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ASSESSING QUALITY OF LIFE: CURRENT APPROACHES

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The authors of this paper consider the concept of the quality of life and health-related quality of life (QOL) by paying special attention to the relevance of the researches taken so far, related to the "quality of life", the impact and ways of estimating the QOL through social, cultural or health interventions, taking into account both social and economic aspects. The detailed objectives of the research were: to present the "broader picture" of QOL and the definitions already established by previous researches; to identify social and economic indicators that can be used to measure the QOL. Specific aims of the literature review were to summarize various definitions of the concepts of QOL in general and explore the difficulties encountered in measuring the QOL, to cite the standard methods and results, and criticize methodologies.

As far as possible, in this literature review, the authors attempted to maintain consistency in terms' use. However, based on the results obtained, it is inevitable to avoid the confusion when using the term QOL. A key part of this is the inter-changeable use of different concepts discussed below. The overall conclusions point to possible options for future researches in this field. *Acta Medica Medianae 2010;49(4):52-60.*

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Introduction

Quality of life (QOL) is more and more considered to be the ideal od modern medicine in terms of biopsichosocial viewpoint, because it allows ethical advancement within clinical evaluation methods. We are the witnesses of an epoch in which human life has become considerably extended, so that the imperative of a modern man is to "add life to years"(1). There is no doubt that the introduction of QOL as the distinctive entity humanized medical knowledge, as it in its essential approach respects patient as a complete person and does not allow the separation of the patient's body from his personality.

A good deal of literature and several dozens of scientific journals have reported a large body of information about researches on the QOL in the field of medicine. In terms of the volume of articles, discussion on QOL within the academic literature centers on the health care field, including nursing, medicine and health promotion considers the effect of medical interventions on the QOL, or subjective well-being of individuals or groups of individuals with shared characteristics, learning disabilities and other types of disability and including mental health (5).

In contrast to health care research generally, occupational medical research has been fairly late in coming to consider the quality of life as a focus of investigation, either by using generic measures or specific questionnaire batteries (6-10). This may be attributable, at least in part, to a more concrete world view, wherein the outcomes of principal concern to the occupational researcher have often been work-related disabling or fatal injury or disease, manifested by frank job loss or lost work time. There may also be an element of class-based assumptions coming into play; that is to say, a presumption that for the industrial or agricultural worker, "quality of life" is a vague luxury, not comparable to the bread-and-butter priority of traditional safety and health concerns (10-12).

Development of Quality of Life concepts

Discussion on QOL dates back to Plato and Aristotle. Although neither the philosophical origins nor historiography of the term can be dealt with here, discussion of these themes may be found in the literature (13).

QOL emerged as an academic discipline in its own right in the 1970s, with the establishment in 1974 of the peer reviewed scientific journal Social Indicators Research. A second key academic publication is The Journal of Happiness Studies, a

multi-disciplinary journal which provides a forum for discussion of what it describes as the two main traditions in happiness research (1) speculative reflection on the good life and (2) empirical investigation of subjective well being. The International Society for Quality-of-Life Studies (ISQOLS) serves as a forum for academic researchers working in this field, encouraging inter-disciplinary research and methodological debate and development.

QOL is also a concern of the social indicators movement, which developed in both Scandinavia and the US in the 1960s and 1970s out of a feeling that economic indicators alone could not reflect the QOL of populations. Over the past 30 years, this has become a fast growing discipline now fully embraced by governments and public sector agencies worldwide, seeking to measure and compare changes in QOL within and between communities, cities, regions and nation states. Several studies of QOL, for example, have been sponsored by organisations such as UNESCO, the OECD, and the World Health Organization (WHO) (14).

Reviewing the database for the period from 1974 to 2008, it was found that QOL was mentioned during 1974 merely in 8 publications, in 1984 in 284 publications, in 1994 in 1.209 ones, in 2003 in 3.519 and in 2008 in 66.592 scientific literary productions. As a central theme, QOL was analyzed in 1974 in two studies, in 1984 in 93 studies, in 1994 in 502, in 2003 in 1.060 and in 2008 in 20.355 studies (15).

Why do definitions matter?

QOL is a vague and difficult concept to define, widely used, but with little consistency. Moreover, it is the view of some researchers that QOL cannot be defined exactly (16).

