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WELL-BEING: AN ESSENTIALLY FUZZY CONCEPT

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Abstract. 'Well-being' is a part of professional conceptual network, which refers to both physical and mental states of an individual and some societal conditions of human life as well. There is no single meaning for the term 'well-being' among the professionals. Nevertheless, the term 'well-being' plays significant role in the World Health Organisation papers. Though well-being has an objective component, identical in dissimilar environments: in macrosocial (e.g. in the established countries and in the countries of post-socialist transition as well) and in microsocial (e.g. in local cultural and linguistic groups), similar particular inputs cause diverse results in dissimilar environments. Well-being has also a necessary subjective component. This does not exclude the idea that the subjective component of well-being may be causally determined by the factors from outside any particular human body. Local linguistic practices, playing language games, and language transition process are different in dissimilar social environments. They have an impact on peoples' subjective well-being and they influence peoples' understanding of well-being both in particular and in general. Caution is necessary in applying the locally effective measures of well-being and means for multiplying well-being globally. Conceptual misunderstandings connected with the obscure term cause the rejection of locally effective means and acceptance of ineffective means for the increase of well-being.

1. 'Well-being' – part of the professional conceptual network

Though the term 'well-being' does not have a single meaning, the WHO professionals frequently use that term in the WHO documents.

In this paper I deal with the concept of 'well-being', which I regard as an element of the WHO conceptual language. This language has been established by the Western politicians and applied in shaping the goals of health promotion as well.[1] It is a constituent of a certain conceptual family.

[1] Though the problem of communal and marital 'well-being' is the most central in the prevalent sociological literature on 'well-being' (See: Acitelli, Linda, E. Douvan & J. Veroff (1997), Mutran, E. & D. C. Reitzes (1984)), it is not my aim to participate in that discursus.

The views have been advanced that different constructions of the relationship between health and well-being do not indicate the existence of a clear unitary account (Buchanan 1994:57; Seedhouse 1994:51).

The constituents of this conceptual family, besides 'well-being' (i.e. 'quality of life', 'health promotion', 'health education', 'prevention', 'health advocacy', and 'health legislation') form a steady conceptual field. Besides 'well-being' and 'quality of life', five of them are established professional categories, which play quite a significant role not only in the WHO vocabulary but in medicine and in politics of medicine as well.

In the field of health, 'well-being' is a frequently used, but not a clear enough term (Seedhouse 1994:51).

For health promoters this conceptual network is essential to elevate the social component of the WHO definition of health. One of the goals of the WHO health promoters using those terms is to show that *health* is a living concept and not only an empty proclamation of the aim which can never be achieved. These concepts help to bridge personal, social, and medical well-being[2]. Among other terms of that conceptual field, the notion of 'well-being' is the most problematical one because both 'personal well-being' and 'social well-being' largely depend on the definition we give to 'person' and to 'society'.

The WHO health promoters often clarify the conceptual area of health promotion in the following way: the goal of health promotion is maximising the well-being of an individual. If the claim is right, the methods of health promotion are more or less identical with the methods of maximising a person's well-being. Thus, the exact measuring of the efforts of health promoters would indicate how much the well-being of a person increased due to the used methods of health promotion.

The WHO papers demonstrate the particular role of the term 'well-being' in the WHO terminology, for example:

> *"Health and well-being are improved through the complex interactions of initiatives in various sectors."* (Kickbusch 1989:13)

> *"Public health is the science and art of promoting health. It does so based on the understanding that health is a process engaging social, mental, spiritual and physical well-being."* (Kickbusch 1989:22)

Given that theoreticians have developed various accounts of well-being, both subjective and objective in nature (Downie et al. 1990, Elster, Roehmer 1991), it might not necessarily be surprising that, according to I. Buchanan, a clear view has not emerged in health circles (Buchanan 1994:58). D. Seedhouse described the situation as follows:

> *"The rhetorical use of 'well-being' in health promotion acts to obscure the analysis of health promotion activity ... Thus they substitute 'well-being' for 'health'..."* (Seedhouse 1994:50)

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[2] " Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity." (From the WHO Definition of Health)

Now that the meaning of health has received serious attention,[3] the aim of this paper is to focus on 'well-being' as an independent notion but not the substitute for 'health', 'quality or life' etc.

2. The concept of well-being has an established philosophical background

People arrange and regulate their lives according to the large number of preferences, which vary from one person to another. They can be very different. Societies regulate the lives of their members with their institutions. In doing so they follow certain aims, which may or may not be identical with the preferences of a particular person. A rough and ready rule is that a person wants to live well. In modern times hardly any established thinker argumented against living well. Distinguished modern philosophers (e.g. J. Locke, A. Smith, J.-J. Rousseau, J. Bentham, W. v. Humboldt, J. S. Mill and many others) attempted to clarify the question about how the public relations and institutions have participated and how they ought to participate in increasing and securing personal well-being. J. Bentham based his answer on the concept of utility[4]. Using the concept of well-being, the WHO health promotion professionals are trying to solve more or less the same problem J. Bentham faced, when he developed his concepts of 'utility', 'benefit', 'advantage', 'pleasure', and 'happiness'. There can be various reasons why the people who preferred the more or less economical concepts of 'wealth', 'welfare', 'well-being' and 'quality of life', achieved the dominant position in contemporary institutions. And why the ethical concepts of 'utility', 'benefit', 'advantage', 'pleasure', and 'happiness' lost their positions as the key concepts in shaping the aims of good life in the second half of the 20th century. The fact is that if a health promoter is working at the WHO or in any other influential institution their use of above-mentioned economical concepts of 'good life' is predetermined.

Nevertheless, I think that the WHO professionals and the contemporary philosophers of well-being, when they speak about 'well-being', they have in view basically the same reality J. Bentham had. In that sense, 'well-being'[5] is just a post-modern term for a basic philosophical concept of 'good life'.

