It is a fundamental want of the religious persons to live in the vicinity of God. Everything else has a much lower priority. As a result, if these persons can almost fill their life with religious activities they have fulfilled their single primary want to the highest extent. No wonder such persons are is happy. (Parallel arguments can be given for the scientific and artistic case.)

This answer, however, opens the door to a more fundamental and far-reaching objection. The devout Christian in our example does not just think that people who are interested in religious life will become happier by living religiously; this person thinks that everybody, interested or not, will become happier. The religious case is here stronger than the scientific or artistic case. It is a fundamental hypothesis in most religions that it is possible for everybody to live a religious life to some extent. It seems, however, absurd to say that everybody, given his or her gifts, would become happier as a scientist or artist.

We disregard here whether the religious claim is true or not. The general idea is plausible enough. There may very well be a set of activities such that everybody, whatever his or her gifts or talents, would find indulging in these activities highly enjoyable — or here we may want a stronger expression: highly rewarding or engrossing. Only a few people know about this fact, only a few people actually want to take part in these activities.

The people who do not know and therefore do not want can still reach complete happiness in the want-equilibrium sense. But it seems absurd to say that they are as happy as the ones who indulge in the blissful activities.

One answer to this is to refer to the richness dimension of happiness introduced earlier. The religious person has something that he or she wants to hold on to that other people do not have. Moreover, this thing has the highest priority in the person's life. He or she wants to hold on to it more than to anything else. Therefore, such a person may be described as happier than most other people on the richness scale of happiness.

The religious person can, however, say that this answer is inadequate.
It is not only the case that the person has satisfied his or her religious wants; the main point is that his or her whole life is so permeated by feelings of engrossment. It can simply not be compared with the dull bureaucratic life of ordinary people. Such a person's life is the life of real happiness.

In responding to this challenge I think we must clearly distinguish between two features, viz. the happiness-aspect and the pleasure-aspect of the engrossment talked about here. We may grant that the religious person frequently has almost sensation-like feelings of extreme pleasure. But pleasure, I have argued, is not a part of happiness. There is a need for independent arguments for the case that the religious person is also happier.

I think we may be able to give an account of this case within our framework. The person I have in mind has an extreme pro-attitude to life. This person sees the meaning of life quite clearly; he or she has a positive attitude to his or her peers and mankind as a whole. This pro-attitude to life normally involves frequent cognitive acts, frequent reflections on how well God has organized the world for everybody. In fact, the person may think that God has organized the world in a way which is such that one could not want it better.

In the case we imagine, then, the happy person thinks not only that God has satisfied all his or her wants; the person thinks more profoundly: God has satisfied all conceivable (justified) wants; the world could, deeply speaking, not be better. This, I would say, certainly is an ultimate kind of happiness; it is the ultimate degree of richness of happiness. We may even say that it forms a species of its own, which may be called the transcendental dimension of happiness. It presupposes a person who in a way transcends his or her own ego and embraces other people's wants within his or her own set.

Thus, in spite of the extreme nature of the religious case it seems to me that it does not require a revision of our conceptual network or our theory of happiness in general.

Notes on some ways of achieving happiness

My reasoning so far has almost exclusively dealt with the characterisation of the notion of quality of life. My suggestion has been to identify quality of life with happiness and I have therefore sketched an analysis of the
notion of happiness. But I have so far said very little about the very important practical question of the means to obtain happiness. Can a theory of quality of life of the kind that I have sketched give us any insight into that matter?

I think that there are certain general conclusions to be drawn already from the abstract theory, even if the concrete pieces of information have to be given by the psychologist or the sociologist. The psychological theory of need to be presented below is such a source of knowledge.

The fundamental idea in my theory of happiness is that happiness consists in the satisfaction of wants. This idea can at first sight give negative associations, since the satisfaction of wants in ordinary speech is often associated with immediate satisfaction of drives or of temporary whims. My theory does not support such an interpretation. Immediate satisfaction of drives may certainly provide some happiness for the moment, but as soon as we are interested in lasting happiness, happiness that is not immediately accompanied by disappointment, boredom or regret, other strategies are required. Then we need appropriate knowledge both about the world surrounding us and about our own personality. We require knowledge about our deeper goals and wants, and also in fact some ideas about what we might appreciate in the future, i.e. some kind of predictive knowledge about our profile of goals.

From this follows something very important which complicates the research on quality of life. Not all people, hardly even the majority of people, have the insight or knowledge required about the world or themselves to design an efficient strategy for long-term happiness. Moreover, certain pieces of knowledge, in particular about the world outside, are often impossible to obtain. No one can with certainty predict future political crises; no one can with certainty predict future natural catastrophes; and no one can with certainty predict the development of their private situation, whether they will live and remain healthy, keep their occupation etc.

Against this background there is of course no completely secure strategy for achieving happiness. This does not prevent that there are wise strategies which can stand firm in standard situations. These wise strategies presuppose knowledge which is often available, but which many individuals lack. In order for these persons to achieve a high degree of happiness it is then required that they get a fair amount of advice. Other people can know more about what is best for them than they do themselves. This is in fact how parents and teachers normally look upon their roles. A parent sees to it that a child gets the most nourishing food
and that he or she gets more than eight hours of sleep; this in order to lay the proper foundation for the child’s long-term health and happiness. A teacher provides knowledge about different areas of life in order to make it possible for the pupil to be properly oriented and thereby get a better chance for long-term happiness.

Do these observations have consequences for the theory of happiness? Is it not the person him or herself who judges when he or she is happy? Have we left the interpretation of happiness in terms of the person’s own goals and the realisation of these? No — and this is an important point. The advice that I have just exemplified is advice which all the time has the subject in mind; it is a way of advising which takes as its starting point the subject’s known desires and wants and other elements of his or her psychology. What this kind of advice aims at is that the subject (the child or the pupil) will reach a lasting state which he or she is content with and prefers to all other natural alternatives. The person who \textit{in the final instance} judges whether the guidance has been successful or not is and must be the subject.

There are other conceivable kinds of education and guidance which have completely different purposes. The purposes can be political, moralistic or purely conventional. A government may recommend a certain way of life among the inhabitants only because this is expected to increase the political stability in the country. A teacher of morals can preach abstinence from drinking, gluttony and fornication, not primarily for the sake of the future happiness of the pupils but simply to imprint the true morals. These kinds of guidance have nothing to do with our discussion.

The abstract wisdom to be derived from this lies very close to the Socratic one: know thyself. You ought to get to know what you deep down want to do with your life and what in the long run best benefits you. For this you often need good advisors, who know more about the world and often know more about you than you do yourself. But the person who can finally assess whether a piece of advice has been good or not is only yourself. It is your happiness that is the issue.

The most extensive and ambitious among us should not only consider the Socratic wisdom but also the Stoic one: If it is within your power, see to it that your wishes and goals are on a realistic level. A continuously unsatisfied ambition which has a high priority entails of necessity continuous unhappiness of some degree.

These conclusions are certainly not new. But remember what is the main purpose of this text. It is intended to provide an analysis of the
notion of happiness. A sign that such an analysis is on the right track is that we recognise ourselves. The analysis must agree with and at best explain truths which are well tried and tested.
Part II

The medical context:
Measuring health and quality of life
Introduction

What does it mean to be healthy? We all have many quite firm views on this matter. To be healthy is to function well. It is to feel strong and vital. It is to lack pain and disability. It is to be able to work, to be able to handle one's daily life and enjoy one's life.

Such could be the answers when one asks a fellow human being about the nature of health. In one way he or she would know quite well what health is and be able to describe its meaning very vividly. And this is to be expected. "Health", "illness" and "sickness" are some of the most common terms in our language. Our interest in and commitment to the phenomena of health and disease is, not least these days, extremely great. Empirical investigations which have been pursued show that health is considered to be one of the greatest values in life. (See Jeffner 1989.)

But not only philosophers know that phenomena with which we are very much acquainted can be very difficult to characterise and define in a strict way. The concepts of health, illness and disease, and also concepts related to these are very difficult to capture and define. And this is not only an academic problem. It can have great practical consequences and it can influence the welfare of people to a high degree. Let me give some examples.

1. The question of labelling someone as ill or healthy. A doctor very frequently faces the decision of declaring somebody to be healthy or ill. Since the doctor acts from a position of authority his or her decision normally entails the ascription of certain rights and duties to the patient. The most prominent among the rights is the right to abstain from one's daily work. But the duties are also apparent. If the patient is labelled as being ill, he or she is obliged to approach the health care system.
patient is also in principle obliged to comply with the recommendations of the doctor.

The medical decision which has these important implications must be founded, according to our common belief, on a clear view of the distinction between health and disease. But what is this view? Is there a common medical opinion on these matters? And if, on the other hand, there is no consensus, could this be a serious matter?

2. The goal of health care. In Sweden a new Public Health Act has been instituted. According to this act it is the duty of the health care organization not only to treat disease, but also to promote health. It does not suffice to take care of those who have been stricken by disease and who actively seek help. It is also the responsibility of the health care personnel to maintain and promote the already existing health of the population. But in order that this shall be done in a sensible way, there is clearly required a reasonable understanding of, and some consensus concerning, the nature of health. But what is health over and above the absence of disease and impairment? Are the medical personnel educated regarding these matters?

3. The unclear borderline zone. Apart from the general problems which surround the labelling of health and illness, there are certain controversies, both from a clinical and scientific point of view, concerning specific categories of human bodily and mental conditions. These controversies are particularly common in psychiatric discussion. They can have to do with the general category of psychopathy or they can have to do with the question whether alcoholism and deviant sexual behaviours are diseases or not.

On some of these matters different cultures tend to express different views. These views have partly changed over time. Particularly telling is the history of how we in the Western world have looked upon the phenomenon of homosexuality.

Homosexual acts have for centuries been considered to be not only sins but also crimes in most Western countries. From an orthodox Christian point of view performing homosexual acts involves a breach of the laws of God; the homosexual act is the most abominable sin. In Leviticus 20:13 it says:

If a man also lie with mankind, as he lies with a woman, both of them have committed an abomination: they shall surely be put to death; their
The religious standpoint was for a long time supported in the Western criminal codes; and as religious authority began to wane secular law took over the persecution. The death penalty for homosexual acts remained in most countries until the 19th century, when it was replaced by milder forms of penalty. It is only during the last few decades that this view has become modified and even become replaced by an "enlightened" opinion, which has characterised homosexuality as a pathological condition. This change of general opinion has come about through influence from several sources. The strongest theoretical source is psychoanalytic theory. According to this theory homosexuality is a morbid change which is dependent on an early disturbance in the development of the individual's personality.

This analysis of the phenomenon of homosexuality, however, has in its turn been the target of extensive criticism by the gay movement and by leading psychiatrists. As a result the American Psychiatric Association decided in 1973 to exclude homosexuality from the list of psychiatric disturbances. This decision was to a great extent provoked by lobbying from the Gay Liberation Front in the US. But along with this social battle a rational argumentation was conducted to legitimate the decision. A leading figure in this discussion was the psychiatrist R.L. Spitzer. Spitzer formulated a series of necessary and jointly sufficient conditions for the application of the concept of disease. These conditions, according to Spitzer, are not fulfilled in the case of homosexuality. And since the American Psychiatric Association could agree with Spitzer about the conditions it was necessary to erase homosexuality from the list of pathological conditions. (For a very lucid treatment of this issue, see Bayer 1981.)

On the notions of health and disease

Two perspectives

In our ordinary thinking on health and disease we often oscillate between two different perspectives. From one of the two perspectives we look upon the human being as a complete individual and investigate whether he or she is healthy or not. This entails posing questions such as: How is this
person? What can this person do today? Can this person pursue the normal social functions?

From the other perspective we pay attention to separate parts of a human organism and study their structure and function. We then ask ourselves the following: Is this organ normal? How does this heart work? What is the liver tissue like? What is the capacity of the lung?

The first perspective, which focuses on the human being as a whole, will here be called the holistic perspective. An investigation which is pursued from this perspective will very naturally use concepts from ordinary language, from psychology, sociology and anthropology. Examples of such concepts are ability, disability, handicap, coping, wellbeing, pain and anguish.

The other perspective, which concentrates on the inside of the organism and its parts, will be called the analytical (and in this study also the biostatistical) perspective. An investigation based on this perspective will mainly use biological, chemical and statistical concepts.

What motivates these two perspectives and why do they play such an essential role in our thinking? The background to the holistic perspective is evident. It is the interest of the ordinary human being. He or she is primarily committed to holistic facts about his or her health and asks the following fundamental questions. How do I feel today? Have I got rid of my pain? Can I go to work? The inner function of the bodily machinery is uninteresting to the person from all other points of view than its being responsible for his or her health or illness. When the person is ill he or she certainly wishes to know what bodily organ is responsible for a particular illness in order to have that organ manipulated and treated.

The origin of the other perspective is the art and science of medicine. Medicine has a number of traditional tasks: to cure diseases, to alleviate pain and in general to restore the health of its clients. In order to accomplish this, medicine must investigate the mechanisms behind health and disease. These mechanisms have to a very great degree been understood in terms of the bodily machinery. As a result, the main concentration of medicine (at least as a science) has been on the parts of the body, in recent years often on the smallest parts and their most subtle functions.

The two perspectives do not exclude each other. Nor could one get a reasonable understanding of the dimension of health/illness if one were totally to exclude one of them. This is an insight shared both by the doctor and the layman. It is certainly also an insight that a theoretician of health must have. A reasonable theory of health must be able to give an
account both of holistic health and of a particular, perhaps anatomically very limited, disease.

So far so good. But how shall these two perspectives be united into one structure of concepts? Which perspective should be chosen as the most basic one? From where shall the basic concepts be chosen? It is interesting to see that in the history of the theory of health attempts have been made to build from both platforms. Some researchers have started their work from a holistic perspective and tried to define concepts such as "disease" and "impairment" on this basis. Others have started with the diseases and the impairments, and from an understanding of these they have tried to characterise the notion of health.

I shall here start my investigation by considering the latter kind of attempt. I shall study a modern variant of a biostatistical theory.

A biostatistical theory of health

The basic idea here is the following. Biological evolution has created a number of species out of which man is one. This evolution has entailed certain changes, but it has also involved a fixation and conservation of the fittest species and their specific characteristics. Man has proved to be such a fit species. And man has a number of characteristics both in terms of structure and function. We have some idea of how these characteristics have, through various causal mechanisms, contributed to the survival of individual human beings and the species as a whole.

The goals of individual survival and of the survival of the species could be called the biological goals of man. These goals are not attributed to the body from the outside, but belong to the internal constitution of the body. Scientists can detect what these goals are by inspecting a large sample of human beings by means of a statistical analysis.

Thus we have now a sketch of the basis for a biologically oriented theory of health and illness. Such a theory has been presented in great detail by the American philosopher Christopher Boorse (1975, 1976 and 1977).

A healthy human body, according to Boorse, is one in which every organ makes at least its species-typical contribution to the goals of survival and reproduction. A body in which this is not completely the case, i.e. where not all organs make their species-typical contribution to the apical goals, is to some degree unhealthy. The particular state of affairs which accounts for the subnormal function is a disease.
Boorse sets about the construction of his theory by introducing the concept of disease. He defines this concept in the following way: a disease is a state of an individual which interferes with (or prevents) the normal function of some organ or system of organs of the bearer of the state (Boorse 1976, pp. 558-559). With this definition as a background Boorse can go on and indicate the application of the general expressions of being diseased and being well. The simple characterisation of these concepts is the following: a person who has at least one disease is diseased. The person who lacks all diseases, i.e. that person all of whose functions fall within the normal range, is a healthy person.

But what is the procedure, according to Boorse, to determine the normality of functions of the species of man? Boorse recommends a statistical method. The species-typical pattern is the statistically typical pattern. The species-typical cardiac frequency is that range within which the cardiac frequency of most people is. The general philosophy that Boorse advocates here is thereby very similar to the one used by clinical physiologists and clinical chemists when they try to determine normal or reference values for various human bodily functions. (Boorse, however, does not pursue any technical discussion about how these values should be exactly determined.)

Boorse very clearly founds his theory on the analytical (or biostatistical) platform. But he is also quite aware of the holistic context of health and disease. He indicates how the two realms should be connected. Boorse distinguishes between two kinds of non-health, viz. disease and illness. What has so far been defined is the concept of disease. According to this definition a disease is identical with a particular bodily (or mental) state. (Boorse 1976 proposes a completely parallel reasoning for the case of mental health and mental disease. The only substantial difference is that he acknowledges a greater amount of apical goals in the case of mental health than in the case of physical health. He does not, however, attempt to specify them in any detail.)

This concept does not at all cover all the usages of the terms “disease” and “illness” in ordinary language. A disease in Boorse’s technical sense can exist in a body completely without the knowledge of its bearer. The existence of the disease need not entail any disability and it need not call for any treatment. These latter characteristics, however, are central to the notion of illness in Boorse’s theory. His precise definition of “illness” is the following: A person is ill, if and only if the person has a disease which is serious enough to be incapacitating, and therefore is (i) undesirable to its bearer, (ii) a title to special treatment and (iii) a valid
It is important to notice that illness presupposes disease. Disablement or other unwanted states which arise for other reasons than disease cannot be called "illness" according to Boorse's system. The biostatistical platform is therefore fundamental also for the pathology of illness. (Observe, however, that Boorse's interpretation of the concept of illness is not universal among English-speaking theorists. Consider, for instance, J.H. Marinker's proposal below.)

Boorse's theory is in many ways simple and elegant. It entails a kind of scientific operationalization of the concepts of health and disease. According to the theory we can in principle numerically determine the limits of the healthy and the diseased bodily functions. The procedure to determine whether a particular individual is healthy or not then amounts simply to applying these values to a particular case.

The theory is also very general. It applies not only to human beings but also to all other biological species. For every species, whether an animal or a plant, we can calculate statistical normal intervals and on the basis of these determine whether a particular individual is healthy or not. This concerns primarily the concept-pair health and disease. It is doubtful whether we can at all talk of illness outside the realm of human beings.

Towards a critique of the biostatistical theory

Does every organ-function have only one normal range? My simplified presentation of Boorse's theory gives the illusion that for every organ or system of organs there is one and only one normal range which is typical for man. It is clear already in Boorse's writings that there are no such unique ranges. Boorse notes that the normal values vary with sex and age. It is particularly important, he claims, to relate the values of the functions to age. If this were not done, then all normal changes of age would be given the status of diseased changes.

But sex and age are not the only variables to which the functions have to be related. A very important factor which is hardly treated in Boorse's theory is the significance of the environment. Another factor is the degree of activity of the individual.