For a range of economic, social and political reasons, QOL has emerged as a desired outcome of service delivery in mainstream and special needs education, health care, social services (particularly for disabled and elderly people) and, increasingly, for cross-cutting public sector partnership policy at all levels.

In a quite different policy context, a psychological concept of QOL that regards aspects of an individual's personality or temperament as the determining factor may result in fewer resources being invested in improving the material circumstances of vulnerable individuals. The reform of the community care system in the UK and elsewhere brought a greater emphasis on the needs of individuals and the use of QOL as an indicator of satisfaction with services.

Virtually, every realm of public policy making and service delivery in advanced capitalist nations is now influenced by notions of Quality of Life (QOL) and well- being. Ager describes QOL as: "a successful 'meme', a concept that has reproduced rapidly in response to conducive environmental condition"(17).

Authors from different disciplines approach the concept from the perspective of their own research interests and objectives, and so the subject of QOL research also widely varies. The definition assigned to the term, and the way in which it is used, are contingent upon research objectives and context (1,18). However, even amongst experts, usage of the term extremely varies. For example, social indicators have been developed to assess the QOL of the general populations of cities, regions or nations, while social and psychological indicators have been developed to assess the QOL of individuals, or groups of individuals with common chara-cteristics.

The definitions - Why is the meaning so hard to pin down?

The reason the term is so ambiguous is partly because of the different ways in which it is used. Its common usage in public life is very loose and is based on the positive connotations of the term "quality". In contrast, its usage by experts focuses more on the second dictionary definition of "quality", that is to describe the basic character or nature of something – something that may be either positive or negative (19). Armstrong and Caldwell regard the significance of the concept in terms of its "rhetorical function", make it as social, medical and technological progress (20). Keith and Schalock argue that QOL can be used in three ways: as a "sensitizing notion that provides reference and guidance", as a "social construct", and as an "organizing concept" or "unifying theme"(18). Or, in the words: "a systematic framework through which to view work aimed toward improving the lives of individuals" (16,21,22).

An awareness of how the term is being used is therefore important, reviewing the health literature, Rejeski and Mihalko distinguish between the use of the QOL concept as a psychological construct, and as an "umbrella term" for various medical desired outcomes (1).

There is a very wide range of definitions and interpretations of QOL - over 100 definitions according to Schalock (22). Also, what should be emphasized is that publications on QOL from medical literature often do not define it. In a recent systematic review, 16 out of 68 health-related QOL models evaluated did not provide a definition of QOL (23). This common failure to define what is being measured, or alternatively to cite definitions used elsewhere without stating a preference, adds considerably to the sense of conceptual confusion. Often, writers will evade issues of definition by focusing on "approaches" or skipping forward to discuss "measures" which imply a type of definition (24,25). Keith argues that it is the view of many researchers that QOL cannot be defined exactly, and that they are therefore more likely to choose to study various facets and dimensions of QOL rather than to attempt to define it explicitly (16).

The individual orientations of the wide range of disciplines concerned with QOL are one factor influencing definitions of QOL and explaining the diversity of definitions. Farquhar gives the example of public health approaches that may focus on communities, compared with medical specialist approaches that focus on the individual patient, condition and disease. Each may require a different type of definition (18,19). The sociologically orientated QOL researchers will choose to focus on the structure and content of groups, communities and societies, while psychology orientated researchers will prefer to look at any one of a range of individual based characteristics such as well-being, mental health etc. (26).

Within the literature, there exists confusion about what is QOL, what contributes to QOL, and what are the outcomes of QOL (27). Taillefer et al. note the confusing tendency of some authors to consider everything part of QOL (23). Unfortunately, in practice, making this distinction is not straightforward, and different authors have arrived at different conclusions.

There has also been a tendency for some writers to conflate QOL with other concepts, and to use the different concepts interchangeably. The most cited examples of these are life satisfaction, happiness, well-being, health status and living conditions, all of which are sometimes used interchangeably with QOL. Referring to the literature of the 1970s Meeberg cites a number of authors who define QOL "in terms of life satisfaction or satisfaction of needs", in other words authors who regard QOL as both uni-dimensional and subjective (28). Adding to the difficulties, in the early 1990s the term "health-related quality of life" emerged in distinction to "quality of life" in general (11,20). Incorrectly, health-related QOL and QOL are often used interchangeably. The definition of health-related QOL is considered in Table 1.

Table 1 – Examples of health-related Quality of Life definitions

Definition	Reference
"QOL is a multidimensional evaluation of an individual's current life circumstances in the context of the culture in which they live and the values they hold. QOL is primarily a subjective sense of well-being encompassing physical, psychological, social and spiritual dimensions. In some circumstances, objective indicators may supplement or, in the case of individuals unable to subjectively perceive, serve as proxy assessment of QOL." (29).	Haas 1999.
"Quality of life is multidimensional in construct including physical, emotional, mental, social, and behavioural components" (30).	Janse et al 2004.
"Quality of life and more, health-related quality of life refer to the physical, psychological, and social domains of health, seen as distinct areas that are influenced by a person's experiences, beliefs, expectations and perceptions (which we refer to here collectively as 'perceptions of health'. Each of these domains can be measured in two dimensions: objective assessments of functioning or health status, and more subjective perceptions of health." (31).	Testa 1996.
"Quality of life is a feeling of overall life satisfaction, as determined by the mentally alert individual whose life is being evaluated. Other people, preferably those from outside that person's living situation, must also agree that the individual's living conditions are not life-threatening and are adequate in meeting that individual's basic needs." (28)	Meeberg 1993.
"A multi-faceted construct that encompasses the individual's behavioural and cognitive capacities, emotional well-being, and abilities requiring the performance of domestic, vocational, and social roles". (28)	Tartar et al 1988. quoted in Meeberg 1993.
"Quality of life is defined as an overall general well-being that comprises objective descriptors and subjective evaluations of physical, material, social and emotional well-being together with the extent of personal development and purposeful activity, all weighted by a personal set of values". (32)	Felce and Perry 1995.
"Quality of life is a concept that reflects a person's desired conditions of living related to eight core dimensions of one's life: emotional well-being, interpersonal relationships, material well-being, personal development, physical well-being, self- determination, social inclusion, and rights." (21).	Schalock 2000.
"A conscious cognitive judgment of satisfaction with one's life." (1)	Rejeski and Mihalko 2001.
"Quality of life is a term that implies the quality of a person's whole life, not just some component part. It therefore follows that if QOL is to be segmented into its component domains, those domains in aggregate must represent the total construct." (27).	Hagerty et al 2001.
"Quality of life is properly defined by the relation between two subjective or person-based elements and a set of objective circumstances. The subjective elements of a high quality of life comprise a sense of well being and personal development, learning growth …The objective element is conceived as quality of conditions representing opportunities for exploitation by the person living a life" (33).	Lane 1996. quoted in Christoph and Noll 2003.
"Quality of life is both objective and subjective, each axis being the aggregate of seven domains: material well-being, health, productivity, intimacy, safety, community and emotional well- being. Objective domains comprise culturally relevant measures of objective well-being. Subjective domains comprise domain satisfaction weighted by their importance to the individual" (34).	Cummins 1997.
"Quality of life is defined as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns." (35).	The WHOQOL Group 1995.

Table 2 A taxonomy of Quality of Life definitions

Type	Name for type	Description
I	Global definitions	The most common, general, type of definition - usually say little about the possible components of QOL. Usually incorporate ideas of satisfaction/dissatisfaction or happiness/unhappiness.
II	Component definitions	Break down QOL into a series of components, dimensions or domains, or identify characteristics deemed essential to any evaluation of QOL.
IIa	(non-research-specific)	Identify a number of dimensions of general QOL, but may not necessarily claim to cover every possible dimension.
IIb	(research-specific)	Explicitly tailored to meet the objectives of a specific piece of research. May therefore overlook or exclude certain dimensions of QOL considered less relevant to the research aims.
III	Focused definitions	Refer only to one or a small number of the dimensions of QOL.
IIIa	(explicit)	Focus on a small number of dimensions of QOL considered essential to QOL, but does so explicitly.
IIIb	(implicit)	Focus on one or two dimensions of the broader concept of QOL, but implicitly, without making this clear.

Source: based on Farquhar 1995.