Several investigations have shown that the numerical values of many functions can vary considerably depending on the natural and cultural environment within which the individual finds him or herself. Otto Klineberg has in a classic work made a comparative study of a number of
physiological functions of Chinese and Americans. He also investigated what happened to those Chinese who moved to the US and replaced the Oriental style of life with a hectic Western life. It then appeared that the physiological values of the immigrant Chinese tended to approach the ones of the native Americans (Klineberg 1950).

In a similar way it is apparent that many of the bodily functions are influenced by the activity of the individual. The most conspicuous example is perhaps how the cardiorespiratory function is immediately and to a very high degree influenced by hard physical work. The normal pulse rate after a 100-metre race is perhaps around 160, a number to be compared with the pulse rate at rest which is around 60.

This is the first serious objection that can be raised against the Boorsian theory. One cannot once and for all numerically determine the normal values of human bodily functions. Strictly speaking they have to be related to every conceivable situation and every conceivable degree of activity of a human individual. The simplicity of Boorse's programme therefore turns out to be illusory. Instead of one normal value for every function we have to consider a great number, not to say an infinite number, of normal values. (Realising this fact the clinical physiologists and clinical chemists of today prefer to talk about reference values — i.e. values related to a particular defined situation — instead of normal values. See, for instance, Gräsbeck and Alström 1981.)

On the other hand the criticism is so far not decisive. Boorse's theory can in principle be modified so that it takes care of the relativity of the normal ranges. One can say that such a person is healthy, whose bodily functions have the values which are normal to him or her considering his or her age, sex, race, eating habits, environment and degree of activity etc.

But can we push the relativisation as far as we please? Can we really say that that person is healthy who has the normal values for every conceivable situation? Let us consider such situations as themselves are, as we say, disease-inducing. Consider the situation which consists in the fact that a person's throat is invaded by millions of microbes, i.e. a paradigm case of infection. For this kind of process there are well-described "normal" reactions. The microbes start producing toxins, which in their turn immediately destroy a great number of cells on the mucous membranes. The body quickly reacts to this attack. There is a great concentration of blood at the focal points of the infection; the body temperature rises; certain tissues create antibodies against the viruses and the pathogenic toxin.
This outline of a description of a process of infection is at the same time a description of a species-typical reaction to a serious attack on the body. Thus, in fact, the infectious disease can be seen as the species-typical reaction to the circumstance of a certain microbial invasion. Here, then, we emerge with a paradigm case of disease which is a statistically normal reaction to a certain environment.

If the paradox of the infection is to be avoided the biostatistical theory must be modified. We cannot be allowed to talk about normal functions in relation to every conceivable circumstance. The damaging and disease-inducing environments must be excluded. The problem with such a delimitation, however, is that it requires intellectual tools which are quite different than the purely biostatistical ones. One problem is to avoid that the definition becomes circular. We must not presuppose that we already know what is a disease-inducing or damaging environment. Then we presuppose such concepts as we are in the process of defining.

In addition to the objection which I have already directed against the biostatistical theory I can now add one which is perhaps even more forceful: a certain reduced function in a human body can be compensated for by a different supernormal function, so that the end result becomes equivalent to, or even better than, what it would have been if both functions had been normal.

Assume that a person's liver has been damaged by a long period of excessive alcohol consumption, and a substantial portion is no longer functioning. Still, however, the liver as a whole can fulfil its main functions, such as glycogen synthesis and purification of the blood, in the required way. Thus something that we intuitively consider to be considerable damage to an organ need not have any consequences on the level of the whole organ function. The example shows that functions can never be viewed in isolation. The human body offers possibilities for extreme mechanisms of compensation. The functional ability of a particular part of the body can in some cases be completely wiped out and still be wholly or partly compensated for by the work of other parts or organs.

But then we encounter another interesting question: compensation in relation to what? What do we mean when we say that one organ compensates for another? At first one could think that the answer would be: the compensation is related to another, more integrated, function. But let us then push the reasoning further and assume that also this higher functional ability is reduced, but that it is in its turn compensated for by another organ system on the same level of integration. We are then driven
to ask: what is it finally that determines whether a human body functions normally? And the answer must be: it is whether the individual as a whole person functions normally. Our reasoning drives us to the point that it is here on this level and only here that we are able to ascribe health or non-health to people. But then we seem to have completely lost the basis for the Boorsian theory of disease. We must try another starting point for our analysis.

Towards a holistic equilibrium theory of health

Let me start this section by returning to the paradoxical case of infection above. My conclusion was that the biostatistical view of disease cannot by itself explain why an infection is a disease, presupposing that the infection can be viewed as the species-typical response to a harsh situation. An alternative to the biostatistical theory must then face this problem and ask: Why is it that we would consider the infected person to be ill and normally call the infection itself a disease? The answer must run along the following lines. The infected person is tired and in pain. This is bad in itself but it also leads to other problems. It disables the person from doing what he or she desires to do or finds it important to do.

This observation constitutes a starting point for returning to the other perspective of health and disease introduced above, viz. the holistic one. This is the perspective which entails viewing human beings as active creatures living within a network of social relations. As a consequence, health and disease should essentially be understood as phenomena which influence the ability of people in their social context.

As I have already indicated, this is the most natural perspective for the ordinary person. It also has an ancient learned tradition. Already Galen (from AD 200) defined health as “a state in which we neither suffer from evil or are prevented from the functions of daily life”. (See Temkin 1963, p. 637.) Many latter-day theoreticians make similar characterisations. The French philosopher and physician Canguilhem says in his book On the Normal and the Pathological that health “is a feeling of insurance in life”; “illness or the ‘pathological’ is the direct concrete feeling of suffering and impotence, the feeling of the life gone wrong” (ibid., pp. 118 and 77). Even more clearly underlining the concept of ability the American sociologist Talcott Parsons says: “Health may be defined as the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialised” (Parsons 1972, p. 117.)
Most characterisations of health which use this holistic platform tend to emphasise two facts: first a feeling, a feeling of wellbeing in the case of health, and a feeling of suffering in the case of non-health or illness; and second, the phenomenon of ability or disability, the former an indication of health, the latter of illness.

These two kinds of phenomena are in many ways interconnected. There is first an empirical, causal connection. A feeling of ease or wellbeing contributes causally to the ability of its bearer. A feeling of pain or suffering may directly cause some degree of disability. Conversely, a subject's perception of his or her ability or disability greatly influences his or her emotional state.

Some would argue that the relation between the two kinds of phenomena is even stronger, i.e. that there are conceptual links between, on the one hand, a feeling of wellbeing and ability and, on the other hand, suffering and disability. According to this idea, being in great pain, for instance, partly means that one is disabled. Some degree of disability is here a conceptually necessary condition for the presence of pain, so that if a person's ability is not affected, he or she cannot be said to be in great pain. (The locus classicus for this kind of position is § 580 in Wittgenstein 1953.)

I need not here commit myself to this subtle interpretation of the connections between the two categories of concepts. It is sufficient to note the strong causal connection: a typical cause of disability is pain or some other kind of suffering. Even rather moderate pain may result in some disability, for instance when we consider more advanced activities such as athletic, artistic or intellectual ones.

The converse, however, is not a universal truth. A person can be disabled, indeed completely disabled, without experiencing any pain or other kind of suffering. This is true of many lame persons and it is of course true of completely unconscious persons.

Thus we can draw the following, slightly simplified, conclusion: suffering always leads to some disablement; disablement can, however, occur without suffering. This asymmetry is important to the theorist of health. If we are looking for the most general kind of criterion of non-health or illness, then of these two factors disability is the more reasonable candidate. This is in fact my own main reason for founding the subsequent analysis almost wholly on the concepts of ability and disability.

This decision, however, does not deny the extreme importance of pain and suffering — as experiences and not just as causes of disability — in
the phenomenon of illness. An adequate description of a particular illness must often include a description of the suffering involved. The task of this study, however, is not to present guidelines for making detailed descriptions of particular instances of health and illness. The task is rather to find criteria which, in the ideal case, can be used in general definitions of the concepts of health and illness. For this purpose the notions of ability and disability are better candidates than the notions of pain and suffering and their opposites.

The equilibrium theory of health

The basic idea

The holistic theory of health to be proposed and to some extent elaborated here will be called the equilibrium theory of health. Various versions of it have been advocated by a number of authors, first by the American Caroline Whitbeck (1981), later by the Finn Ingmar Pörn (1984) and myself (1987).

First a word about the term "equilibrium" itself. In the theory of medicine it is common to associate this term with bodily balance or homeostasis (the kind of state that the regulating functions of the body tend to maintain irrespective of external influence). This concept of homeostasis or equilibrium has its place within more biologically oriented theories of health. The equilibrium which is in focus in the present theory is something quite different. It refers to the balance that may exist between a person's ability and his or her goals of action. The fundamental idea is precisely that a person is healthy, if and only if, he or she can realise his or her goals of action. Ingmar Pörn expresses his intuitions in the following way:

Health is the state of a person which obtains exactly when his repertoire is adequate relative to his profile of goals. A person who is healthy in this sense carries with him the intrapersonal resources that are sufficient for what his goals require of him (Pörn 1984, p. 5).

If the person cannot completely realise his or her goals then he or she is unhealthy to some degree. Health thereby is an ideal state which is difficult to achieve; non-health or illness is a dimension within which we
can find many degrees. ("Illness" (as a general predicate applicable to a person as a whole) and "being ill" will in my own theory be used as synonyms for "non-health" and "being unhealthy". Unfortunately, the term "illness" has quite different uses in different theoretical frameworks. For a closer discussion of this, see my presentation in chapter 6.)

It is important to see that health is a very particular kind of ability or capacity. The distinguishing feature is that it is connected to a specific set of goals. We can thereby separate health from various other kinds of capacity, for instance physical strength and intelligence. Both the strong and the weak person can be healthy; so can both the intelligent and the less intelligent. Their health depends on their particular goals.

Another important consequence of this idea is that the notions of illness and disease become quite distinct concepts. In a way they belong to distinct categories of concepts. A person as a whole can have a higher or lower degree of illness, i.e. have a higher or lower degree of ability vis-à-vis his or her goals. A disease, on the other hand, is a bodily or mental process which tends to cause illness in the bearer of it. A disease therefore is a typical cause of illness, but does not itself constitute illness. Cancer is a disease, because it is a bodily process which tends to limit its bearer's ability in many ways, thereby compromising health.

A further important point here is that diseases are not defined in terms of their abnormality, be it statistical or otherwise. They are defined on the basis of their relation to health, which according to the holistic approach has other conceptual presuppositions than in the Boorsian biostatistical framework. Cancer is a disease not because it is a statistically abnormal state; it is a disease because it tends to reduce the ability of its bearers to realize their goals.

(The reasoning here is simplified insofar as it is based on a concept of pathological disease, where diseases can be more or less completely identified with bodily processes. The same simplification is made by Boorse. Sundström (1987), however, has shown that clinically interpreted diseases are much more complex entities, partly entailing symptoms, signs and various kinds of disability. Given such a notion of disease it would be improper to say that diseases cause illness. It is then more proper to say that diseases may partly entail certain forms of illness. I think that we can grant this very important observation and still maintain that there is a distinction to be made between the concepts of disease and illness. To say that one has a disease is to say something different and normally more specific than to say that one is ill.)

Diseases are similar to injuries and defects. All three categories can
cause or entail illness. But there are also differences between them. If diseases are *processes*, injuries and defects can be viewed as *states*. Defects are, in contradistinction to injuries, *congenital* states. About all the different pathological categories, however, it holds that they tend to restrict the ability of their bearer and thereby entail illness. (A convenient term which has been proposed for the whole category of states and processes which tend to compromise health is *malady* (cf. Culver and Gert 1982).)

The theory does not, however, claim that disease, injury and defect are the only possible causes of illness. It allows for the possibility that other kinds of internal factors can result in a limited ability in the case of a particular person. A personal problem could be such a possible cause. Nor does the theory say that diseases, injuries and defects always entail or lead to illness. Latent diseases, insignificant diseases and certain diseases in an early period of their development can exist without affecting the ability of their bearer.

The equilibrium theory specified

After this preliminary introduction of the equilibrium idea let me now present and to some extent analyse a precise definition of the concept of *health*:

A person P is completely healthy if, and only if, P is in a bodily and mental state such that he or she has the ability to realise all his or her vital goals, given standard circumstances. (Nordenfelt 1987, pp. 76-80.)

From this follows: P is unhealthy to some degree if, and only if, P, given standard circumstances, cannot realise all his or her vital goals or can only partly realise some of them.

Health is here viewed as an ideal state. Complete health then presupposes that the individual can realise all his or her vital goals. This thought is compatible with the assumption that there is also a level, that we might call *acceptable health*, which is clearly below complete health, but which still fulfils the most fundamental requirements of the individual. The problem of determining this level cannot be solved by conceptual analysis. It is a matter of decision, mainly by the individual him or herself. ("Acceptable health" can of course also become a technical...
concept for the decision-makers in the society. At a certain time a certain minimum level of health is defined, which every citizen should have the right to in the sense that the citizen is entitled to health care if he or she falls below the level.)

My definition of health certainly requires a number of clarifications. Let me particularly comment on the crucial notions of “vital goal” and “standard circumstance”.

**Vital goal:** \( x \) is a vital goal of \( P \)'s if, and only if, \( x \) is a state which is necessary for \( P \)'s minimal happiness.

In the basic description of the equilibrium theory I focused on the individual's ability to realise his or her goals. The crucial question now is: Which are these goals? Do we simply deal with what the individual wishes for or wants at a certain point in time? Or is it a question of what the individual in some objective sense needs?

The vital goals of a person, according to my suggestion, coincide to a great extent with the goals that a person consciously sets for him or herself. They do not completely coincide, however, and there are at least two kinds of reasons for saying so. Consider first the very ambitious but completely unrealistic person. This is a person who sets very high goals; he or she perhaps wants to become an Olympic champion or make an outstanding political career. Very few of such far-reaching goals can be realised, but we can here assume that this does not worry this person very much. He or she continues to be as alert and vital as before.

If we were to identify vital goals in our theory of health with all such goals as are consciously set by a person, then the unrealistic person would automatically come out as quite an unhealthy person. This is of course a counterintuitive conclusion. The fact that the person does not bother about the goals not being materialised is, I should say, a sign that the goals are not vital. They do not have a high priority in the sense that I tried to explain in chapter 4.

If, on the other hand, the absence of the Olympic medal or the absence of the political career were to cause great unhappiness in this person, then they would be vital goals. Then this person's inability to realise them would be a criterion of some degree of illness. (To make this diagnosis, however, does not necessarily entail that one considers that there is anything "wrong" with the basic ability of this person. The therapy to be suggested in this case ought to be directed towards the person's profile of goals.)
Vital goals should be distinguished from consciously set goals for another reason. There are, as we already noticed, persons who have very low conscious goals. These goals can be so modest that not even a serious injury to these persons would prevent them from realising the goals. On the other hand we might observe that a certain person with such low ambitions feels poorly, that he or she in fact suffers from the injury. According to my view, he or she then has some vital goals over and above the consciously set ones, which have not been realised. It is obvious that the person has not reached minimal happiness.

Thus I have tried to give examples of situations where a borderline must be drawn between a vital goal and a goal that is consciously set. This distinction must not, however, overshadow the fact that the two kinds of goals often in practice coincide. Most people are reasonably realistic. Most people know what is in their best interest. The goals that they consciously give a high priority will therefore in practice be identical with their vital goals.

By introducing the concept of a vital goal I have reached a point where my two main concepts of health and happiness have been linked together. The link can be summarised in the following way:

To be healthy is tantamount to having the ability, given standard circumstances, to realise one's minimal happiness.

This can look like a very strong connection between the two concepts. However, it is important to observe exactly what it entails. This relation between the concepts allows, for instance, the following: a person can be completely healthy and at the same time be very unhappy. It allows also that a person with a very low degree of health can be very happy. The circumstances under which a healthy person lives can be extremely unfavourable. The healthy person who lives in the circumstances of war or who has lost a near relative is rarely a happy person. Moreover, a healthy person can abstain from using his or her ability to reach the vital goals.

A person with a low degree of health and a small ability can, on the other hand, be compensated for his or her disability, so that the vital goals can still be reached. This is in fact what the doctor or nurse tries to achieve when he or she provides a patient or client with the things needed. The compensation can, for instance, entail that the patient/client receives technical devices which will enable him or her to do what he or she finds important.
Observe here that health is connected to a minimal level of happiness and not to any kind of complete happiness. (The latter has already been shown to be a problematic concept.) To be healthy is, according to my analysis, to be able to achieve what has a high priority in one's life. The healthy person need not be able to realise everything that he or she wants.

Let me now also consider the other technical concept that I have introduced in the definition of health, viz. standard circumstance. A moment's reflection shows that the ability which is assumed to constitute health must be related to a certain class of circumstances. Every kind of ability is an ability relative to certain circumstances. When we are very careful in our way of expressing ourselves we also specify these conditions. We say, for instance, that we are able to move to a certain place, if we can borrow a car, or that we can write a business letter in French, if we have the use of a dictionary. In ordinary speech, however, we often ascribe an ability to a person without specifying any particular conditions for this ability. We may say of a two-year-old child that it is now able to walk and is now able to produce a certain set of sentences. The fact that we do not indicate any conditions for the execution of these abilities does not, however, entail that there are no such conditions. The fact is instead that we consider these conditions as more or less self-evident. We mean that the two-year-old child can walk given normal circumstances, for instance given the fact that the surface is even and that there are no unexpected obstacles on the ground etc. We mean perhaps also that the child can express some simple sentences, if it is encouraged by its nearest and dearest and if there are no distracting factors in the environment.

In a similar way we must analyse the ability that constitutes health. When one says that one is so healthy that one can work, one certainly presupposes one's ordinary work and under the ordinary conditions. A healthy person cannot manage to do his or her work given any kind of conditions. He or she can for instance not work if some foreign troops occupy the working place. Nor can the healthy person work if some persons use physical force to prevent it.

But then which are the standard circumstances? (I choose the word "standard" instead of "normal" since I wish to avoid the association with what is statistically normal.) It is not so easy to say, since it must be a very broad, not to say disjunctive, set of circumstances. In our ordinary way of conceiving the set it must also be very vaguely delimited. There can be a lot of changes in a person's surroundings, both of a personal, cultural and natural kind, without these conditions leaving the class of
standard conditions.

An important observation to be made is that the total set of standard circumstances of a person P at a certain time is relative to a cultural situation. The standard circumstances are not the same for those who live in Communist China, capitalist Western societies, tropical Congo or Greenland. What a person needs to be able to do in order to manage in these very different environments varies a lot. Consider the following examples where I compare the situation in Sweden with that in Greenland.

"Running one's household" entails in a country like Sweden the execution of rather simple operations from a bio-mechanical point of view (walking to the local shop, placing saucepans on a stove and turning knobs on the stove), but it entails some rather advanced knowledge about how to operate the machines in the kitchen. To be able to run one's household, given the standard environment of Sweden, means to be able to handle all these things. "Running one's household" among Eskimos in Greenland entails something entirely different. The theoretical knowledge needed is different, and the manual skill needed is much greater and much more varied. Among other things survival there entails hunting and killing wild animals and the preparation of food from the stage where an animal has just been killed.

The standard circumstances in Sweden thus include advanced machines and other helping devices in the household. The standard circumstances in Greenland, however, do not include all these things. As a result of this a person's ability to run his or her household means partly different things in the two cultures. Since an adult person's health, according to our analysis, is partly constituted by his or her ability to run the household, it follows that the concept of health is in this sense culture-relative. One and the same person with the same physical and mental capacities, can in one culture emerge as healthy but in a very different culture as ill.

Consider now a criticism that can be raised against my characterisation of health with the help of the notion of a standard circumstance: It is unclear which is the exact framework for a certain culture's standard circumstances. A definition of health which makes use of this concept can therefore hardly contribute to an exact theory of health.

When one raises this criticism one ought to consider the difference between analysing a given concept and stipulating a definition for certain scientific and technical purposes. In this book I have so far tried to give an analysis of the concept of health. Such an analysis does not tell us anything specific for a precise definition of the notion of standard
circumstances. My conclusion then also is that our ordinary (but certainly also our medical) use of the notion of health has great vagueness.

This does not prevent us from being able to sharpen our language through stipulation. In many cases we ought to do that, not least in order to support scientific communication or communication for clinical purposes. An important area for the application of these ideas is the sector of rehabilitation. The rehabilitating personnel must often know quite exactly under what circumstances a person can perform a certain action. Can Brown, for instance, walk up his stairs without the help of some other person and without the help of a stick or other supporting device? What other conditions have to be fulfilled? If the personnel lack answers to these questions they cannot give meaningful recommendations regarding rehabilitating measures.

On diseases and health. Some consequences for medicine

I have said that diseases, injuries and defects are such inner processes and states of a human being as tend to limit this person's health. Health in its turn has been defined here in terms of the person's ability to reach his or her vital goals. Does it not then follow from this that the set of diseases has to be built up from such bodily and mental processes as in fact tend to limit a person's ability (or as make him or her set unrealistic goals)?

But is that the way the disease concepts have been formed through the history of medicine? And is the ICD (The Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death) constructed according to this principle? Or is my proposal in complete opposition to such medical realities?

I certainly do not suggest that the historical evolution of disease-concepts has been based on the kind of theory of health which I have proposed. On the other hand I do not think that the facts, as they stand, are in stark opposition to this theory. I think that the realities of medical concept formation largely support the theory. The vast majority of diseases (as well as injuries and defects) are such inner bodily processes or states as, if they last for a while, tend to result in suffering and disability. This is the case with all the well-known categories such as infections, cancers, circulatory, endocrine and mental diseases. This does not mean that the disease concepts are based on a single person's vital
goals. They are identified according to what will lead to suffering and disability in people in general. This is natural, since the science of medicine aims at giving us as general knowledge as possible.

But how is general knowledge in this context possible if people partly have different vital goals? The simple explanation of this is that most diseases strike people in a very basic and general way. The typical symptoms of disease are pain, other kinds of unease, fatigue and direct disability. In all such cases the subject is generally affected and has a lower degree of ability. He or she has less possibility for action, irrespective of what he or she wishes to do, i.e. irrespective of what his or her vital goals are. A carpenter and a professor who have been stricken with pneumonia can be equally handicapped with respect to their work, in spite of the fact that their jobs are quite different and that, in general, their goals in life may be quite different. Similarly a painter and an actor who are stricken with depression can be equally disturbed in their daily life, in spite of the fact that they do very different things in life.

Practically all conceivable vital goals have in common that they presuppose some concentrated activity. Most diseases, at least if they last for a while, tend to threaten all kinds of concentrated activity. The generality in the theory of diseases is, as I interpret it, based on this simple fact.

This does not mean, however (as I have already indicated) that exactly every instance of a disease has to lead to a reduction of health in exactly every bearer of the disease. Nor does it mean that everybody's health is equally much reduced in the event of disease. Such observations are well-known to the staff of the clinic.
6 The concept of subjective health

We have all experienced waking up one morning and feeling rotten. We may have had a sore throat, or a thick nose, or we may just in general have felt tired and heavy. We have thereby experienced the first indications of illness.

But in cases like these we rarely content ourselves with the immediate and direct observations. We do not always “trust” our own senses and our own judgment. We wish to make some objective check on our feeling. We may want to inspect our throat with the help of a mirror or check our body temperature with the help of a thermometer. If the check does not show any sign of “objective” disease, however, our normal reaction will be to try to shake off the feeling. We say: this was obviously “nothing”. We ignore the symptoms and go to work.

This situation involves a typical conflict between subjective symptoms and objective signs. A common way of describing this kind of situation in sociological and social medical literature is to say that the person is subjectively ill but objectively healthy.

I think that there is an important distinction between objective and subjective health, and I shall here try to explore it somewhat. I think that it is particularly important to study this distinction in the context of analysing the notion of quality of life. There is a great tendency in some of the medical discussion (compare the qaly approach in chapter 9 below) to identify quality of life with some kind of subjective health.

I shall first make an observation which directly follows from my own concept of health. The kind of “objective” control that the checking of temperature entails is not, strictly speaking, the same as ascertaining whether one is in good health or not. The latter must involve checking whether the subject can realise goals or not. The check which is conventionally performed (and for which there are many good reasons) deals with whether there are any typical signs of infectious disease. One compares therefore not subjective illness with objective illness but instead
subjective illness with objective signs of disease.

In order to make a careful preparation of a notion of subjective health I shall look at some current conceptual structures dealing with the opposite of health. In recent medical sociology and anthropology a distinction is normally made, first between the notions of *disease* and *illness* and second, although less frequently, between *illness* and *sickness*.

The rough ideas behind these distinctions are well captured by J. H. Marinker (1975, pp. 81-84).

(a) [Disease] is a pathological process, most often physical as in throat infection, a cancer of the bronchus, sometimes undetermined in origin, as in schizophrenia. The quality which identifies disease is some deviation from a biological norm.

(b) Illness is a feeling, an experience of unhealth which is entirely personal, interior to the person of the patient. Sometimes illness exists where no disease can be found.

(c) [Sickness] is the external and public mode of unhealth. Sickness is a social role, a status, a negotiated position in the world.

Marinker and others claim that these distinctions exist already in ordinary English usage of the terms. This is quite interesting, since most other Indo-European languages lack this terminological multiplicity.

This, then, is the starting point. ‘Disease’ is a (physical) process in the body; ‘illness’ is a feeling or experience, normally associated with a disease; ‘sickness’ is the social role adopted by a person who is ill.

This picture is unfortunately blurred and made more complicated by various conceptual suggestions in the more technical literature on the subject. I shall not here attempt to review this literature but just indicate some of the more influential definitions and thereby concentrate on the distinction between disease and illness.

A.R. Feinstein in his theoretical work *Clinical Judgement* (1967) proposes the following:

For each patient who undergoes treatment, a clinician observes at least three different types of data. The first type of data describes a *disease* in morphologic, chemical, microbiologic, physiologic, or other impersonal terms. The second type of data describes the *host* in whom the disease occurs... The third type of data describes the *illness* that occurs in the interaction between the disease and its environmental host. The illness consists of clinical phenomena: the host’s subjective sensations, which are
called “symptoms”, and certain findings, called “signs”, which are discerned objectively during the physical examination of the diseased host (pp. 24-25).

There is certainly some similarity between Marinker's and Feinstein's characterisations. They seem to mean almost exactly the same by “disease”. Their notions of illness, however, only partly overlap. Marinker says that illness is, exclusively, a feeling or an experience of unhealth. Feinstein claims more generally that illness is an event (or process) occurring in the interaction between a disease and its host. This event or process consists both of subjective sensations (feelings) and of objective signs detectable through physical examination.

Boorse, as I have already noted, proposes the following distinction between disease and illness:

Diseases are internal [bodily] states which interfere with functions in the species design (Boorse 1977).

A disease is an illness, only if it is serious enough to be incapacitating, and therefore is (i) undesirable to its bearer, (ii) a title to special treatment and (iii) a valid excuse for normally criticizable behaviour (Boorse, 1975).

The main difference between Boorse and the others is that illnesses for him constitute a subset of diseases, viz. those diseases which have noticeable and undesirable consequences for their bearer. He does not, like the others, refer to these consequences themselves as illnesses.

A third, more technical proposal has been made by Pörn and myself. Here, illness is viewed as the opposite of health but belonging to the same continuum as health. A disease is viewed as an internal bodily cause of illness.

This conception brings us in a way closer to Marinker's and Feinstein's positions. In their theories illness is also considered to be a causal consequence of disease. Illness for them is a set of feelings or a set of physical signs associated with (normally caused by) disease. (Marinker accepts that illness can exist without disease. Feinstein does not indicate that possibility, and Boorse explicitly excludes it. Pörn and myself here follow Marinker. Disease for us is only one possible cause of illness.)

The main difference between on the one hand Pörn and myself and on the other hand Marinker and Feinstein is that we try to fit the concepts
into a broader framework including the positive concept of health.

Let me summarise these conceptual structures in the following way:

Marinker: illness = feelings and experiences normally following disease
Feinstein: illness = subjective sensations and objective signs caused by disease
Boorse: illnesses = a subset of diseases
Pörn/Nordenfelt: illness = non-health

How can this excursion help us to explain the notions of subjective health and non-health? Observe first that I have already adopted the Pörn/Nordenfelt conceptual construction in identifying objective non-health and illness. This gives us the following characterization of (objective) illness:

P is ill (to some degree) if, and only if, there is some vital goal of P's which is such that P is unable to realise it.

In proposing a notion of subjective illness (or subjective non-health) I shall listen to Marinker's and Feinstein's suggestions. They indicate two kinds of specifications which I find it important to distinguish between.

(i) Subjective illness as the subject's awareness of being ill. Here subjective illness is a purely cognitive state. The subject believes that he or she is ill. This belief can be true and therefore constitute knowledge. The person then knows that he or she is unhealthy. When, on the other hand, the person's belief that he or she is unhealthy is false, then the person is subjectively unhealthy but objectively healthy.

We can also note that the converse case is quite possible. There are persons, for instance some mentally ill persons, who lack insight into their health status. They may erroneously believe that they are quite healthy. They are subjectively but not objectively healthy.

All four combinations of health, illness, subjective health and subjective illness are completely possible and reasonable given this interpretation of the concept of subjective health and illness, just as they are according to current sociological conceptualisation.

When a man P is subjectively ill in the sense indicated here, P normally has a number of reasons for his belief. P may have had some experiences
or he may have observed some bodily signs. He may directly have noticed his inability to do things he needs to do in his daily activities. A further alternative is that P has been informed by some other person, in particular a person with medical competence, that he has some disease. These reasons for his belief, some of which will occur in our second interpretation of subjective illness, are here not part of his subjective illness. Subjective illness in interpretation (i) is the mere belief or awareness that one is ill.

(ii) **Subjective illness as a set of mental states associated with illness.** When a person feels ill he or she is not only aware of some illness. The person also has a number of experiences. He or she feels pain, feels tired, or feels that his or her body temperature is rising. In grave cases the person may have other unusual experiences. He or she may hallucinate, have a feeling of unreality or feel deeply depressed. The examples given here are examples of sensations, perceptions and moods which we typically associate with illness. They are often our best reasons for believing and claiming that we are ill.

I shall now propose that being subjectively ill in sense (ii) is tantamount to having a subset of the mental states typically associated with illness. To have a pain in the chest, to hallucinate or to feel depressed is to be subjectively ill on this interpretation.

Being subjectively ill in sense (ii) normally leads to subjective illness in sense (i). When one has great pain in one's chest one normally believes that one is ill. But clearly the connection between sense (ii) and sense (i) is not a necessary one. People can have sensations which are typical symptoms of a disease, though without being able to identify these sensations as symptoms. This is most clearly so with small children, who do not yet grasp the concept of illness. They can be in great pain, but cannot identify these sensations as disease-symptoms. Sense (i) and sense (ii) of subjective illness are therefore not only theoretically differentiable. They are also far from being necessary concomitants of each other in practice.

Sense (ii) of subjective illness faces a number of theoretical problems. I shall briefly discuss a few of them.

(a) What is the relation between the mental states constituting subjective illness in sense (ii) and illness in the objective sense?

There is, in general, no simple causal relation between illness (as I
understand the concept) and subjective illness. It is not the case that the disability of the patient with a cardiovascular disease causes his or her pain. It is not the case that the disability of the schizophrenic person causes his or her hallucinations. In fact, the causal chain is more typically of the opposite kind: pain, fatigue, perturbation and depression cause or express themselves in inability.

On the other hand, this kind of causal relation is not universal. Certain disabilities, as in paralysis or when a limb is broken, may exist without any concomitant sensations.

Most subjective illness, however, is caused by some internal malady, not necessarily a disease but possibly an injury, a defect or an impairment. By observing this we are brought back to the intuitions of Marinker and Feinstein, where diseases are viewed as internal states or processes leading to certain sensations and other experiences.

(b) How do we more precisely define the set of mental states constituting subjective illness in sense (ii)? Which are the sensations, perceptions and malperceptions, and moods that constitute subjective illness in sense (ii)?

This is an intriguing question since very few of the subcategories which have so far been exemplified are exclusive indicators of illness. One can be in pain for a variety of reasons: a needle can be pricked into one's finger; one can be carrying a heavy rucksack on one's back; one can be tired as a result of pure exhaustion after having have run a marathon; one can be depressed as a result of a traffic accident in which one has lost a close relative. In none of these cases would we be talking about subjective illness.

Must we then require that the mental states of subjective illness (ii) be a result of some malady, either a disease, injury, defect or impairment? There is a temptation to say that they must, since this would superficially give a handy way of defining the category. On the other hand, if we claim that they must, then we get an interesting discrepancy between subjective and objective illness. According to Pörn's and my own theory objective illness can have other causes than maladies.

In order not to get a discrepancy in this respect between objective and subjective illness we cannot derive support from the concept of malady in the characterisation of subjective illness. We need to follow the same route as in the case of objective illness. A person is ill or unhealthy in the objective sense, if and only if his or her ability is limited by internal
factors. An inability which is determined by external obstacles, as when one is by force prevented from doing what one wants, does not constitute illness. In a similar fashion, if one were to have difficulty in walking through a snowstorm, this is not a sign of illness either. I propose that we use the same kind of criteria for identifying subjective illness. The pain which is the consequence of immediate strain does not then constitute subjective illness. Nor is the fatigue which is an immediate consequence of one's own activity an element of subjective illness.

It is important that the criterion that is to exclude subjective illness should concern direct obstacles and direct external strain and nothing else. Indirectly, both objective and subjective illness are quite typically caused by external factors: by microbes, poisons or other disease-inducing substances. Then, however, the causal connection between the external factor and the illness has been mediated by diseases or injuries. These are in their turn inner processes and states which have normally existed for some time after the intrusion of the external factor.

(c) How do we distinguish between subjective illness and low quality of life?

I shall here raise a further problem, particularly pertinent to this essay, which is not yet solved. How are we to distinguish between subjective illness and such general reduction of quality of life as has some malady as a remote cause?

Since causation is a transitive relation the causal result of a disease is not only confined to its immediate effects but includes in principle everything in the causal chain following it. Some of these effects are obviously part of, or are relevant to, the subject's quality of life in a general sense of the word. But are we inclined to call them all parts of his or her subjective health or illness?

We have already excluded many items from being potential parts of subjective illness by requiring that they should be mental states of the subject. Thus the fact that a sick man becomes unemployed or the fact that his marriage breaks up does not count as a part of his subjective illness. Such things are, however, certainly pertinent to his quality of life in general. (These issues will be dealt with much more in the next chapter.)

Consider now those mental states which typically follow from the sensations, perceptions and moods that constitute the ingredients of subjective illness. I have in mind the subject's emotional reactions to his
or her subjective illness. Being in pain normally results in distress about being in pain; having a distorted visual perception will equally result in distress. To this we can add the anguish and fear of danger that may accompany some of these symptoms of disease.

Are all such reactions to subjective illness parts of the illness? One may argue that it would be wise to include them, since they may affect the course of the illness. It is common knowledge that strong affection, such as anguish, fear or distress, may cause a worsened pathological development and prolong an illness.

This, however, is hardly a conclusive argument for including them within the illness itself. A local disease in one part of the body may have consequences in another part, from which a perfectly adequate defence reaction has repercussions on the initial disease, so that the disease becomes fatal. Is this a reason for saying that the defence reaction is part of the disease?

If we do not distinguish between a person's emotional reactions to his or her illness and the illness itself we cannot adequately account for locutions such as: I was worried about my illness, or, I was afraid that my illness would prove to be dangerous.

Another reason for excluding them is the fact that identical emotions can occur in other contexts, where they are, per definition, not parts of any illness. One can be worried, afraid, distressed about any kind of state of affairs. It seems odd to say that as soon as one has a negative emotion directed towards one's illness, it automatically becomes a part of the illness.

But what should we say about the depression of the mentally ill? Is that not an emotion and is that not obviously part of an illness? There are two points to be made here. First, the kind of depression which is considered as illness in the psychiatric literature is basically not an emotional reaction to any particular external event; the pathological depression is not exogenic. It is an objectless mood which colours the whole experience, without being directed towards any particular state of affairs. Secondly, if it were an emotion with an object, the object would not normally be an illness previously existing in the subject. The person who is depressed in the pathological sense is not primarily depressed about the illness of which the depression is a part.

My general conclusion, to which I shall refer in my subsequent analysis of some quality of life instruments, is thus that emotional reactions to one's illness or disease are not, in general, parts of one's subjective illness. They play, however, an important role in determining one's
quality of life in a more general sense. To this we shall return in a later section.

So much for the analysis of subjective non-health or subjective illness. What about its positive counterpart: subjective health?

My answers will be analogous to the former ones and can be presented in a straightforward way. There is a sense (i) of subjective health of a purely cognitive nature. To be subjectively healthy in this sense is to be convinced that, or believe that, one is healthy. The belief involved can be true or false. Thus subjective health (i) is compatible both with health and illness.

To be subjectively healthy in sense (ii) is to be in one of a privileged set of mental states which together define subjective health (ii). These are fewer than in the case of subjective illness and perhaps not as easy to pinpoint. There are, however, recognisable feelings referred to by such locutions as feeling fit, feeling healthy and feeling strong.

There is also a third, eliminative, sense of subjective health. By subjective health (iii) we may simply mean that the subject is not subjectively ill in sense (ii). In an eliminative sense a subject may be said to feel well when he or she simply does not feel ill.