Table 3. Three types of Quality of Life model

Model Type	Description
Conceptual Model	A model that specifies dimensions and properties of QOL (the least sophisticated type of model).
Conceptual Framework	A model that describes, explains or predicts the nature of the directional relationships between elements or dimensions of QOL.
Theoretical Framework	A model that includes the structure of the elements and their relationship within a theory that explains these relationships" (most sophisticated type of model).

Source: based on Taillefer et al 2003

Table 4. Objective and subjective social indicators

Frequently used objective social indicators	Frequently used subjective social indicators
represent social data independently of individual evaluations	individuals' appraisal and evaluation of social conditions
Life expectancy	Sense of community
Crime rate	Material possessions
Unemployment rate	Sense of safety
Gross Domestic Product	Happiness
Poverty rate	Satisfaction with "life as a whole"
School attendance	Relationships with family
Working hours per week	Job satisfaction
Perinatal mortality rate	Sex life
Suicide rate	Perception of distributional justice
	Class identification
	Hobbies and club membership

Source: based on Rapley 2003.

Table 6 Methodological pluralism applied to Quality of Life measurement

Systems level	Measurement focus	Measurement strategies
Microsystem	Subjective nature of QOL ("personal appraisal")	Satisfaction survey Happiness measures
Mesosystem	Objective nature of QOL ("functional assessment")	Rating scales (level of functioning) Participant observation Questionnaires (external events and circumstances) Engagement in everyday activities Self-determination and personal control Role status (education, employment, living)
Macrosystem	External conditions ("social indicators")	Standard of living Employment rates Literacy rates Mortality rates Life expectancy

Source: Schalock 2004.

Table 5 Core Quality of Life domains

Felce 1996.	Schalock 2000.	SZO 1995.	Hagerty 2001.	Cummins 1997.
Psychology	Psychology	Health	Social indicators research	General population adults/ Students/ Disability
Six possible domains:	Eight core domains:	Six domains:	Six possible domains:	Eight core domains:
Physical well-being	Physical well-being	Physical well-being	Health	Health
Material well-being	Material well-being	Environment	Material well-being	Material well-being
Social well-being	Social inclusion	Social relationships	Feeling part of one's local community	Community well-being
Productive well-being			Work and productive activity	Work/ Productive activity
Emotional well-being	Emotional well-being	Psychological well-being	Emotional well-being	Emotional well-being
Rights or civic well- being	Rights			
	Inter-personal relations	Level of independence	Relationships with family and friends	Social/family connections
	Personal development			
	Self-determination	Spiritual	Personal safety	Safety

Definition typologies and Quality of Life models

In an attempt to provide conceptual clarity, various researchers have produced typologies of QOL definitions.

In her taxonomy, or classification of definitions, based on a systematic review of the expert literature, Farquhar (18) identifies three major types of QOL definition, as shown in Table 2.

In another systematic review of QOL models, Taillefer (23) identified three different types, as shown in Table 3.

Objective versus subjective approaches

Early efforts to define and measure QOL took either an economic or objective social indicators approach. However, the study in the 1970s showed that objective measures of life conditions accounted for only a modest proportion of individuals' subjectively reported QOL and/or well-being (2,36). In addition, Cummins reports a range of studies from the early 1970s onwards demonstrating that individuals report levels of satisfaction with where they live regardless of the objective poverty of their environment (34). The crucial amongst these were studies by Andrews nd Withey and Campbell et al., which helped re-orient QOL research towards subjective measures (19). The prevalent use of economic indicators as measures of national QOL began to be challenged as studies refocused on subjective responses to life conditions. Sometimes referred to as the "American" social indicators approach, these studies embraced concepts such as happiness, life satisfaction, and well-being and attempted to measure these at a population level. An alternative hypothesis began to be put that individual well-being might owe more to the personality or inherent disposition of individuals than to objective conditions (32). Examples of the two different types of social indicator are shown in Table 4.

Today, there is more or less a consensus around the need to combine objective with subjective aspects of QOL, based on an acknowledgment of the strengths and weaknesses of each approach. One example is EUROMODULE, a cross-national research initiative, in the social indicators tradition involving research teams from 19 European nations. It uses national social surveys to collect comparative data on living conditions, welfare and QOL, and accords equal weight to objective and subjective indicators, regarded as "just two sides of the same coin" (14). Many models incorporate both objective and subjective domains of QOL (16,27,34) because "A thorough understanding of subjective well-being requires knowledge of how objective conditions influence people's evaluations of their lives. Similarly, a complete understanding of objective indicators and how to select them requires that we understand people's values, and have knowledge about how objective indicators influence people's experience of well-being. From these argument, each discipline needs to borrow insights about quality of life from the other fields" (36).

The debate continues about the relative importance of objective versus subjective factors in determining QOL, and about the relationship between the two. These have achieved a profile in public policy debate most recently in the discussions around national confidence, in which it is asserted that psychological factors - low self-confidence and self-esteem - may contribute significantly to many of socio-economic problems (objective factors) (37).

For some writers, subjective approaches to QOL, where the individual's experience, or perception, of how well they live is the main criteria, remain most valid (34, 38). This view is sometimes based on the idealist or postmodernist view that there is no objective "reality" beyond our subjective experience of the world and that QOL reflects the subjective values held by individuals.

For ethical and moral reasons, some writers view the lack of correlation between subjective and objective factors of QOL not as a reason for disregarding objective conditions, but as an important reason for retaining them. "This instantiating definition of QOL that ignores objective assessment of life conditions may, therefore, not provide an adequate safeguard for the best interests of vulnerable and disadvantaged people" (32). Other evidence from the mental health field demonstrates a strong correlation between psychological well-being and objective socio-economic factors. In the first population survey of emotional well- being, in the USA in 1957, those respondents who reported being least happy with their lives were found "more likely to have psychiatric problems, to be widowed or divorced, to have less education and lower income levels, and to be black" (39).

An alternative explanation of the lack of correlation between objective and subjective dimensions of QOL is that objective life conditions - which vary widely in capitalist economies - shape individuals' expectations of what is possible and thereby condition their subjective assessment of their lives. The individuals' reports of their subjective QOL relate strongly to their personal frames of reference. These frames of reference are "shaped by experience. One cannot assume that a person's frame of reference will embrace all possibilities; it is affected by the judgment of what is possible and typical for a person in that situation" (32).

The Scandinavian social indicators experts argue that subjective social indicators, (satisfaction with life), reflect people's aspirations and are therefore a measure of adaptation to current life conditions, rather than a measure of life conditions themselves (19).

Cummins has taken the debate about subjective and objective approaches to defining QOL a step forward in his theory of subjective well-being. Reviewing the evidence from a wide range of studies, he postulates that subjective and objective QOL are generally fairly independent. Subjective QOL, he argues, is "held under the influence of a homeo-static control", as a matter of survival, human beings have developed a sense of positivity that allow them to maintain constant levels of subjective QOL within a considerable range of objective conditions. Only when objective QOL reaches extremely low levels, for example, in the presence of chronic stress due to caring for severely disabled relatives, or long term unemployment, is this homeo-static control disrupted and subjective QOL "driven down". In these conditions objective and subjective QOL are revealed as inter-dependent, but at an individual level, this process is "influenced by cultural and individual values that have yet to be systematically explored" (34).

Is Quality of Life uni-dimensional or multi-dimensional?

While there are examples of uni-dimensional definitions of the concept of QOL, the majority of QOL definitions stress the multi-dimensional nature of the concept, typically manifested in the specification of a number of QOL domains.

Unidimensional definitions include those where QOL is regarded as synonymous with health alone (40); alternatively, QOL has been defined solely in terms of life satisfaction. Rejeski and Mihalko describe the "mainstream psychology" definition of QOL as being "the conscious cognitive judgment of satisfaction with one's life", a concept that has been operationalized using both undimensional and multidimensional measures, i.e. in terms of satisfaction with life in general, or of satisfaction with specific "domains" of life considered separately (1). One of the most popular measurement instruments consists of a single question "How do you feel about your life as a whole?" rated on a Likert scale of life satisfaction/dissatisfaction (41).

QOL domains

There is a consensual view that, taken together, the core QOL dimensions, or domains, should sum up the concept of QOL as a whole. The number and range of individual domains specified within QOL definitions is large, although some writers note the "considerable overlap" that exists between these (16,36).