Concerning emotions I shall make the same distinction as in the illness case. To be happy with being healthy is something over and above being healthy. To be proud of or be relieved about one’s health is also something over and above being healthy. These emotions contribute, in general, to one’s quality of life, but are not parts of one’s subjective health.

Glossary within the field of subjective health and illness

P is subjectively ill (1), if and only if P believes or knows that P is ill.

P is subjectively ill (2), if and only if P is in one or more mental states, within a specific set, that have direct internal causes.

P is subjectively ill (3), if and only if P is subjectively ill in both senses (1) and (2).

P is subjectively healthy (1), if and only if P believes or knows that P is
healthy.

P is subjectively healthy (2), if and only if P is in one or more mental states, within a specific set, that have direct internal causes.

P is subjectively healthy (3), if and only if P is subjectively healthy in both senses (1) and (2).

P is subjectively healthy (4) (the eliminative sense), if and only if P is not subjectively ill in sense (2).
7 To measure subjective health

Introduction

With my concepts of happiness, health and subjective health as a basis I shall now make an investigation of four concrete and pragmatic ways of assessing and measuring people's quality of life. All my examples are related to the measurement of quality of life in a health care setting. The first, the Nottingham Health Profile (NHP), and the fourth, the Rosser instrument, are conceptually very close to health care, whilst the second and third, Kajandi's instrument for measuring quality of life (KI) and Aggernaes's need-related instrument, have a more general scope and could find uses outside the field of health care. The NHP explicitly claims that it measures *subjective health* and not general wellbeing, the Rosser instrument measures health-related quality of life, whilst Kajandi and Aggernaes consistently employ the term "quality of life" for the dimension measured by the instruments in question.

All the instruments highlight conceptual problems, some of which have been dealt with in the previous chapters of this book. The NHP struggles with the crucial distinction between subjective health and general wellbeing. The instrument seems to cover a somewhat arbitrary mixture between the two. The NHP obviously covers subjective health both in senses 1 and 2 as explicated in chapter 5. However, it does not do so in any exhaustive sense, and no theoretical considerations are offered regarding the inclusion or exclusion of any particular items. The Rosser instrument is more precise and has a strong focus on health. It covers, however, both objective and subjective health (in our sense) and the authors do not provide a conceptual basis for the elements of the instrument.

The Kajandi instrument (KI) covers a broad field of human wellbeing. In contradistinction to the NHP it provides some theoretical background
for its design. The KI relies heavily on the Norwegian psychologist Siri Naess's concept of quality of life. The latter is basically a concept of subjective (hedonistic) wellbeing, but it also explicitly contains elements of a eudaemonian concept of the good life. The KI talks in terms of external interpersonal and inner neutral conditions. This — on the face of it — clear-cut division between objective, relational and subjective parts of human welfare is in an inconspicuous way blurred in the deep-level characterisations of the categories. I shall use some of the theoretical tools introduced in this study to analyse these categories and see how they can be systematically explicated.

Aggernaes's instrument, finally, has a solid conceptual background discussion. In this discussion the distinction between health and quality of life is drawn quite clearly. Moreover, it has interesting affinities with the conceptual construction proposed in this essay. My critical remarks concerning this instrument mainly deal with its dependence on the notion of a fundamental human need.

To measure subjective health: the Nottingham health profile (NHP)

Background

A group of researchers connected to the Department of Community Health at Nottingham University, England, undertook during the last years of the 1970's to design an instrument for the measurement of subjective health. The instrument, which is of the questionnaire type and is called the Nottingham Health Profile, was the result of their effort to meet the strongly felt need of measuring people's subjective health as opposed to what is assessed by standard medical techniques. Since the NHP is one of very few similar questionnaires in Europe, it has been widely used, and translated into a number of European languages, including Swedish. Consequently it has been put to a variety of tests for validity and reliability. The NHP has also been used to investigate crosscultural variations in the understanding of the phenomena of subjective health.

In a recent paper Sonia Hunt (1988), one of the constructors of the NHP, emphasises the following facts as strong reasons for getting a clear picture of people's subjective health status:
(i) Perceived health has been found to be more closely related to the use of health services than medical condition (Hunt 1988, p. 24).

(ii) When objective measures of health have been used for comparison, the risk of mortality has been found to be 2-3 times greater for people who report their health as poor, than for those who rate their health to be excellent (Hunt 1988, p. 24, Kaplan 1983).

(iii) There is a low degree of agreement between doctors and patients on whether treatment has been successful or not (Hunt 1988, p. 24, Orth-Gomér 1979).

In order to get a reliable picture of subjective health (or the "phenomenology of health", Hunt 1988, p.25) the questionnaire used must, according to the constructors, be expressed in the everyday language of the intended respondents, in contrast to the language of the health professionals. Therefore the statements of the instrument should contain no technical terms and instead consist basically of colloquial and other expressions typically used when people report about their ill health. (Some expressions used in the NHP have been found to be so colloquial that it is hard to find equivalents for them in other European languages; see Hunt & Wiklund 1987.)

The components of the NHP

The NHP is basically a questionnaire divided into two main sections. The first section contains 38 statements related to a person's experience of health and illness. When confronted with the questionnaire the respondent is asked to answer yes or no to each of the statements, depending on whether he or she finds the statement true or not. The second section is very short and asks in general whether the respondent's present state of health is causing him or her problems with various parts of his or her life, such as work, social life, home life and sex life.

The first, more detailed section, can in its turn, from a semantic point of view, be divided into 6 categories. These categories are given the following labels in various presentations of the NHP (for instance Hunt & Wiklund 1987): Physical mobility, Pain, Energy, Sleep, Emotional reaction and Social isolation. In the actual questionnaire, however, the items are not explicitly categorised in this way. The statements have been randomised so that an item about pain can be immediately followed by an item about sleep and this can in its turn be immediately succeeded by an
item about emotional reaction.

Some statements in the questionnaire refer to more serious states of the body or mind than others. Among the various items one can find, on the one hand, the extreme statement:

I feel that life is not worth living

and, on the other hand, the very moderate statement:

I find it hard to reach for things.

The severity of a state of affairs described plays a role in the final evaluation of a person's state of subjective health. The statements are ranked as to severity within each category, from 1 to 8 in the category of Physical mobility, from 1 to 8 in Pain, from 1 to 3 in Energy, from 1 to 5 in Sleep, from 1 to 8 in Emotional reaction, and from 1 to 5 in Social isolation.

The ranking has not been derived from a logical analysis of the statements. Nor does the individual whose subjective health is assessed perform his or her own ranking. Instead a population of several hundred patients and non-patients were asked to make their judgments of the severity of the states referred to. They did this by comparing all statements in each category with each other in a pairwise fashion. (The method used is referred to as Thurstone's method of pairwise comparisons. For a detailed presentation of the method see McKenna et al. 1981). Weights given to the statements were then adjusted to give a maximum score of 100 within each category.

In a particular evaluation, scores from one category are not added to scores from another category. The final measure is thus not presented as a number but as a profile, describing the variations in scores between the categories.

On the basic concepts of the NHP

What is subjective health according to the NHP? Is the instrument based on a conceptual analysis and a working definition of the concept of subjective health?

It is clear that the Nottingham group have not worked in this way. They have not attempted to characterise the conceptual components of subjective health, nor of health in general. The choice of the 38 items has
not been guided by any general philosophy of health. The procedure has instead been empirical, summarised by Hunt in the following way:

Work began with the collection of statements by interview from a cross-section of patients and non-patients. The statements referred to experiences of health and illness. Eventually over 2,000 statements were gathered, describing typical deviations from feelings of physical, social and psychological wellbeing... The statements were analysed for frequency, redundancy, ambiguity, ease of reading and understandability. The reading age requirement for each item was set, at ten years. This analysis eventually reduced the number of statements to 138.

A number of major and minor studies were carried out to test the face validity and sensitivity of the items in practical clinical situations, and subsequent analysis showed that just 38 items were sufficient to express the typical phenomena of distress (Hunt 1988, p. 26).

This description of the empirical procedure used here highlights in particular one problem, of which the constructors sometimes show their awareness. This awareness, however, seems to be the result of certain empirical studies (Hunt et al. 1986) and not the result of an analysis of the design.

Consider the following propositions included in the paragraph quoted above:

(i) The statements referred to experiences of health and illness.
(ii) [statements] describing typical deviations from feelings of physical, social and psychological wellbeing.
(iii) 38 items were sufficient to express the typical phenomena of distress.

In these expressions different concepts are referred to and the reader is not informed as to their internal relations. Consider the following possible interpretations.

(a) The constructors of the NHP mean the same thing by "statements referring to experiences of illness" as by "statements describing typical deviations from feelings of wellbeing" as well as by "expressions of phenomena of distress".
The locution "deviations from feelings of physical, psychological and social wellbeing" is indeed similar to the phrasing of the controversial WHO definition of health from 1948 and could therefore be taken to refer to an analytic component of "feelings of illness".

(b) The constructors of the NHP have found that the informants seem to mean the same by the expressions used in (i), (ii) and (iii). Hence the choice of statements from the wide area of deviance from wellbeing among the items in the NHP.

(c) Neither the constructors of the NHP nor the informants mean the same by expressions of types (i), (ii) and (iii). "Statements referring to experiences of health and illness" is to be interpreted in a vaguer way. The statements are statements which are typically used by informants when they experience subjective illness. (The NHPs very much concentrates on the negative aspect of health, i.e. illness. For comments on this, see Hunt 1988, pp. 30-31). When patients experience subjective illness, they also often describe their negative reactions to this experience. Such descriptions are thus included in the NHP, although they do not precisely refer to the experience of illness itself.

To put this latter interpretation concisely: not any kind of bad feeling is a feeling of illness, although many kinds of bad feeling are typically present concomitantly to feelings of illness.

A specification according to these and other possible interpretations is quite important. The need for such an analysis has been emphasised by the constructors themselves (Hunt et al. 1986 and Hunt 1988) as a result of certain studies. They have, for instance, found that scores on the NHP vary with socio-economic status and with the type of accommodation possessed by the subject. People in the lowest socio-economic groups have a significantly poorer subjective health status (in the NHP sense) than people in higher groups. Similarly, people living in rented housing feel worse than people who own their homes. Therefore, the constructors claim: it seems as if the items of the NHP "do not measure health status, but rather felt distress, which may be a consequence of health problems, but may equally arise from adverse living conditions and psychosocial stress" (Hunt 1988, p. 29).

The constructors have, however, set the stage for this troublesome conclusion. Compare the language used in the quoted conclusion with
certain expressions in the paragraph presenting the genesis of the items. Hunt there refers to "typical phenomena of distress". In this locution it is not guaranteed that the phenomena of distress are peculiar to ill health, that they cannot equally well come about as a result of other disadvantages in life.

When one gets down to a detailed analysis of the categories of the NHP it becomes immediately clear that they are not all in any strict sense health-related. (This is so according to my own characterization of health, but, moreover, according to almost any conception of health which does not simply identify health with wellbeing.) Consider, in particular, the categories of sleep, social isolation and emotional reaction. Almost all the items in these categories are compatible with an experience of good health, as intuitively understood. Let us imagine a person placed in a difficult or tragic situation, which has primarily nothing to do with his or her body or mind; the person may have lost a close relative, may have lost his or her job, or may be faced with extreme financial difficulties. Confront then such a person with the following statements:

I lie awake for most of the night.
Worry is keeping me awake at night.
Things are getting me down.
I lose my temper easily these days.
I have forgotten what it is like to enjoy myself.
The days seem to drag.
I am finding it hard to get on with people.

It requires very little imagination to see that these mental states are adequate reactions to a great variety of unhappy circumstances of which illness is only one. The items are open in the sense that there is no reference to the objects or causes of the mental states. The situation would have been very different with the following phrasing:

I lose my temper easily because of my illness, or
I sleep badly because I am in pain, or
I wake up feeling depressed about my ill health.

Had there been clauses of this kind, we would have secured that the various emotions, moods or states concerning sleep had been health-related. Then we would also, however, have introduced a complication. We would have requested from the subject an hypothesis about the causes
of his or her mental states. This can be easy enough in the case of direct objects of emotions (as when the subject is depressed about his or her illness) but can be more difficult in other cases.

(Notice, though, that this kind of causal judgment is requested in Part 2 of the questionnaire where the subject is asked: Is your present state of health causing you problems with your job, social life, home life, sex life, etc? Here it is not made clear, however, whether health is to be interpreted in terms of the items in Part 1 or not.)

To conclude: a brief analysis of the items in three of the categories of the NHP reveals that they refer to general distress and not to any particular health-related distress. To reach this insight we need not perform any empirical studies. The following statements are both obviously true and in the context relevant:

(i) Negative emotional reactions, such as depression, sorrow, anguish and fear, can have a great variety of disadvantageous and unhappy states of affairs, including ill health, as objects and causes.

(ii) Social isolation can be a result of negative emotions and moods. These in their turn may or may not be health-related. Social isolation can also be the effect of unfavourable character traits, such as shyness and irascibility, or of belonging to a racial or religious minority group.

(iii) Problems with sleep can be the result of negative emotional reactions or moods which basically have medical causes. But they can equally well be the effects of negative emotional reactions to any kinds of states of affairs.

The three remaining categories of physical mobility, pain and energy are more closely related to a kernel notion of health and illness. To illustrate that, consider my own notion of health:

P is healthy, if and only if P is able, given standard circumstances, to realise his or her vital goals.

Given this notion the most central feeling of illness would be the feeling of (or awareness of) disability. Many of the items in the three categories come close to this. The whole section of physical mobility deals with disabilities or feelings of disability. Similarly, the items in the energy
category are very close. If it is true that “I am tired all the time” then it follows that I am aware of (or feel) a general disability. The pain category is also quite central, since pain is one of the main intrapersonal causes of disability. In Nordenfelt 1987 (pp 35-36) I even suggested that there is a conceptual relation between pain and disability: part of the meaning of being in great pain is to be to some extent disabled.

Notice, however, that also items in these categories can be unrelated to illness. Pain can have an immediate external cause; physical immobility can be due to immediate external prevention, lack of energy can be due to exhaustion. In judgments of illness we presuppose that such conditions do not obtain. The constructors of the NHP must also have tacitly presupposed this.

It could now be asked how exhaustively the field of subjective illness and disabilities is covered by the NHP. I think it can be argued that the NHP covers too little ground. The disabilities, or feelings of disability, described are far from exhaustive. The physical mobility category almost exclusively focuses on movements of the limbs, primarily the legs (as in the items concerning the abilities to stand and walk) or the arms (as in the item of reaching out). Such basic abilities as eating, drinking, talking or writing are not covered. Nor are those more complex abilities included, which depend on the execution of mental faculties. (For a systematic treatment of disabilities, see Nordenfelt 1983 or 1987.) It is clear that awareness of disabilities of all these kinds, for instance inability to eat, drink, talk and write, many of which are not uncommon, belongs to the field of subjective illness.

Concluding remarks

My comments so far have indicated that at least three categories in the NHP do not contain items which describe subjective health, given the more narrow notion that I myself, and obviously today also the constructors, use. All items, however, have to do with quality of life or happiness in a general sense. The NHP is therefore, we may conclude, a measure of a mixture of subjective health and quality of life. The quality of life element of it, however, hangs in the air, since it is not clearly related to the subjective health part.

A rival of the NHP, an instrument called The Sickness Impact Profile (SIP), designed in the U.S. at the beginning of the seventies, has in this respect some conceptual advantages over the NHP. The SIP covers more
extensive ground than the NHP, taking into account a great number of human activities (sleep, eating, work, home-management, recreation, social interaction, emotional behaviour, communication, etc.). The SIP also has the following features:

(i) A measure according to the SIP describes the impact of sickness on a person's daily activities. All the items therefore refer to activities, not - as in the case of the NHP - abilities, relations or mental states.

(ii) Subjects are asked to respond positively to the statements only if they consider the activity (or inactivity) described to be related to their health or illness.

Thus although almost all of the given items (which are supposed to be negative states) can be true of a healthy person for a variety of reasons, the constructors of the SIP have in principle blocked these instances from being reported. Their instrument is an instrument of quality of life as affected by illness. (They actually use the term “sickness”, thereby meaning “the non-professional definition based on lay observations”; Gilson et al. 1975.)

However, the SIP does not give a definition of sickness. The subject is requested to rely on his or her own interpretation both of what sickness is, and of what constitutes causal consequences of sickness. Moreover, the SIP is not throughout consistent as to the distinction between sickness and the activity-consequences of sickness, which is what is actually measured. In some of the presentations of the SIP it is alleged to provide “a measure of perceived health” (Bergner et al. 1981, p. 787).
A Swedish instrument

Let me now introduce an instrument put forward by the Swedish psychologist Madis Kajandi and his group at Ulleråker hospital, Uppsala. I shall here call it the KI. This instrument is very different from the NHP.

1. The KI does not have the limited scope of measuring subjective health or factors mainly related to health, although it is primarily intended to be used in the sector of psychiatric care.

2. The KI is based on a number of conceptual considerations. The contents of the instrument have been highly influenced by the Norwegian psychologist Siri Naess.

3. The KI explicitly aims at covering all the important factors influencing or involved in a person's quality of life.

On the conceptual basis

A starting point for the construction of the KI was the characterisation of quality of life given by Siri Naess (1979, pp. 56-64 and 1987, pp. 16-26). According to her theory a person's quality of life has four components: (1) Activity, (2) Good interpersonal relations, (3) Self-esteem, and (4) A basic mood of happiness.

These central components can in their turn be divided into a number of dimensions, which have the following labels:
Activity
1 Enmeshment
2 Energy
3 Self-realisation
4 Freedom

Interpersonal relations
5 Intimate relation
6 Friendship

Self-esteem
7 Self-confidence
8 Self-acceptance

Basic mood of happiness
9 Emotional experience
10 Security
11 Happiness

Naess claims that the main components as well as the sub-items are equally important parts of one's quality of life. No category can be reduced to another. This is not to deny that there may be empirical relations between items in the different categories. It is, for instance, quite likely that items in the first three categories influence items in the fourth. One may therefore be tempted to say that the real wellbeing lies in category 4, and that the others are presuppositions of 4 (i.e. playing the role of sources or conditions of happiness).

This is not, however, Naess's intention. Category 4 is not primarily a category for such happiness as has items in categories 1, 2 and 3 as its object. Instead, it comprises a mixed bag of character traits (such as openness and receptiveness), cognitions (such as insight about nature), general moods (feeling of security, harmony; absence of anxiety, fear and restlessness) and general happiness with life. I shall return to comment on this rich variety of features in all of Naess's categories.

Of importance is that all (or almost all) of Naess's components of quality of life refer to intrapersonal categories. Quality of life with Naess is, according to her intentions, a psychological concept, roughly equivalent to wellbeing. What is to be measured is, basically, a person's subjective state and not his or her objective surroundings.