A number of studies of QOL domains have been conducted in an attempt to produce a definitive list (27). However, the notion of incorporating a definitive standardized set of domains into QOL definitions is subject to criticism. For example, Keith (16) argues that, as the core dimensions of QOL may vary from one culture to another, cross-cultural generalisations about QOL domains are invalid. There are also ethical and political issues surrounding the "imposition" of a pre-determined QOL definition onto individuals or communities.

Table 5 sets out the results of some of these reviews drawn from different disciplines, with the findings of other key works investigating core QOL domains.

Other writers stress that domains identified in QOL definitions must be potentially neutral, positive or negative. This is important because "QOL measures are designed to capture the totality of life experiences, both positive and negative", because most conceptual models of QOL stress the dynamic nature of the concept (27,42). In discussing their model, Felce and Perry stress that all the dimensions (domains) "are shown in dynamic interaction with each

other and as potentially interdependent at all times" (31).

The nature of the relationship between subjective and objective domains of QOL, briefly described above, is clearly central to this: "As well as affecting each other, each dimension is capable of being influenced by a range of external factors that define the individual's biological make-up, developmental and cultural history, and current environment. Such external influences might include genetic, social, and material inheritance, age and maturation, development, employment, peer influences and reference points, and other social, economic and political variables. As the all elements that define quality of life are all open to external influence, assessment of all is necessary to any measurement system purporting to examine or rate quality of life. Knowledge of one set cannot predict another, and the relationships may not remain constant over time" (31,43).

Measuring Quality of Life

There are many different approaches to measuring Quality of Life (QOL). How QOL is measured clearly relates to how the term is defined, and therefore to what is being measured. The types of measures developed and the position taken on methodological issues therefore vary between different disciplines according to their objectives and philosophical outlook. As we shall see below, the key issues surrounding the measurement of QOL therefore closely relate to the key debates over definitions.

A helpful methodological overview is provided by Schalock (summarized in Table 6) (22). While he is concerned with measuring the QOL of people with intellectual disabilities, the principles he outlines have a wider relevance. He advocates a "pluralist" methodological approach because it addresses the multidimensional nature of QOL, and acknowledges that the different dimensions of QOL may best be measured by using a range of techniques. Thus QOL may be measured, simultaneously, from both subjective and objective perspectives, including both subjective and objective assessments of objective factors. The combination of multiple research approaches to the same research subject, known as "triangulation", overcomes some of the weaknesses and problems of individual research methods, producing stronger research findings.

We can make a broad distinction between methods used to measure the QOL of the general population, and those used to measure the QOL of individuals. In both approaches the dominant research methodology can be described as positivist and based on quantitative methods. Qualitative methods are used in QOL research, particularly in the development of QOL instruments, but more in some disciplines than in others. They are less likely to be found in social indicators field, and more likely to be found in disabilities or psychology research, where observational techniques are often used in tandem with measurement instruments.

QOL of populations is based on the "social indicators" tradition. This usually involves the identification of indicators and measures relating to a range of QOL dimensions/domains. Often, these are aggregated to construct a single index of QOL. These indicators may be both objective and subjective, drawn from socio-economic statistical data collected by governments or survey data.

For QOL of individuals including ethnographic studies, and observation of behaviour, the dominant approach measures QOL using some form of self-assessment instrument, i.e. a questionnaire. This is the case for each of the first two of Schalock's types of "measurement focus": personal appraisal and functional assessment (44).

Today, "almost factory tools " exist to deal with measurement QOL, in which nearly 1.275 various instruments have been developed to assess QOL, especially within the last twenty years. Although numerous, of those that were classifiable into subsequent fundamental types, 1819 (46%) were disease or population specific, 865 (22%) were generic, 690 (18%) were dimension specific, 409 (10%) were utility, and 62 (1%) were individualized (45). Regardless of the kind they belong, instruments should satisfy the main requirement which means that questions such those objectively reflect the functioning state and subjective rating state of participants' health.

Measurement problems

Whether the assessment is at the individual or general population level, there is a number of common measurement issues.

As already noted, the search for the definitive set of "core" QOL domains has produced widely varying results, although with some areas of consensus. Summarising a range of about 60 QOL instruments used in medicine, Birnbacher says that most measures take into account three core dimensions of QOL: the physical, psychological and social dimensions (46).