Although this is the main intention there are some problems here: some items, although related to the subject, are not attitudes or feelings (what I take to be the core ontological categories of wellbeing) but are instead relations between the subject and other subjects.

Under the heading of activity, one finds the following: the subject has opportunities to fulfil his or her plans, has freedom to choose. He or she has influence and takes part in decisions which delimit freedom. Category 2, Interpersonal relations, is basically a category of relations, although it
is sometimes inserted that the subject appreciates these relations. Moreover, some interpersonal relations, such as friendship, analytically presuppose an attitude and a set of positive experiences.

Relations such as having the opportunity to realise plans or being a member of a professional group or a group of neighbours are, however, highly compatible with the fact that the opportunity is not used or that the membership does not lead to a feeling of contact. Such items, mainly belonging to the field of welfare, therefore seem to blur the intention to give content to a concept of wellbeing.

Has Naess here just overlooked her own guidelines? No, other passages in her book indicate that her concept is not a pure concept of hedonistic happiness. It is partly a eudaemonian concept. The phrase the good life occurs now and again in her book. It seems therefore as if she requires that certain non-attitudinal, non-experiental features shall be included in a person's quality of life, even if the person does not derive pleasure or hedonistic happiness from them. The lonely person, the person who does not belong to any group or has few opportunities in life, is per definition, with Naess, a person with a reduced quality of life.

Concerning the value of social life Naess is in fact very explicit:

We would assign an intrinsic value to the social relations: It is better to be happy together with others than to be happy alone. If person A and person B are equally active, happy and have an equally high self-esteem, but A has better social relations, we would consider A's quality of life as being higher per definition (Naess 1987, p. 18).

One of the reasons why Naess incorporates a certain number of eudaemonian elements in her concept is probably her fundamental reluctance to equate quality of life with satisfaction (roughly in the want-equilibrium sense discussed above). Since want-equilibrium is one of my basic concepts it can be of interest to consider Naess's arguments against this idea of quality of life.

Some of her arguments have already been presented in my general discussion of the concept of happiness. But let me rehearse my main conclusions here. First a summary of Naess's statements:

(a) A person who has 90 of 100 wants satisfied can have a much better time than the person who has all his or her ten wants satisfied. According to the want-equilibrium criterion the former is in a worse position.
In order to be able to choose — in order to have wants — one must know the alternatives.

People have different aspirations concerning life. Old people are often more satisfied than young ones.

People can consciously or unconsciously interpret their situation in terms of what is socially acceptable.

On the number of wants and the ratio between wants. (Naess 1979 pp. 20, 23-25 and 1987 pp. 28-31). If a man P among his 90 satisfied wants has all his high-priority wants, then P would come out as a happier man than Q, on what I call the richness scale of happiness. On the other hand, it is very easy to give an example where P must be much unhappier than Q, although he has 90 and Q just has 10 satisfied wants. Assume that among P's unsatisfied wants we find his want to have his son back from the army, or his want that his wife will recover from a serious disease.

The whole issue of the ratio between satisfied wants and wants is dependent on the notion of degrees of importance among wants. Naess's argument, therefore, does not strike at a more sophisticated version of the want-equilibrium model.

In order to choose one must know the alternatives. As we have discussed in Part I, some people have fewer and more unpretentious wants than others, because they do not know the alternatives. A person who does not know of the existence of five-room flats cannot explicitly want to have such a thing.

But, as I argued, the fact that such a person cannot have very specific wants concerning alternative resources does not mean that his or her wants are completely limited by his or her knowledge. The fact that a person suffers from poor circumstances is partly tantamount to saying that he or she wants something different, however generally this is conceived.

Thus a person with a limited number of specific wants, which are realised, need not at all on my theory be a person who is satisfied overall. He or she may have a number of unspecific wants which have not been satisfied.

People have different aspirations in life. Old people are often more satisfied than younger ones. It is not entirely clear why these statements constitute an argument against a want-equilibrium theory of happiness. Does the second statement imply that old people, although often satisfied with life, are still less happy than younger ones? This is far from obvious.
I wish to iterate the insights of the Stoics. Happiness is more easily attainable for the person who has realistic expectations and aspirations. Elderly people with realistic aspirations are, therefore, in a better position to acquire happiness.

(d) People can interpret their situation in terms of what is socially acceptable. Also here it is unclear what this is an argument against. If it is an argument it seems to be directed against all methods of obtaining knowledge about a person's state of happiness by asking for his or her own judgement.

There is clearly here a methodological problem. We know through introspection that it is sometimes difficult to give a reliable picture of one's own general state of mind. One must possess some reflective ability; one must be able to disregard the disturbances of the moment and be able to make a judgement which is true of a longer period.

But if one were to take such a methodological argument very seriously, then one should completely drop the development of a hedonistic concept of quality of life and instead aim for a eudaemonian one. But this conclusion is not drawn by Naess. On the contrary. In her characterisation of quality of life one can find items such as the following:

A feeling of being useful; being satisfied (sic) with one's own achievement
being in a mood of happiness
lack of feeling of emptiness, depression, distress or pain.

Is there not a risk, when the subject reports about items of this kind, that he or she will answer in the direction of what is expected or “socially acceptable”? (This incidentally does not hold solely for the reporting of mental states but equally for the reporting of relations and activities.)

The design of the KI instrument

The concept proposed by Kajandi himself is based on Naess's theoretical considerations. The concrete outcome, however, is rather different. The KI is more inclusive and includes a multitude of conditions of life other than mental states. The instrument is divided into the following three sections:
(a) external conditions of life
(b) interpersonal relations
(c) inner mental states

**External conditions** are in their turn divided into working situation, economic situation and living situation. **Interpersonal relations** are divided into pair-relations, relations of friendship, family relations (the original family) and relations to one's children. **Inner mental states** divide into enmeshment, energy, self-realisation, freedom, self-confidence, self-acceptance, emotional experiences, security and basic mood of happiness.

The KI is not a strict questionnaire. The variables are to be covered in an interview, where an experienced interviewer asks questions which can partly vary depending on the actual development of the interview. The judgment regarding the interviewed subject, moreover, is not solely based on the verbal answers of the subject. Other information, explicitly or implicitly given through gestures, body language or otherwise, is taken into account.

Let me in my analysis first consider the category of **external conditions** and as an illustration use the following detailed characterisation of a maximally good working-situation:

The individual works exactly according to his potential. He is neither stressed by too high requirements nor understimulated by too low requirements. He likes his job and goes to it every morning with pleasure. The working environment and his mates are excellent and he has great scope for deciding about his own situation. His employment is secure and he feels no threat of unemployment or other undesired changes (Appendix 1, Kajandi et al. 1983).

Strictly speaking, the KI does not here only describe external circumstances. It refers in most expressions to the subject's *experience* of his or her working conditions; whether he or she is *stressed*; whether he or she *likes* work; whether or not he or she *feels* secure or *feels* any threat of unemployment.

Observing this we can see no clash with the want-equilibrium theory. The items roughly concern whether the subject wants to hold on to various features of the working situation or not, whether he or she wants a change or not. (Observe my analysis of the various kinds of suffering or distress. Suffering from X partly means wanting to have something different than X.)
The general impression one gets from an analysis of the external conditions category of the KI is thus the following. The fundamental type of question asked by the interviewer concerns whether the subject likes his or her conditions or not. So far, then, the externality of the conditions is only spurious.

However, a few statements are not unequivocally of this kind. Consider the following items in the subcategory of working situation.

The individual works according to his potential
The individual has great scope for deciding about his own working situation.

According to one interpretation these statements are elliptic in the sense that the individual's experience of these facts is just left out and presupposed. According to another interpretation, the mentioned items have such a self-evident positive value that there is no need for questioning the subject about his or her experience.

Consider for a moment the second interpretation and challenge the eudemian idea that working according to one's potential is a self-evident value. Imagine a man who does not at all want to maximise all his potential. He does not want to exploit certain of his talents, because doing so might imply moving to another department or even another working place altogether. That may involve conflicts with other of his interests.

Admittedly such a case may be discovered via other statements in the instrument. Consider therefore the straightforward case where a person for no particular reason does not want to work according to his or her potential or according to any implicit societal norm for the kind of person he or she is. The person simply does not have the ambition. How does the KI treat this case? Is the subject's own judgment finally decisive? Or does an inbuilt evaluation play a role?

Kajandi is obviously struggling with this problem in a short discussion of unemployment. He first says: The basic evaluation of unemployment is that it is something negative (my italics). The subject may, however — he goes on to say — in rare cases experience unemployment as something partly positive. In the assessment such reported experiences may result in a judgment [on the part of the interviewer] which is not completely negative. What is assessed is how the subject experiences the situation of being unemployed (Kajandi et al. 1983, Appendix I).

Kajandi wavers between two positions and the reader cannot be completely convinced that it is the latter statement which is decisive. Why
does the interviewer need to have a prejudgment to the effect that unemployment is something negative? Why must his or her openness as a researcher have to be blocked at this point?

I can be rather brief in commenting on the category of Interpersonal relations. My observations here are rather similar to the ones concerning the External conditions. The KI here basically focuses on the subject’s experience of his or her relations and the emotional impact the relations have on him or her.

A well-developed contact with one's children is characterised by the following:

The contact results in feelings of warmth and friendship. The individual feels happy with his or her role as a parent. The individual is content with the children's development and is pleased with having the children.

(Appendix 1, Kajandi et al. 1983)

On the other hand also here the idea of a basic (normative) evaluation occurs. The KI makes its own evaluation to the effect that a pair-relation is something good, that having friendship relations is something good. (Interestingly and surprisingly enough this evaluation is explicitly not made concerning the having of children.)

The question can be asked again: Why does the KI have to make these explicit evaluations, given the fact that its instructions normally emphasise that what is to be measured is the subject’s own experience and evaluation of his or her life situation?

Consider now the category called Inner mental states. It can first be observed that the label is not entirely adequate for the subcategories and items listed. Some of these refer to states which are, strictly speaking, neither inner nor mental; some other items refer to states which are inner but not mental. Freedom and self-evaluation are examples of the former. “Freedom” normally refers to a set of relations between an individual and an external world, entailing that the individual is unprevented from performing a certain set of actions. Freedom should be distinguished from the feeling of (or awareness of) freedom, which is probably what Kajandi primarily has in mind, given his examples of interview-questions. The feeling of freedom certainly is a mental state.

Self-realisation is, in Kajandi's own words, the degree to which the individual has developed his or her talents and potentialities. Thus self-realisation is also a relation, viz. the one between a person's actual achievements and the states of affairs he or she has a potential for
achieving. As in the case of freedom there is here also a mental correspondent, viz. the feeling of self-realisation, which again perhaps is what Kajandi wishes to primarily focus on.

Energy is clearly not just a mental state, but comprises a person's basic resources, both physical and mental, for acting and accomplishing what he or she sets out to accomplish. Energy is an “inner” property in the sense that it does not entail resources external to the person, but it obviously need not be mental. But in analogy with the previously mentioned properties, a person may be aware of his or her resources and thereby be in a mental state connected with the possession of energy.

Leaving these complications aside I shall now make some further observations about the items collected under the label Inner mental states. The inclusion of many of them in a quality of life instrument can be justified on the basis of my theory of happiness presented in Part 1. Many of these states have a clear relation to the realisation of a person's wants.

A person who feels free believes that he or she can choose between different actions in order to realise his or her goals. A person who is self-confident believes that he or she is well-prepared and in general able to fulfil his or her tasks and realise his or her goals. A person who feels secure believes that his or her most important values (what he or she mostly wishes to hold on to) are sheltered from damage or intrusion.

In general, the mental states referred to here (as well as some others) involve the reflection on certain basic conditions for the realisation of wants. Freedom and security are such important conditions, so is energy as well as the general ability referred to in self-confidence. Other items have different relations to wants and want-realisation. Self-realisation implies that one's most important wants have in fact become realised. Enmeshment, in the KI explication, presupposes at least one interest, one want above the basics, which the subject is involved in exploiting and realising. Emotional sensitivity, finally, is a necessary condition for experiencing the happiness which shall issue from the realisation of wants.

Some notes on Kajandi's method for the assessment of quality of life

I have now described and discussed the main components in the life quality concept of KI. In a concrete assessment or measurement of a person's quality of life all these components should be considered. The
external conditions of the person's life must be characterised, so must his or her interpersonal relations and inner psychological states.

The main method that Kajandi considers when it comes to making an assessment of this kind is a structured interview. A trained interviewer performs this by following a guide designed for the purpose (Kajandi et al. 1983, Appendix 2). The overall assessment, in terms of an estimation on a five-graded scale, is made on the basis both of the explicit information from the respondent and of implicit information derived from facial expressions, gestures and other kinds of body language. Kajandi, however, also uses another method which functions as a supplement to the interview, viz. a self-assessment performed by the respondent. (Appendix 5, Kajandi et al. 1983, contains the formula for the respondent's self-assessment.)

Kajandi has made a pilot study where he has compared the two studies. He summarises the results of this study in the following way:

In conclusion it can be said that the subjective experience somewhat deviates from the judgment of an “objective” assessor. Most of the time the deviation is of the kind that the respondent experiences the situation as being somewhat better than the external assessor does. However, the deviations are rather small (Kajandi et al. 1983, p. 21).

We can now pose the following interesting question. Does it follow that the concept of quality of life becomes different when it is the subject that makes the judgment about his or her quality of life? Does the self-assessment in itself make the concept more subjective and in fact come closer to my own concept, which is based on the subject's want-satisfaction?

The answer is that this need not be the case. There is an important distinction to be made between on the one hand a subjective concept of quality of life (as, for instance, my own), and on the other hand a subjective judgment of one's quality of life (where the quality of life can still be defined in objective or mixed subjective-objective terms).

Suppose that quality of life should be defined in terms of a person's economic standard, his or her income, wealth, standard of housing etc. Assume that there is also an “objective” scale of evaluation attached to this definition. This kind of “quality of life” can then be judged and measured both by an external assessor and by the subject. They can make this assessment either more or less correctly and completely, but they can very well measure the same thing and stick to the same concept.
The situation becomes completely different if the respondent is asked not only to estimate his or her income, wealth etc., but is also asked about what economic standard he or she would like to have. Then we do not just have a different method for getting the same kind of answer. We ask a different type of question. The concept of quality of life has changed. The concept of quality of life has been transformed into something which comes close to my own concept of want-equilibrium.

What then holds in Kajandi's case? Several things in the presentation indicate that the self-assessment in his case is not only a supplementary method, but that a partly different concept of quality of life has been introduced.

In the questionnaire used for self-assessment the respondent is asked, in connection with every question, (whether it concerns housing, work or financial state) to make the judgment whether his or her situation is very good not very good or bad. The respondent is thus asked to evaluate his or her own situation. And what is more important, the respondent has not been given the definitions and tentative norms which I have just discussed above and which function as a basis for the judgments of the interviewer. (See Kajandi's discussion on p.79.)

A conclusion emerging from this reasoning is thus that the KI works with two distinct concepts of quality of life. One of the concepts is a mixed objective-subjective concept. The other one is a subjective concept which has great similarities to my own.

Problems regarding quality of life measurement in the case of psychiatric patients

There is an interesting argument against a subject-based concept of quality of life which is not sufficiently discussed but alluded to in Kajandi's writings. The argument can be illustrated by the following example. Consider a female psychotic patient who has left a mental hospital as a result of the modern mental health policy entailing the closing down of the old asylums. This woman rents a small flat and lives under very simple circumstances. She does not get a job but survives through allowances from the social security system. When asked this woman claims that she is completely happy with life. She says that she does not need or want anything more. An external observer, however, cannot agree. The observer sees that the woman does not eat properly, that the hygienic standard in the flat is appalling, that she has no contact
with relatives and that she has practically no friends. The observer also predicts that the woman's situation will become untenable in the near future. In spite of the declaration made by the woman herself the observer therefore concludes that her quality of life must be very low.

There seems to be some force in this example. But what is it an argument against? Is it an argument against a subject-oriented notion of quality of life like the one that I have proposed in this book?

I claim that it is not an argument against my notion. The important thought contained in the argument has to be directed against something else. Let me go into this stepwise.

(i) **The case of a conscious lie.** A subject-oriented concept of quality of life does not entail that everything that the subject says concerning his or her happiness is the truth. The subject may for some reason or other simply tell a lie.

(ii) **The case of a genuine mistake.** Another perhaps more plausible and interesting case is the case of mistake. The psychotic woman (and this may indeed hold for many “normal” persons) does not properly understand the question. She may not understand that she is supposed to weigh in all kinds of circumstances in her overall judgment of her situation in life. As a result she may give an answer which is not completely in accord with the truth.

(iii) **The case of a genuine confusion.** This case may be more typical for the psychotic; the woman may not have proper access to her own value system. She may be completely confused as to what she really requires or wants in life.

I certainly agree that these cases occur and that it may therefore sometimes be the case that an external observer knows better whether a subject has a high degree of quality of life or not. This, however, is a statement concerning an *epistemic* question and not a statement concerning a *conceptual* question. The external observer may have better access to knowledge about the psychotic woman's quality of life. This does not entail, however, that he or she uses a different concept of quality of life. The observer may all the time have the woman's happiness in the long run in mind when he or she makes this judgment.

It is important, given the example, that we emphasise the aspect of *long-term* happiness. The external observer may be able to see better than
the psychotic woman herself what will be the long-term consequences of her bad habits concerning nourishment and hygiene and of her solitary life. At the same time there is certainly a risk of paternalism and conventional judgment about how a person ought to behave. I am not endorsing the latter in my acknowledgement of the possibility of external expertise in quality of life matters.

A summary of the analysis

What do we end up with? We have a list of external conditions, interpersonal relations and internal conditions, which are such that they are normally considered desirable by most subjects, either because they are immediately gratifying or because they are seen to be means for the realisation of goals. All this is basically consonant with a want-equilibrium analysis of happiness or wellbeing.

On the other hand, the procedure described involves the following risk: For a number of individuals (and these could be numerous) it may be the case that external conditions other than work, housing and economic welfare, as well as interpersonal and inner conditions other than the ones captured in the KI instrument, are seen to be more immediately gratifying or more suited to the attainment of certain central goals. Thus to these people such things are more important for their quality of life.

Among external conditions can be mentioned such as climatic, political, cultural and religious conditions. Why should these be omitted without discussion? As to interpersonal relations there are people who derive much pleasure from human contacts which are not of a pair or a deep friendship kind but which can be, for instance, intellectually rewarding. Moreover, social isolation can be a chosen state of affairs.

The KI does not acknowledge man's relations with non-humans and nature as such. Nor does it, in general, acknowledge the whole field of leisure life, which to many people is of greater importance than working life. (Some of these things can be indirectly captured by the psychological category of enmeshment. Enmeshment is said to be the mental state where the individual takes an interest in something and becomes involved in it. The object of this involvement can certainly be life in close contact with nature or leisure life in general. But it can equally well be elements in work or things which have to do with housing or basic economic matters. Hence there is still an imbalance in the way the KI treats different sections of life.)
The conditions for actions, which are mostly of an inner character and which are listed in section III, are not exhaustive either. A salient absent factor is health, or the experience of health, except for the extent to which it is included in energy. By experience of health I mean again the experience of one's ability to reach one's vital goals. Above the level of health we can find more exceptional abilities or kinds of strength which can be a source of happiness to many people: intelligence, creativity, imaginative power etc. The experience of such abilities is at most indirectly captured by the KI, and in that case by the category of self-confidence.

But if my observations are correct the following central question can be asked: why not construct an instrument starting from the theoretical point of view that the key to a person's wellbeing is his or her plans, aspirations and interests, and his or her ability and opportunities to fulfil these? Why instead, as with the discussed instruments, lock oneself up in a framework constituted by a more or less arbitrarily selected list of items, and let the questions within this framework determine the evaluation of a person's quality of life?

It is difficult to avoid the suspicion that the KI has assumed from the beginning what ought to be the most important things to a human being and what ought to be the foundations of his or her quality of life. There is then perhaps a eudaemonian element in the KI instrument.

The normative view is in a way compensated by the instrument for self-assessment which supplements the instrument for the interviewer. Strictly speaking, however, this supplement introduces a new concept of quality of life. The question can then be asked: which of the two concepts constitutes the "real" quality of life? Or is the "real" quality of life some kind of sum of the two concepts?
To measure health and quality of life in health care II: The idea of human needs

The idea of human needs

There is a completely different discussion of quality of life which is ultimately anchored in psychological, in particular psychodynamic, theory and which leans upon the concept of human need. The main idea in this tradition is that a person has a high degree of quality of life, if and only if his or her fundamental needs have been satisfied. The classic platform for this thinking is the work of the American psychologist Abraham Maslow represented by *Motivation and Personality* (1954) and *Toward a Psychology of Being* (1968), where he presents his famous theory of the hierarchy of the human needs.

I shall here pay attention to this tradition, in particular in the form it has taken in the theory of quality of life presented by Anton Aggernaes, a Danish psychologist. Let me first introduce the general concept of need.

On the general concept of need

The concept of need is more problematic than it can look at a first glance. Several of the theoreticians who have used it have not been completely conscious of its degree of complication. This leads to some unclarities which could be avoided.

a. *The original instrumental sense of “need”*

In ordinary speech we often say that we have need of something or simply that we need something for a certain purpose. We say, for instance, that we need a hammer in order to nail up a picture, that we need to take a walk to get rid of certain tensions in the body, or that we need to take an exam in order to get a desired job. The noun “need” or the verb “to need” here simply functions as a three-place relation: P needs x in order...
to reach $T$. $P$ is the subject of the relation, $x$ is the object of the relation and $T$ the goal of the relation. (If we wish to reason even more carefully we ought to introduce a further position, which should mark the circumstances under which the need-relation is assumed to hold. The relation thereby is in practice a four-place one.)

The thing that a person needs (the object of the need) is according to this line of thought completely dependent on the goal set by the agent. The object constitutes a necessary means to reach the goal. The hammer is necessary to nail up the picture, the exam is necessary to get the desired job etc. If the goal varies, then the means also vary. The object of the need is completely relative to the goal of the need.

We can call this a purely logico-linguistic analysis of the concept of need. A need is, according to this analysis, a purely abstract relation with three (or four) positions. This type of relation can be instanced in many different ways. What is fundamental to the particular instance is the goal-setting. We can arbitrarily set any goal. From such a goal-setting follows a particular list of objects. The objects must fulfil the condition of being necessary means to realise the goal of the need.

This abstract analysis of the concept of need cannot, however, on its own give us any guideline for the understanding of human quality of life. In such a case the quality of life is just a matter of stipulation. Everybody who at a particular time sets a goal, for him or herself or for someone else, can thereby enrich the definitions of quality of life infinitely. This is not what the need-theoreticians have had in mind.

b. **Needs as factors of motivations or dispositions for action**

Psychologists like Maslow have based their theories of needs on certain biological and psychological presuppositions. They claim that there are certain need-objects which are biologically or psychologically founded and which are such that they are universal to all mankind. These objects of need are claimed to have the status of *fundamental human needs*. Among these universal needs Maslow counts so-called physiological needs, as well as the need for security, the need for closeness and love and the need for self-respect and self-realisation. To satisfy one's fundamental needs means to Maslow to satisfy precisely the needs mentioned here.

As a result a theory of quality of life based on needs need not be arbitrary or empty. The concrete direction is to be found in the list of fundamental needs. The connection to quality of life is from here evident.
A person attains quality of life by satisfying his or her physiological needs, his or her needs for security, closeness and love etc.

But what procedure do Maslow and his associates suggest to identify the fundamental human needs? How can we say that it is universally human to have a need for food, security, love, self-esteem and self-realisation? Is it the case that all humans have set a goal that is common to them all, and which is such that the mentioned objects of need are necessary means for realising this goal? This question is natural given my basic analysis of the concept of need. But has Maslow posed it? And is it by posing this question that he has in practice identified the fundamental needs?

No, there is a completely different route that has been taken by the psychological theorists of need. They have identified the needs by studying actual human behaviour. According to Maslow one can find that people in fact strive to satisfy the needs that he has listed. Moreover, he has found that people choose to satisfy the needs in a certain order. First, the physiological needs must — at least to some minimal extent — be satisfied, before the need for security becomes apparent. When this need in its turn has been realised, then the need for closeness or love is brought to the fore. This process then goes on until we have reached the top of the hierarchy of needs.

Thus the fundamental needs are identified by Maslow on the basis of universal human strivings. In this respect the Danish psychiatrist Anton Aggernæs thinks in a similar way. He says, for instance:

> By a need I understand tendencies of action towards determined goals, which can be either of the character of attaining, maintaining or avoiding certain states of affairs (Aggernæs 1989, p. 58).

It is misleading, however, to say that this completes the characterisation of fundamental needs in their systems. It is not enough that we shall have a universal tendency of action in order to say that there is a fundamental need in the sense of Maslow or Aggernæs. A fundamental need is for them also something that is directed to a positively valued end state. In this respect Aggernæs expresses himself more saliently. Aggernæs says that people suffer unless their fundamental needs are satisfied. This element is a part of his very definition of fundamental need.

Maslow does not present such a clear definition. On the other hand one can find similar formulations in some of his commentaries:
The so-called psychopathic personality is an example of permanent loss of the love needs (p. 98).

People have strong, healthy character structure as a result of basic satisfaction (p. 100).

Thwarting of unimportant desires produces no psychopathological results; thwarting of basically important needs does produce such results. Any theory of psychogenesis must then be based on a sound theory of motivation (p. 104; all quotations are from Maslow 1954).

Thus if the fundamental needs are not satisfied this will, according to Maslow, lead to an unhealthy state, in certain cases specifically to mental illness. This suggests a reconstruction of Maslow's theory which is in accordance with my basic analysis of the concept of need: A human being has a need for food, security, love, self-esteem and self-realisation in order to attain and maintain his or her physical and mental health.

The goal which is the logical key to the identification of the fundamental needs is therefore health. A slightly different specification is given by Aggernaes and will be presented in the following section.

On needs and quality of life in the theory of Anton Aggernaes

Aggernaes (1989) presents a thoughtful theory of quality of life in which the concept of a fundamental need is a cornerstone. The structure of his theory can be summarised by means of the following schema:

Fundamental human needs are such needs as all human beings have and as are moreover such that people suffer unless the needs are satisfied.

Health is constituted by the prevailing and potential resources of the individual and the environment to satisfy his or her fundamental needs.

Specified objective quality of life is the degree to which the individual has satisfied his or her needs.

Specified subjective quality of life is the degree of satisfaction that the individual feels in connection with the satisfaction of needs.
General subjective quality of life is the degree of satisfaction that the individual feels with life as a whole.

Aggernaes acknowledges that he is strongly influenced by Maslow's thinking, but for different reasons, partly explained in his book, he suggests an alternative to the concrete list of fundamental needs which was introduced by Maslow and mentioned above. Aggernaes accepts four types of fundamental needs: a. elementary biological needs, b. the need for warm human relationships, c. the need for a meaningful occupation, and d. the need for living a varied life.

The observations that I find it most important to make about this system are the following:

(i) **Aggernaes differentiates between resources for quality of life and the quality of life itself.** The distinction which I have continuously made throughout this book between resources for quality of life, be they internal or external to the individual, and the quality of life itself is made with great emphasis in Aggernaes's book.

(ii) **Aggernaes makes a conceptual connection between health and quality of life.** In a way similar to my own Aggernaes connects health with quality of life. Health consists in his case of the individual's resources for achieving quality of life, in particular for realising his or her fundamental needs. Somewhat surprisingly, however, Aggernaes incorporates all conceivable welfare factors, both external and internal, in the concept of health. A person's working situation as well as his or her housing conditions are elements of the person's health in Aggernaes's sense. To me it is much more natural — and more in accordance with ordinary language — to confine the scope of health to the inner welfare of man, i.e. to such factors as have to do with the individual's body or mind.

(iii) **Aggernaes works with three concepts of quality of life.** In contradistinction to the theory proposed in this book Aggernaes suggests three different concepts of quality of life: objective, subjective and general subjective quality of life. This multiplicity is partly dependent on the place that the concept of need has in the system. Aggernaes finds it natural to distinguish between the individual's objective satisfaction of a need, i.e. the objective fact
that the individual gets food, security, appreciation, love and the opportunity for self-realisation (to an extent that can be considered normal for a certain population), and the individual’s experienced pleasure that results from the satisfaction of the need. Furthermore, this experience is to be distinguished from the person’s experienced satisfaction regarding the course of his or her life as a whole.

Problems with Aggernaes’s theory of needs and quality of life

Aggernaes’s theory is clear and well-developed. It raises however a number of fundamental problems. One such problem is in fact created by the central place taken by the concept of need in his system. It seems to me as if Aggernaes because of this runs the risk of a kind of paternalism that is similar to the one that he eloquently criticises. What point do we make by claiming that a person who has sufficient food and water, who has a meaningful occupation and lives a varied life etc., has a high degree of objective quality of life? Suppose that this person hardly ever has a quiet moment; suppose that he or she has no time for studies which he or she is longing for; suppose that the country in which he or she lives suffers from civil war; suppose that the person has just lost his or her spouse in a tragic accident etc.

It is true that the conceptual network of Aggernaes makes it possible for him to distinguish between objective quality of life and general satisfaction with life. He could say of the mentioned cases that here we have an individual who has a high degree of objective quality of life but a low degree of subjective quality of life. At the same time, however, Aggernaes has in his treatment committed himself to the notion that the satisfaction of fundamental needs is the basis of quality of life, in all essentials also the basis of subjective quality of life. My drastic examples show that this need not at all be the case.

One can therefore seriously put the following question to Aggernaes: why do we have to follow the route via needs in order to characterise the concept of quality of life? Why could we not simply identify quality of life with what Aggernaes calls general subjective quality of life — a concept which is indeed close to my happiness with life? Aggernaes must mean that the satisfaction of needs is important for the very reason that it ultimately contributes to the individual’s experienced satisfaction. It must ultimately be the occurrence of such an experience (or the lack of such an experience) that serves as a criterion of what is to be counted as
fundamental needs. Observe that Aggernæs explicitly says that people suffer unless their fundamental needs are satisfied.

I therefore wish to argue that the concept of need becomes an unnecessary strait-jacket for the characterisation of quality of life. Aggernæs is in his book frequently forced to defend his system against those who claim that there is a multiplicity of human interests and strivings. Engagement in art, science, sports or religion is important to many people and often contributes greatly to the life satisfaction of these people. We can find few such types of engagement explicitly treated in Aggernæs's system.

Aggernæs's line of defence is that many of these activities should be regarded as subordinate either to the fundamental need of meaningful occupation or to the need of variation in life. To be engaged in art, science or sports is, according to Aggernæs, each a different way of satisfying one or more of these fundamental needs.

This line of defence is, as far as I can see, insufficient. It can of course be the case that one chooses an activity because it offers variation and gives meaning to life. But it can also be the case that one does so because the activity affords an immediate experience of satisfaction. I myself do not engage in physical exercise because it gives me variation in life or because I find it particularly meaningful. There are in fact many other things that interest me more and give me a much stronger feeling of variation. I indulge in sport for the simple reason that it often gives me immediate satisfaction and it gives me in the long run a feeling of greater strength. In short I have a number of important goals which cannot easily be subsumed under any of the alleged fundamental needs.

There are particular theoretical difficulties pertaining to the notion of meaningful occupation. "Meaningful" is a notoriously ambiguous term. According to a very common use "meaningful" simply stands for something which serves a purpose. Following this interpretation an activity is meaningful as soon as it serves some purpose that the subject has. But then meaningful occupation cannot be a fundamental need in Aggernæs's system. The meaningful occupation will then be subordinate to the higher purpose that one happens to have, be that the diffusion of Islam, the writing of a drama or the participation in a football match.

The fundamental need ought then to be formulated in the following terms: all people have a need of realising their goals. This formulation can hardly be contested. But is it enlightening? Have we then got some new insight about human psychology?
(It must be granted that Aggernaes mostly has a further specification of "meaningful occupation" in mind. He delimits it to refer to goals which lie outside the agent. He thereby excludes goals which are completely selfish. Thus his statement, if true, gives some information about human nature. Still, the main thrust of my argument will hold. We would be very much more enlightened about the prerequisites of a particular person's quality of life if we were simply told about his or her particular interests or goals.)

What seems to be strikingly absent in the need theory of quality of life is the importance of the course of the world for human happiness and quality of life. Political events, local developments, events in family life, successes and failures which we encounter all the time, influence our quality of life enormously. A single external event can totally change our judgment of the total life situation. A big and unexpected inheritance can change our possibilities in life radically. The loss of one of our nearest and dearest can cause grief that no fundamental need-satisfaction can compensate for.

It is true that some external events influence our quality of life because they constitute opportunities for need-satisfaction or because they prevent need-satisfaction. The influence is rarely simply direct (see on this point my treatment of welfare in chapter 3.) It is only that the mediating factor need not be a fundamental need. It can be another kind of vital goal that the individual has and which may indeed be quite peculiar to that individual.

My conclusion therefore is the following: A general theory of quality of life must be able to account for the importance of external welfare, not just as involving resources for need satisfaction, but also as involving other sources of happiness.

What can be learnt from Aggernaes’s theory?

Aggernaes's theory is in many ways so comprehensive and thoughtful that it deserves a lot of attention. It is also so clear that it is easy to find and formulate the critical points that I have just made.

In order to balance my criticism of theories of need in connection with the study of quality of life I now wish to underline their strength. A way of looking at theories of need is to regard them as attempts to find some general formulae for human nature. These theories do not just aim at defining the notion of happiness or quality of life. They also seek to
pinpoint the best routes to reach these states of affairs given the laws of human nature. My own emphasis is very much on the question of characterisation. I have much less to say about general means for attaining happiness.

The theorists of need are certainly right in claiming that there are common traits in human nature which determine some basic conditions of happiness and quality of life. There certainly are such common biological and psychological minimal conditions. It is an important task to describe these conditions. It is essential, though, to consider that such a description cannot result in a description of all the conditions which must be fulfilled for the happiness of any particular individual. There is therefore a great risk in trying to define quality of life in terms of the satisfaction of needs.
An economic approach

My discussion so far has for many reasons been limited to studying methods for the assessment and measurement of individual quality of life at a particular point in time. I have discussed internal and external states of welfare and their relation to a person's life-satisfaction or happiness. I find that this restricted task has been well motivated so far. There have been sufficiently many difficult problems to tackle.

A modern treatment of the issue of quality of life in connection with medicine and health care would however be deficient if it did not pay attention to the so-called qaly project for the analysis and measurement of health-related quality of life. This extremely ambitious programme, which has both the US and the United Kingdom as its base, has as its ultimate purpose to make measurements which could serve as a basis for the allocation of health care resources on a national level. The project therefore aims at answering questions such as the following. Where should we concentrate our medical resources? Should we prioritise primary care before specialist care? Is hip-joint surgery more important than heart-transplantation or renal dialysis?

All these questions should be answered from the perspective embodied in the following questions. By what measures do we create the optimal quality of life in the population? How should we concentrate our resources and how should they be balanced against each other in order for us to create the highest possible degree of quality of life? In order to answer such general questions we must be able to answer a number of specific questions of the type: how much more do we raise the quality of life of a person by measure A than by measure B?

From the aspect of the history of ideas it is exciting to note that the health economists of today are involved in a project which very much resembles the one undertaken by the utilitarian philosophers of the 19th
century, in particular Bentham and Mill. The difference is only that Bentham and Mill talked in the general terms of happiness or pleasure. The York economist Alan Williams and his colleagues limit their task so far to treating what they call health-related quality of life. Their project is however hardly less problematic than the one of the old utilitarians.

The project of the health economists raises the degree of complication in relation to my previous discussion in this book by several dimensions. First, it requires a basic instrument for the measurement of quality of life of the kind that I have discussed. One must have a basic instrument for measuring the state in which a particular person is at a particular point in time. Second, this project requires that the time factor is considered in a concrete way. It is important to know how stable a certain state of health is. Assume that a certain operation improves the state of a person by a factor of 3. This state, however, is not stable. It gradually worsens to return to the original state within two years. Assume that another operation normally improves the state of health of a person by a factor of 1.5. This state, however, is almost always stable and can be expected to last throughout life. Which operation can be judged to raise human quality of life most?

This illustrative example indicates immediately a third complicating dimension. A future state of health is hardly ever something that we know about. A physician can only predict the result of some intervention (as well as the stability of this result) with a certain probability.

Fourthly, an allocation project of the kind envisaged also requires some exactness in the judgment of the results of different measures. It is not sufficient to order them along an ordinal scale, for instance by saying that the result of renal dialysis or a heart-transplantation normally entails a greater improvement of a person's quality of life than the result of a hip-joint operation. We must also be able to indicate how much more mankind is helped by the former measures than by the latter. A simple ordering is compatible with the fact that the measures are almost equally important from the point of view of quality of life. If that is the case a marked differentiation between the measures for purposes of allocation is hardly warranted.

Fifthly, we introduce the problem of assessing the quality of life of a large group of people. We cannot expect that different people will have similar initial states of quality of life. Nor can we presuppose that they will respond similarly to various kinds of treatment. Is there here a sense in which we can calculate a mean or average level of quality of life? And if so, how should we calculate this mean or average state?
To this complication we must add, *sixthly*, the purely economic requirement that we shall be able to attribute real costs to different types of measures. This aspect will not, however, be treated in the present book.