Some degree of subjective judgment is involved in selection domain. For example, the WHO QOL Group has been criticized for its decision to have six QOL domains, or for the omission of other domains found in most prior QOL scales, such as material well-being or productivity/employment (27,35).

An alternative approach is to investigate individuals' views about the things that contribute to their QOL, and derive QOL domains through this process. Rapley describes this approach, involving subjects as participants, as "emancipatory" contrasting it with "mainstream" QOL research which imposes QOL models on individuals in a potentially "oppressive" and "disempowering" manner (19).

About subjective - objective debate. As writers differ n what they are trying to measure, therefore so do their methods. They may be trying to measure (a) solely a subjective perception of the external conditions of QOL, (b) subjective perception balanced against objective indicators, (c) subjective perception and objective indicators combined into a single index of QOL, or (d) solely objective indicators of external conditions of life. The most common opinion is that social indicators may be good objective measures, but tell us little about how individuals actually feel about their lives. Whereas on the other hand subjective measures of people's objective conditions are likely to be affected by their temperament and social expectations and may not provide a reliable indication of their actual circumstances. For this reason, Diener and Suh advocate the combined use of social indicator and subjective well-being measures. As the limitations of each type are different, they argue that, "they provide alternative views of societal quality that are unlikely to be affected by common errors of measurement" (36).

Similarly, Schalock argues for a core set of QOL dimensions with both objective and subjective aspects - i.e. each dimension may lend itself to either subjective or objective assessment (44). The advantage of this approach is it breaks down a rather false dichotomy between objective and subjective approaches.

There are the relationship and differentiation between QOL and related concepts such as well-being, life satisfaction, functional status and health status, as the second major area that requires further study in QOL research (2). Conclusions refer on the necessity to "tease out the fine distinctions among these closely related concepts" following as a "step out of the quagmire of poorly defined QOL:" the terms QOL, satisfaction with life, functional status, and well-being can no longer be used interchangeably. They represent different levels and aspects of the broad concept of QOL. If one chooses to focus on the subjective aspects of QOL, then it must be clear that that is what is being discussed is either 'well-being' or 'subjectively perceived QOL.' For those who choose to focus on objective indicators of QOL, it must be clearly identified as either 'functional status' or 'objectively perceived QOL.' Those who study satisfaction with life must either clearly state that as the purpose of their investigation or make it clear that they are interested in studying an aspect of well-being or subjectively perceived QOL. Those who claim to be reporting on QOL must provide evidence of subjective and objective indicators. If they do not, they should acknowledge that a particular aspect of QOL is being addressed" (29).

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PROCENA KVALITETA ŽIVOTA - SADAŠNJI PRISTUPI

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Autori ovog rada razmatraju koncept kvaliteta života i kvaliteta života u vezi sa zdravljem, posvećujući posebnu pažnju važnosti dosadašnjih istraživanja kvaliteta života, uticaju i načinu merenja kvaliteta života kroz društvene, kulturne i zdravstvene intervencije, uzimajući u obzir socijalne i ekonomske odrednice. Sa ciljem da se prikaže „šira slika" kvaliteta života i definicije zasnovane na prethodnim istraživanjima, uz identifikaciju socijalnih i ekonomskih pokazatelja za procenu kvaliteta života, načinjen je specifičan pregled različitih definicija i koncepata, ukazano na poteškoće prilikom merenja kvaliteta života, a pozivajući se na važeće metode, rezultate i kritički osvrt metodologije. Prilikom literaturnog pregleda, pokušaj autora je da, koliko je bilo moguće, održe konzistenciju upotrebe termina. Međutim, na osnovu postojećih nalaza, neizbežna je konfuzija koja postoji u literaturi prilikom upotrebe i značenja kvaliteta života. Ključni deo toga su zamenjivi pojmovi u različitim konceptima, prodiskutovani ovde. Opšti zaključak upućuje na moguće orijentacije za buduća istraživanja u ovoj oblasti. *Acta Medica Medianae 2010;49(4):52-60.*

***Ključne reči**: kvalitet života, subjektivne/objektivne mere, mogući pristupi*