The York school model for assessing qalys

A presentation

The famous health economist Alan Williams at the University of York has, together with a number of colleagues, elaborated a sophisticated method for the measurement of health-related quality of life with the general purpose that I have just sketched. He has also performed some preliminary applications with respect to certain medical treatments. The results of these treatments have been provocative and hence a lot of attention has been paid to the work of the York school recently.

The debate has partly dealt with the theoretical foundations and methods of the York school. But it has equally much considered the ethical foundations for political and economic decisions within health care as based on qaly calculations. I shall here to some extent consider both these discussions. But let me first summarise the basic idea of a qaly.

At bottom there is an instrument for assessing an individual person's health-related quality of life (or simply: health). This instrument was designed by the English psychiatrist Rachel Rosser. The instrument is strikingly simple. Its fundamental idea is a matrix with two dimensions, viz. *distress* and *disability*. The dimension of disability is divided into eight states, from no restriction at all to unconsciousness. The dimension of distress is divided into four states, from no distress at all to a state of severe distress. The two dimensions can thus in principle be combined into a matrix with 32 cells. Three of these cells become however automatically superfluous, since unconsciousness cannot be combined with any degree of distress. The real number of cells then is 29. Consider the table.
Table 1: Matrix of health states according to Rosser & Kind 1978

<table>
<thead>
<tr>
<th>Distress (physical and mental)</th>
<th>No distress</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
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<td>3</td>
<td>9</td>
<td>10</td>
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<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>8</td>
<td>29</td>
<td>30</td>
<td>31</td>
<td>32</td>
</tr>
</tbody>
</table>

1 = No disability.
2 = Slight social disability.
3 = Severe social disability and/or slight impairment of performance at work. Able to do all housework except very heavy tasks.
4 = Choice of work or performance at work very severely limited. Housewives and old people able to do light housework only but able to go out shopping.
5 = Unable to undertake any paid employment. Unable to continue any education. Old people confined to home except for escorted outings and short walks and unable to do shopping. Housewives able only to perform a few simple tasks.
6 = Confined to chair or to wheel-chair or able to move around in the home only with support from an assistant.
7 = Confined to bed.
8 = Unconscious.

The idea then is that this matrix should cover all conceivable states of health or illness. This should hold whether the distress or disability is dependent on a pulmonary infection, a heart disease, pancreatic cancer or schizophrenia. Any kind of illness should have a cell in the simple matrix. This is the attractively simple idea. It must also be admitted that the framework is general enough to cover most possible states. It is quite often very difficult, however, to locate a concrete state of illness exactly in any particular cell. I shall return below with some critical comments.

The matrix thus organises the different states, but so far there is no ordering of them. It is of course clear that cell 1 represents a state which is better than the one represented by cells 5 or 9. But it is not clear what relation is supposed to hold between, for instance, cells 10 and 13 or
between cells 15 and 18. Moreover, the matrix does not say anything about a cardinal ordering of the different states.

In order to accomplish this Rosser, together with the York economist Paul Kind, worked out a psychometric test which could attribute absolute numbers to the various cells. The test had the following structure. A number of people were asked to order states from six chosen cells. They were also asked to say how many times sicker a person in cell x is than a person in cell y. This statement was to be made under the presupposition that the states belonged to persons of the same age and that all states had the same prognosis. After having ranked the first six states the test-person was asked to rank the 23 remaining alternatives. Finally, he or she was asked to rank the state of death and attribute a value to that state.

Kind and Rosser published in 1978 an investigation where 70 people went through this procedure. The mean values that Kind and Rosser got from this investigation after a mathematical calculation involving a linear transformation to a scale where the number 1 stands for complete health and the number 0 stands for death, are given in table 2.

Table 2: A ranking of utility numbers for health states (Kind, Rosser and Williams 1982)

<table>
<thead>
<tr>
<th>Disability</th>
<th>No distress</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.000</td>
<td>0.995</td>
<td>0.990</td>
<td>0.967</td>
</tr>
<tr>
<td>2</td>
<td>0.990</td>
<td>0.986</td>
<td>0.973</td>
<td>0.932</td>
</tr>
<tr>
<td>3</td>
<td>0.980</td>
<td>0.972</td>
<td>0.956</td>
<td>0.912</td>
</tr>
<tr>
<td>4</td>
<td>0.964</td>
<td>0.956</td>
<td>0.942</td>
<td>0.870</td>
</tr>
<tr>
<td>5</td>
<td>0.946</td>
<td>0.935</td>
<td>0.900</td>
<td>0.700</td>
</tr>
<tr>
<td>6</td>
<td>0.875</td>
<td>0.845</td>
<td>0.680</td>
<td>0.000</td>
</tr>
<tr>
<td>7</td>
<td>0.677</td>
<td>0.564</td>
<td>0.000</td>
<td>-1.486</td>
</tr>
<tr>
<td>8</td>
<td>-1.028</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

One remarkable result of this investigation is that the test-persons considered two states — in bed with serious suffering and unconsciousness — to be worse than death.

By this method the 29 cells were ranked and cardinally ordered. The numbers given in table 2 constitute the basis for creating the unit of a
qaly, which is short for "quality-adjusted life-year". This unit has the following simple definition. One qaly is the product of the number attributed to a certain state of illness, according to the Rosser scale, and the number of years during which the sick person is in this state. A person who is in complete health for one year thus experiences exactly one qaly. It is however possible to obtain one qaly by living for two years in a state of health which has the number 0.5, which means roughly the state of being in bed with slight suffering. We can now easily see that the mathematical possibilities of getting one qaly are infinite.

Qaly is the unit that the group led by Alan Williams has used to calculate the reasonableness of different medical measures. Among the more notable results in their work is the following. They have found that heart-transplants on average create 4.5 qalys, whereas renal dialysis creates 5 qalys and hip-joint operations 4 qalys (Williams 1985). Since hip-joint surgery is so relatively cheap per gained qaly we here have a strong health-economic argument for steering economic resources to this particular kind of medical treatment.

Some comments on the theory of qalys

The problems with the qaly-project are multifarious and lie on different levels. Professor Williams and his group are quite conscious of most of these problems and they have been discussing various modifications of the project. (Consider, in particular, the careful discussion in Loomes and McKenzie 1989.) One can also claim that the qaly model is to be seen as a framework for thinking in the area of health measurement. Within this framework different methods for measurement are possible. It is, as Williams also maintains (1988), not self-evident that the different states of non-health shall be given values once and for all by a certain population containing 70 respondents. (Alternative procedures in terms of alternative health scales and choice of test populations are presented in, for instance, works by the Canadian G.W. Torrance and his pupils at McMaster University in Hamilton, Canada.)

However, certain fundamental questions should be directed to the representatives of the qaly project. In my case I wish to raise these questions from the point of view of the analysis of quality of life presented in this essay.
1. The qaly theory deals with measurement of health and not quality of life

The choice of the Rosser scale for the introduction of the qaly concept indicates clearly that Williams and his colleagues wish to measure health and not quality of life in that broader sense of the word that Kajandi and Aggernaes analyse or in the sense of happiness that I have myself proposed. This choice is primarily motivated by the fact that the qaly theory should be used for medical applications exclusively and mainly for decisions regarding allocation of resources on the macro level.

In all its simplicity the Rosser scale is based on an important idea. The measurement deals exclusively with the parameters of disability and distress. These are, as I have myself argued, the fundamental parameters of health (including subjective health). The criticism that should be raised against the Rosser scale thus concerns details. Let me give two examples.

The constructor does not seem to observe the important connection that must hold between distress and disability. Cell 4 is an almost inconceivable cell. Here we shall have to deal with a case of no disability at all, but with serious, almost unbearable, distress. According to the scale the severest conceivable distress thus need not result in any disability at all. One may wonder how a migraine patient would react to such an assumption. A parallel observation can be made concerning cell 8, serious distress and a light social disability.

A fundamental question can also be raised concerning the distinction between levels 5 and 6 on the axis of disability. Level 5 is described as being a very serious state of health. A person on this level cannot go out to work and cannot pursue any studies. Simple housework is the only activity possible. Level 6, however, is completely described in mechanical terms. A person in this state of health is sitting still or bound to a wheel-chair. But these mechanical restrictions need not involve as serious social limitations as are described for level 5. A person bound to a wheel-chair can very well perform skilled work.

In short, disability is a multidimensional parameter. The Rosser scale does not follow a unitary principle in its characterisation of the different levels. This leads to unclarities concerning the interpretation of the levels.

2. The fundamental psychometric method

There is a strong and difficult assumption lying behind the psychometric method adopted by Rosser and Kind. They presuppose that it is
meaningful to pose the following question to a test subject: How much sicker are you in state x than in state y? How should a person interpret this question unless there is a detailed explanation? The rational counter-question would be: how much in what respect?

In the later methodological discussion, however, several other methods have been proposed. Some of these are much better anchored in economic theory. I shall here briefly describe one of these methods. This is the standard-gamble method, which was first introduced by the economists von Neumann and Morgenstern. (For an introduction to this and other methods in the area, see Brooks 1990.)

Assume that we wish to attribute a numerical value to a certain state of health $H$. A test subject is asked to consider what this state of health involves. The subject is then confronted with a hypothetical choice. He or she shall state his or her preference regarding living in this state for the rest of his or her life or instead undergoing a medical treatment which with a (supposedly) known probability $P$ leads to full health but with some probability leads to death. The number $P$ is then varied until the test subject reaches a state of "equilibrium", i.e. when he or she is hesitant as to undergoing the treatment or not. Assume, for instance, that equilibrium is reached when the probability is 0.8 that the treatment $T$ will lead to complete health. The utility number for $T$ is then taken to be 0.8. Since the probability numbers vary between 0 and 1 the scope for utility values will also be between 0 and 1.

This measurement — in contradistinction to the psychometric one — does not involve any direct evaluation of a particular state of health. One is however supposed to be able to deduce such an evaluation indirectly from the subject's willingness to take risks in order to get rid of the state or improve the state. The fundamental thought in this philosophy thus is the following: if the willingness to take risks is great, then the state of health is serious, whilst if the willingness is small, then the state of health is not so serious or even indifferent.

3. **Qalys and their relation to the time factor**

A basis for the calculation of qalys is, as I have said, a very simple mathematical principle: one qaly is the product of the health value and the number of life years. 50 years with full health give 50 qalys, 20 years give 20 qalys. 50 years with the health value 0.1 give 5 qalys, and 5 years in complete health also entail 5 qalys.

There are a number of critical points to raise concerning this simplistic
principle. Some of them have already appeared in the literature.

(i) *There is a need for some principle for discounting qalys over time*

Many debaters find it unreasonable to maintain that 50 years with full health entail a value that is 50 times greater than the one obtained during one year in complete health. This criticism seems particularly pertinent in a decision perspective, when the decision-maker conceives all these years in the future. The years which are closest in the future are more important to the subject, and complete health during these years is normally judged by the subject to be more valuable than being completely healthy during some very distant years.

As an answer to this kind of objection one could think of introducing some standard principle which is such that the value for complete health (and thereby in principle all states of health) is discounted for each year by 5 per cent. The value of being completely healthy during year 2 is then 0.95 qalys. And the value for year 3 is 0.9025 etc.

To use precisely 5 per cent as the discount rate is a usual convention in economic contexts but it is a convention which, strictly speaking, lacks a psychological foundation. The real value must vary a lot between individuals. To a person who is involved in a long-term project, for instance in completing a doctoral dissertation within six years, being completely healthy might very well be of equally great importance for all these six years. A very old person, on the other hand, who may consider that he or she has lived his or her life, may judge that his or her future state of health is almost indifferent with the possible exception of the next few months.

(ii) *Is there any point in adding qalys from a period which essentially consists of great suffering?*

Being completely unable to do one's work and being in deep distress is a health state which, according to the Rosser-Kind scale, has the qaly value of 0.7. Being for 10 years in this state would therefore give 7 qalys, or given some discount rate a slightly smaller number. This value should be compared with the value of being completely healthy for 7 years.

There is of course no unequivocal scenario that makes a comparison possible in this case. A person in great distress who is incapable of working can have compensations in life; he or she can have wonderful support from the family; he or she can perhaps find some meaningful
occupation instead of the lacking work ability. It is, however, very likely, in particular when we consider the condition of being in serious distress, that we are dealing with a person who is in general very unhappy. Let us imagine the following case of a proud industrial entrepreneur with a small number of collaborators. He is a man who spends all his time enthusiastically in his work. Suddenly he is stricken with a very disabling disease which is also very painful. Let us suppose that he is in this state for 10 years. Since the firm is completely dependent on his contribution, we can safely assume that the firm goes bankrupt during his illness. His life's work collapses. Instead of living an active expansive life he is now forced to be passive, and moreover he is all the time in great pain. During long periods he cannot escape the feeling that his whole life has been wasted. Would it not be an act of scorn to ascribe 7 qalys to this ten years of hell and thereby put it on an equal footing with seven years of full health?

The example can look extreme. One can claim that few persons are struck in such a hard way by a long period of illness. Moreover, and as a matter of principle: in my example I have mixed components of health with such components of quality of life as should rather be viewed as consequences of a state of health. The qaly analysis — in the version advocated by Williams — is strictly limited to health-components. This is true but it may at the same time reveal a weakness in the qaly method. Is it reasonable that we should neglect such serious consequences of illness as are very probable and as would normally be carefully considered in a clinical situation?

But perhaps a great mistake lies already in the evaluation made by the 70 test persons. We must remember that inability to work is an item on the Rosser-Kind scale. Such an inability, combined with great suffering during 10 years, must come as a terrible blow for the subject. It is therefore tempting to suspect that the 70 test persons in York did not fully consider the consequences of their judgments.

Some health-economists have considered the problem of duration of periods of illness. They realise that the health state cannot be judged irrespective of the time aspect. According to some suggestions (see, for instance, Loomes and McKenzie 1989 and Karlsson 1991) one cannot ascribe any utility value to a health state per se. Instead one must consider and compare courses of states of health, where combinations of health states and time lapses shall be viewed as inseparable units. Such courses of health states can be given values on a utility scale. This theoretical move is a step towards meeting the criticisms that I offered above.
4. On applications of the qaly method

I have already pointed out that the qaly method has been proposed mainly for health-economic purposes. It is expected to afford a basis for resource allocation according to the classic motto: allocate resources to the place where they produce the greatest amount of utility. It is however quite conceivable that other representatives of the health care system accept the results of the qaly thinking and apply them for instance in clinical work or the general work of care. There is reason to warn against such a transference.

In the qaly theory a series of health states have been given a utility number on the basis of judgments given in 1978 by 70 healthy Britons. Since the judgments by these persons differ somewhat, the utility number comes out as some kind of mean value. In the real clinical work a physician or other caregiver stands in front of a specific patient, who is ill. This state of illness is uniquely evaluated by the patient, partly because he or she puts it into his or her total life context. The patient can have a demanding physical occupation; he or she can be facing a difficult decision in life; he or she can be alone and can just recently have lost a dear one.

All these completely individual factors must be considered in the work of clinical care. A utility number which constitutes a mean of other people's judgments cannot be guiding in the care of one particular patient.

Some ethical remarks on the qaly method for the allocation of resources

On qalys and needs

The theory of qalys has aroused great interest among health economists and it is now being developed in many directions in these circles. At the same time the theory has prompted a critical discussion among ethicists and ideologists of health care about the plausibility of using qalys for the distribution of health care resources. This, mainly ethical, critique is well worth consideration. It certainly does not just strike at the qaly theory; it is pertinent to all other methods which exclusively base allocation decisions on the capacity of a medical treatment to raise people's health,
or quality of life.

In part this discussion is a replica of the classic debate about the limitations of utilitarianism as a universal ethical theory. According to utilitarianism in the sense of Bentham and Mill it is our ethical duty to create the greatest possible amount of happiness in the greatest possible number of people. When we face a choice of action, when we have to choose between an action a and an action a1, we are supposed to make a “happiness calculus” and with the help of this calculus try to decide which of the two actions best fulfils the ethical prerequisite, i.e. creates the more happiness or at least most minimises the amount of unhappiness.

A problem with classical utilitarianism is that it does not say anything about the distribution of the happiness-units among the population. Suppose that we are in a situation where we can distribute 100 units of some utility within a population of 100 individuals. Mathematically we can distribute these units in a great many ways, but what about the ethical status of these different ways of distribution?

One may claim that it belongs to the spirit of Mill’s principle that certain extreme distributions should be avoided, in particular the one which entails that one single person gets all the units of happiness. But the principle does not give any salient indication of how the units should be ethically distributed. There is need of a further ethical principle to guide us in situations of this kind. Most ethicists have for this purpose proposed a principle of justice. If we are to distribute a particular amount of utilities in a population, then the distribution shall be as just as possible. What, then, does this mean?

The fundamental cornerstone of justice is equality. A point of departure for a discussion of justice then is to say that all utilities should be distributed as equally as possible. If we have 100 units of happiness and the population consists of 100 people, then every person should obtain one of these units.

This simplistic interpretation of justice seems absurd in the case of health care. It must at least be supplemented and modified. There are two main such modifications already proposed in the literature, viz. the justice of merits and the justice of needs. We apply a form of justice of merits when we say that a person, in contradistinction to other members of the population, deserves to get access to some utility. For instance, the person who has done some work deserves to have a salary. The person who has not done the same amount of work does not deserve the same utility.

The justice of merits, which certainly has its place in many sectors of
society, is highly controversial in health care. On the other hand, in societies with a highly developed private sector of health care, like the United States, payment often functions as a merit for the access to a particular form of health care.

A reason why payment is considered controversial as a ground for qualification is that one can doubt that that there is any initial justice concerning economic resources. People have very different abilities to pay in the first place. This argument is then often supplemented with the point that health care is a very special utility. Health care deals with such basic functions of a human being, sometimes with his or her very existence, that it becomes inhumane to require a certain amount of money for a person to deserve this kind of care. There is, one can argue, another kind of justice that must work here, viz. the justice of needs.

According to the idea of justice of needs, the health care resources should be allocated so that the person with the greater need for health care should get the greater amount of health care. To everybody according to his needs, is the well-known Marxist slogan, which is certainly intuitively reasonable in the case of health care. This thought has indeed been codified in the Swedish Public Health Act. The government says in its draft of the Bill the following:

The need for health shall, within the framework of the economic resources, be the sole determining factor for the extension and character of health care. In this also lies that, in a situation of deciding priority between two patients, the person with the most acute need shall be given priority. (Government Bill 1981/82:97, pp. 27-28.)

Is the idea of justice of needs compatible with utilitarianism in the form suggested by the qaly theorists? In order to answer this properly a number of distinctions must be made.

Let me first distinguish between the idea of acute needs and that of great needs, which are often confused in the Swedish debate. The Government Bill uses the term “acute”. By this term we normally mean that something must be done quickly, as in the case of serious accidents or the case of a coronary infarction. A life-saving measure must be performed immediately, otherwise the patient might die. But the acute contribution need not be great. To save a person’s life with the mouth-to-mouth method is neither resource- nor time-consuming. Conversely, the extensive and resource-consuming needs do not necessarily have to be urgent. A long-term patient can have great need of health care without the
need having to be acute.

When we are talking about prioritisation we have to separate these two senses: priorities in terms of time, and priorities in terms of the accumulation of resources.

My subsequent discussion will primarily deal with needs in the latter, resource-demanding, sense. I shall do this by comparing three different kinds of cases which are all realistic in ordinary health care. My cases involve a comparison between two imagined persons, Brown and Smith, and I shall try to decide in what sense one of them can be said to have a greater need for health care than the other.

Let me now first relate back to my previous discussion of the concept of need. I there argued that the concept of need is completely open as long as we do not specify the goal of the need. A statement saying that a person needs an object is not understandable unless one knows for what purpose the object is needed. In the same way talk about health care need is senseless as long as we have not specified the goal of health care. If we say that Brown has a greater need for therapy T than Smith has, then we must make it clear for what purpose therapy T shall help Brown and for what purpose it shall help Smith.

I think that it is quite obvious that the goals may differ and that it is sensible to let them differ. We can conceive of different levels of health and different aspects of health, as well as different levels of quality of life, as the goals in different instances of health care. A full discussion of this is very demanding and must be left for a further project.

For my present purpose I shall make the following simplifying stipulation. I assume that the goal for both Brown and Smith is complete health, and I assume that we know what this entails. The statement that Brown has a greater need for therapy T than Smith can then be given at least the following three interpretations:

a. Brown and Smith are on the same level of health, but therapy T can raise Brown's level of health more than it can raise Smith's level of health.

b. Brown and Smith are on the same level of health, but if Brown is not treated with T, then Brown will fall down radically on the health scale or even die. Smith's level of health, on the other hand, will be much less lowered if Smith is not treated with T.

c. Brown's level of health is much lower than Smith's, and T can improve
Brown's health. (This interpretation is compatible with the case that T can improve Smith's health equally much.)

These are three rather different, but each in itself quite reasonable, interpretations of one and the same expression. It is also easy to find medical illustrations of each of them. But which interpretation is to be chosen? Shall we consider all of them? Is there in such a case some order of priority between them? We can imagine that we are in a situation with three patients in front of us and we have access to a certain drug which is relevant for the treatment of all three patients. But the dose that we have is such that it only suffices for one of the patients. We assume also that it would be pointless to split it up into three portions. We know that the drug would have effect on person A; we also know that if B does not get the drug in time then he or she will get seriously ill, and C is a very sick person from the beginning. Who shall we treat in this kind of situation?

Let us first observe some matters of principle concerning these interpretations. The first two differ from the third. They are variants of a utilitarian principle. To satisfy a need is in these cases to create or maintain an optimum of health or quality of life. Case a concerns the creation of an optimal positive state of health, whereas b concerns the prevention of a serious negative state of health. Although these principles are different and may indeed conflict in certain instances, they are based on the same utilitarian philosophy of welfare. Thus they suit quite well the qaly model for the allocation of medical resources. A resource should be allocated where it creates or maintains the maximum amount of qalys.

The third case c is different. The application of this principle need not at all entail the maximisation of human health. (In order to sharpen the example we can imagine that the treatment of Smith could entail a greater improvement of the health in the world.) Yet we may reasonably maintain that Brown has a greater need for treatment and that this fact should be considered in actual health care.

Behind such a position we can trace at least two kinds of thinking. One of these concerns justice. Most of us think that the people who are in the worst state should receive much more of our concern and attention. They must at least in some way be compensated for their appalling situation. The people in the worst position must reach at least some minimal level of decent human life, before anybody else can expect attention and a share of the resources. And this should be done irrespective of the maximisation of utilities.

But there is a further idea which has deeper roots in our ethical
thinking. This is the idea of mercy, which has been given to us through Christianity. According to this idea we shall help a person in distress, even if the help is against all odds. A person in distress should be supported as much as possible even if the possibility of raising his or her health or happiness is small or even negligible.

It is interesting that the idea of mercy, with its strong anchoring in our culture, has received so little attention in the professional discussion concerning medical ethics. In order to see its strength, imagine a mother who has her seriously hurt child in her lap. Assume that the child is so badly injured that there is no chance to save its life. Would it be reasonable to say that she ought to leave her child, because a utilitarian calculus says that she might do more good somewhere else?

If we are to take the idea of mercy seriously, which I think we must, then the qaly model for the allocation of resources must be modified. In certain cases of serious illness it cannot be reasonably maintained. The seriously ill must be given attention and care irrespective of any prognosis.

One might say that we could arrive at a similar conclusion given a very inclusive concept of quality of life, like the one that I have proposed in this book. What I suggest that we shall do for the seriously ill is to alleviate their anguish, to comfort them and to make them feel that they have our attention. All this would presumably raise their quality of life to some extent.

I agree that a more inclusive qaly concept would counter the ethical objection somewhat, but still not completely. The ethical motive for mercy or, in general, for altruistic action cannot, in my opinion, be exhausted by utilitarian considerations. I therefore claim that case c constitutes a counterinstance to the qaly model for allocation of medical resources. This is very obviously so in the case when qalys are constructed according to the Rosser-Kind analysis. Their qalys are units of health and they do not cover any other sector of general quality of life.

Let me conclude. The concept of health care need can be interpreted in at least three different ways. An application of these interpretations can have radically different consequences. If we find that all these interpretations have relevance for the allocation of health-care resources, then we must in every case face the question: which interpretation or which combination of interpretations can be applied in this case? My main conclusion has been that the two principles which deal with health maximisation, however important they are in many cases, cannot always be applied to the seriously ill. Hereby I do not solely mean people who
are terminally ill. I also refer to the big population of chronically ill or chronically disabled people, who cannot approach a normal human existence as to work or home-life. We must therefore, as far as I see it, face the following maxim: the most severely ill and disabled must have a high priority, even if this would lead to a lower increase of the collective health of mankind than if the same resources had been devoted to other persons.

**Are elderly people discriminated against by the qaly thinking?**

A completely different and more specific question which is often discussed in the ethical debate about qalys is if there is a risk that the qaly model, when applied in actual resource allocation, may treat elderly people unfairly in relation to younger ones. I shall here briefly comment on this issue.

First, it is clear that the exponents of the qaly model do not explicitly say anything about elderly people or diseases of elderly people. The issue must then have to do with probable consequences of a strict application of the qaly model. Would such an application necessarily have as a result that resources were moved from the care of the elderly to some other kind of health care? And why would we get such a consequence?

According to one of the most prominent critics (the philosopher John Harris 1988) it is the time-factor which is built into the very concept of a qaly that is crucial here. Assume that a very old woman is treated for some disease. Because of her age she cannot, irrespective of the success of the treatment, live for a very long time. Hence there cannot be so many qalys resulting from this particular treatment. Therefore the justification for treating the old person could not have been high in the first place.

This reasoning presupposes further premises which need not be adopted in the qaly philosophy for the allocation of resources. Qalys are units which are primarily ascribed to treatment measures. The qalys are calculated as mean values based on the experience of using a certain treatment in the case of a great many people, both old and young. Assume that the mean life-quality result of a particular treatment x is 4 qalys. Then x is assigned this value. If this number is considered to be high in comparison with numbers of other treatments, then big resources should be allocated to x. In this procedure there is no discrimination whatsoever against any *patient*. An 86-year-old person who needs the treatment x
shall in principle be treated, so should a 20-year-old person.

On the other hand, it is certainly possible to calculate age-related qalys. One can draw a distinction between the treatment of 20-year-old people with hypertension and the treatment of 80-year-old people with the same disease, and consider the difference in obtained qalys between the two categories. (See, for instance, the classic study by Weinstein and Stason 1976.) A result of such an investigation will most probably be that the qaly-number for the treatment of the elderly is lower than the qaly-number for the treatment of the young. In this sense such an investigation could have age-discriminatory effects. (Observe, however, that it is still possible that we shall obtain the reverse result for certain diseases and certain types of treatment.)

Another way in which we can have an age-discriminatory effect is when we focus on such diseases as normally only strike very old persons. The result of treatments of such diseases can for natural reasons only be followed during a few years. As a result there can only be a small number of qalys. This will unfortunately be the effect even if the "real" cause of death of the elderly people should be something completely different from the disease under scrutiny.

Thus the qaly philosophy can be constructed so that it has an age-discriminatory effect. With certain diseases and certain treatments it also seems with some necessity to have such an effect. However, it is doubtful whether it is at all typical of this philosophy to have these potential risks. There are politicians and even ethicists who explicitly advocate (see Callahan 1987) a drastic reduction of advanced treatments of the elderly using arguments of a completely different kind.

What can we learn from the qaly method for the measurement of quality of life?

The endeavours by Alan Williams and his colleagues to measure health are in my opinion both interesting and informative. One has to admire both their courage and their resolute aim to follow in Bentham's footsteps. Through their very concrete operationalisations of the concept of health they can quite clearly illustrate the difficulties in the measurement of health and quality of life. These difficulties lie, as we have seen, on many levels, viz. (i) in the connection to the basic concepts, (ii) in the gradation of the levels of health-related quality of life, both in
terms of the verbal description and, in particular, in the mathematical operationalisation, and (iii) in the ethical and political evaluation of the place of qalys in the allocation of health care resources.

As I have indicated, I find the qaly theory quite worthy of serious attention, but I think that it should be continually scrutinised and applied with great reservation.
11 Conclusions and general remarks

A summary of the analysis

The main purpose of this study has been to develop a theory of quality of life, where this concept is interpreted as happiness-with-life. To study a person P's quality of life thus is to study whether P finds his or her total situation to be the way he or she wants it to be.

I have emphasised throughout the essay that this enterprise is different from studying P's situation, i.e. characterising his or her general welfare. Moreover, I have argued, it is different from studying P's health, whether it is objectively or subjectively understood. Quality of life is thereby in this study clearly distinguished from all the following notions: objective welfare, subjective welfare, health and subjective health.

These distinctions can be drawn while still admitting various conceptual and causal connections. A person's health and a person's external situation are certainly important determinants of his or her quality of life. In the case of health this is obviously so and can be well explained within my theories of health and happiness. Health can affect a person's quality of life in at least the following three ways:

(i) The concept of health is analytically related to the concept of happiness.

Since health, per definition, is a person's ability to realise his or her minimal happiness, given standard circumstances, health is a major contributory factor with regard to happiness. The healthy person is in a normal context able to create his or her minimal happiness.

(ii) Subjective illness (in its second sense elaborated in chapter 5) involves pain, fatigue or other immediately unpleasant sensations.
The elimination of such mental states thus raises the subject's level of sensational pleasure. This in its turn, according to our theory, typically raises the level of happiness.

(iii) Partly because of (i) and (ii) health has a very high priority on people's preference-scales. Thus believing or knowing that one is healthy can by itself contribute to one's level of happiness.

Observe also that illness, and its various causes such as diseases, can lower quality of life through all these paths.

(i) A disease, say a cancer, reduces a person's ability to perform his or her daily tasks. Thus it may in this way create unhappiness.

(ii) The disease causes a high degree of pain. Thus, indirectly, it contributes to unhappiness.

(iii) The knowledge of the disease and its probable future course results in a lack of confidence in the future. This reduces the subject's degree of happiness.

If health contributes to happiness, so do of course all those other elements in a person's situation, be they internal or external, which he or she considers to be favourable, or which cause states of affairs which he or she considers to be favourable. A good set of character-traits, a well-developed social life, decent housing and a minimal economic standard are things which have a high priority to almost all people. Conversely, if the subject finds that he or she lacks any of these necessities he or she will fall below the limit of minimal happiness.

But, as I have pointed out before, both the realisation of health and the realisation of a favourable environment are compatible with unhappiness. As long as one has not ascertained that P finds the total situation (at least concerning matters of high priority) to be as P wants it to be, one cannot with certainty claim that P has a high level of quality of life.

In the light of this observation one can question all those studies of quality of life which have as their basis a characterisation simply of health or a combination of certain health matters and certain situational features. What do they tell us about a person's general happiness with life? Conversely, there is a point in criticising those studies which claim to characterise a person's health but which also include such features of
happiness as may be completely independent of the person's health.

The main lesson to be drawn from our analysis is the following. The purpose of a measurement or characterisation of quality of life must be clear. Is our purpose mainly to study:

(i) P's health, or

(ii) some aspects of P's health, e.g. those aspects of his or her health which are consequences of a particular disease, or

(iii) P's subjective health (in any of its senses), or

(iv) P's situation from a welfare point of view, or

(v) P's happiness with life, or

(vi) P's happiness or unhappiness with certain facts, e.g. certain consequences of his or her health status, or

(vii) a particular combination of the mentioned factors, and in that case why this particular combination?

Quality of life - what next?

As is evident from my theoretical conclusions, I find no reason to dismiss all kinds of quality-of-life investigations. On the contrary I am of the opinion that judgments of people's health and quality of life, i.e. judgments of how people are and how they like their life, must always adhere to many practical activities in society, not least social care and medical care. In these judgments it must at least be possible to use comparative words: we must be able to say that Mr. Smith is today better than he was yesterday; that Mr. Brown is happier today than he was a year ago. We must also sometimes — in order to make political decisions or in order to make economic resource allocations — obtain a reliable idea about the life-quality status of the majority of a certain population and how they would react to a certain measure. In order to invest in a medical drug, for instance, we must have a reliable idea of how most people, if they were in a certain state of disease, would react if they were
to be treated with the drug.

I find all this indisputable. The great issue is the following: what level of precision or what level of sophistication shall we seek as a basis for such decisions? This question is important for the following reason. It is not only the case that it is theoretically and practically difficult to construct sophisticated instruments; there is also, as I have tried to show, the great risk that technically sophisticated instruments, despite their having an air of objectivity and stringency, will lead to completely misleading results.

My main argument has been that the single person is the ultimate judge concerning his or her own quality of life. Such instruments as have prefabricated values of measurement — instrument which, for instance, ascribe a certain number to a certain bodily defect or disability — need not at all mirror a particular person's judgment of his or her situation. It can very well be the case that a certain area in life is more important to Mr Brown than another area. Brown can experience pain in his leg and have certain difficulties in moving around. An investigation concerning these organs and functions of Brown's may result in a low score on a life-quality scale. But assume that Brown's profession and interests are such that his pain does not affect him at all, then his real quality of life is not considerably affected. But an investigation using the bureaucratic formula, where a certain arithmetic procedure is applied, may tell us that Mr Brown is having a very bad time. The neat mathematical result thereby does not give us a reasonable idea of what the investigation primarily should tell us.

Another important point that my study is intended to show is that such life-quality investigations as should serve as a basis for decisions concerning a single person should be clearly separated from such investigations as concern decisions regarding large groups. Judgments concerning the quality of life of single persons have a much better prognostic value.

When for instance a nurse meets a patient she has many means to get a picture of the state of health and quality of life of the patient. First she is not limited to what the patient says. She can see what Mr. Smith looks like, how he behaves, if he expresses unease or anguish or if he looks calm and expresses self-confidence. The content of a person's statement can therefore be checked by certain independent factors. Moreover, the nurse can get a detailed picture of the patient's way of life and his goals in life. She can get to know what is particularly important for this person, whether it concerns family life, professional life or leisure activities. To
the extent that one can detect shortcomings in this patient, whether they concern the health of the patient or his constitution or external circumstances, these shortcomings can be related to what is important for the patient. The measures taken can therefore be adequate for the patient. In this way we can make a real quality of life investigation concerning this particular individual, which considers him in his individuality.

Such judgments are frequent in all kinds of care. Never or hardly ever do we need quantified measurements in these judgments. (Within medicine there are of course the continuous measurements of physiological or chemical variables. These, however, do not claim to measure quality of life; they may at most give indirect indications of a person's health or quality of life.) What should be decisive for a particular course of action is instead the individual's own judgment of what is essential to him or her. What is the individual's own main goal? What is most important for him or her to do? Are these goals important or difficult to reach because of some bodily or mental shortcoming? In such a case what can we do to help this person?

We meet a completely different situation when we are to make quality of life judgments as a basis for more general decisions. Then we cannot take the goal profile of all individuals into account. In order to accept a particular drug for regular use we cannot require that it shall give a positive result in all kinds of use. Some kind of judgment concerning the majority of cases must here be decisive.

The measurement procedure must also for practical and economic reasons be less extensive and more simplified than in the individual case. One cannot test a drug on all individuals who can conceivably have use of it. Only a selected population can be asked and only a limited number of questions can be put. The investigator is then obliged to resort to standardised questionnaires and a standardised procedure for interpretation of answers.

I cannot dismiss investigations of this kind. However, these investigations must be scrutinised very severely and they should be used with the utmost care. If we make serious misjudgments as a result of them the consequences can be fatal.

The corrective of general procedures for the measurement of quality of life must come from what we consider to be the ideal individual study. In an individual study we have some chance of reliable knowledge about a particular person's quality of life. That general study which mostly resembles the individual one in spirit and insight is to be preferred.
Glossary

*Welfare* (minimal sense): The set of those kinds of conditions which are instanced in everybody's subjective welfare-set.

*Subjective welfare* (of P): The set of those conditions external or internal to P, which P wants to be the case, or which are causes of conditions which P wants to be the case.

*Happiness with life*: P is happy with life, if and only if P believes that his or her conditions in life are as he or she wants them to be.

*Want of high priority*: Want x has to P a higher priority than want y, if and only if P in a choice between x and y, in a situation where both cannot be realised, would prefer to have x.

*Minimal happiness with life*: P is minimally happy with life, if and only if P believes that every condition is fulfilled which is of high priority to him or her.

*Health*: P is healthy, if and only if P is able, given standard circumstances, to realise all his or her vital goals, i.e. to realise all those states of affairs which are necessary and together sufficient for his or her minimal happiness.

*Subjective health*:

(i) P is subjectively healthy, if and only if P believes that he or she is healthy,

(ii) P is subjectively healthy, if and only if P is in a specified mental state. (Roughly, P feels fit, and is free of pain, suffering and fatigue.)
Bibliography


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Kajandi, M., Brattlöf, L and Söderlind, A.: 1983, *Livskvalitet: Beräkningar av ett livskvalitetsinstrument* *s* *reliabilitet*, Department of Psychology, Ulleråker University Hospital, Uppsala.


Naess, S.: 1979, Livskvalitet: Om å ha det godt i byen og på landet, INAS-report 79: 2, Oslo.


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