Unfortunately there is not enough evidence in the WHO publications[6] whether the WHO professionals are using the concept 'well-being' primarily as a

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[3] Seedhouse (1986), Nordenfelt (1993)

[4] *"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 ever 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, or happiness, (all this in the present case comes to the same thing)...."* (Bentham 1988)

[5] A profound analyse of the related terms see in (Nordenfelt 1988)

[6] See (Nutbeam 1985, Kickbusch 1989)

descriptive or as a normative concept or in the mixed sense. Not enough clarity in that question may cause the same slip that happened when J. Bentham's fundamental ideas became the subject of subtle analysis and forceful development by J. S. Mill (Mill 1991:131–201).

Take the following example: If somebody says that "one's well-being is desirable in that particular situation", this does not imply that "one's well-being is already desired in that particular situation". It rather shows that "one's well-being ought to be desired in that particular situation". But let us make a philosophical excursion to the roots.

In "Utilitarianism", J. S. Mill initiated an argument from the analogy between desirability and visibility. His aim was to prove that the Greatest Happiness Principle is correct. He initiated the argument with saying that just as the only proof that something is visible is that someone sees it, so the only proof that something is desirable is that someone desires it. (The action that produces the most happiness overall is the most desirable one.)

Here I refer to the shrewd reconstruction of that argument by E. Sober (Sober 1995:445):

> *Seeing something proves that it is visible (1).*
> *Desiring something proves that it is desirable (2).*
> *The only thing that each person ultimately desires is his or her own happiness (3).*
> *His or her happiness is the only thing that is ultimately desirable for a person (4).*
> Normative conclusion: *Each person should perform those actions that promote the greatest happiness (5).*

That analogy between *desirability* and *visibility* is too weak and causes problems.

If something is visible, this means that it is possible to see it. But if something is desirable, this does not primarily mean that it is possible to desire it. It would be more correct to say that it preferably should be desired. In case of 'visibility' and 'desirability' we ought to pay serious attention to the difference between a descriptive and a normative concept.

If somebody says that "*one's pleasure is desirable in that particular situation*" this does not imply that "*one's pleasure is desired in that particular situation*", but "*one's desire could be (or had to be or might be) desired in this particular situation*". From the statement "*X is desirable*" does not necessarily follow "*x is desired*".

In step three of the argument the word "*ultimately*" means that everything else people want, they want it only as a means to secure their own happiness. The real or concealed goal in providing starving people with food, a utilitarian considers, is to prevent oneself from seeing the suffering of the starving people. According to the theory of J. S. Mill, if one wants the starving people to be provided with food, this therefore means securing one's own happiness. Though at least in that particular case, pleasure and happiness are not the good ends themselves, but rather manifestations of psychological egoism.

Nevertheless, it is evidently true that not all people relate with others on the ground of psychological egoism; and *vice versa*, the psychological egoism is not the only manifestation of the '*subjective component of well-being*'. There also exist millions of altruists in the world (e.g., doctors do not cure cancer and the Red Cross people go into the areas of disaster for the sake of their own happiness). The view that if the means of feeding starving people and the means of health care to non-insured people are provided by the state, then it results in institutionalised desire of happiness, is also superficial. We may characterise the institutions (WHO, Red Cross etc.) as goal directed or as non-goal directed and as effective or as ineffective, but they certainly cannot have a desire for happiness in the same sense the individuals have.

Further, the institutions of health often have to deal with the people who have destructive and self-destructive desires. The best thing for those people would be not to get what they want. To change what the mad people desire would be good for many others as well.

As a consequence, the fact that your own happiness is the most desirable thing for you does not imply you should maximise everyone's happiness, including yourself. The conclusion of the argument *(4)* requires you to act unselfishly and sometimes to sacrifice your own happiness. Doing so brings with it a more than compensating increase in the happiness of others. We cannot draw this last conclusion from the claim that *"the only thing that is ultimately desirable for a person is his or her own happiness"*.

3. Well-being has an inevitable subjective component

Is a true estimation of one's well-being based on objective measuring or subjective feeling?

The question on the proportion of the measurable and non-measurable components of well-being is relevant to the concept of well-being in the discourse about health and politics.

Every examination of a personal well-being must rest on what the examinee says, writes or indicates in body language. An examiner interprets verbal and observable expressions.

It is a matter of technique, whether the inquiry of well-being will be entirely or partly based on personal answers. I am not the only one who doubts the existence of a reliable test, which would at the same time ignore the subjective feelings of a person. How can an examiner judge whether someone has added to his/her 'well-being' or not? The person, after all, is the only one who has true access to his own subjective feelings and can truly define his own intrinsic 'well-being'.

Can a person be mistaken about how they feel? [7]

[7] (Sellisel kujul küsimuse vormi pakkus mulle ehtne ameeriklane. Seda võivat nii kasutada, et vältida viisakuskordust her and him, she and he.)

The question on fallibility is consequential in the following respect.

The idea that a person is in error about what they feel seems to be absurd. It is true that people can be mistaken when using words and expressions about what they feel. They may attach wrong words to things and facts. They can also be under external or internal psychological pressure not to express their actual feelings.

For example, an examinee says she feels well. But we see her lift her eyebrows and frown. Most psychiatrists recognise that instinctive bodily expression as a sign of depression. That particular examinee can hardly feel well. We are right to assume that she has a reason not to express her actual feelings. But using wrong words does not mean that she actually feels wrong. People can express (or disguise) their state of well-being in different ways. The possibility to give clearly wrong signals about their state of well-being is a prevalent indication of both the subjective and objective components in well-being.

"Subjective component" is a notion which has multiple meanings in well-being. For example, a professional soccer player, who has ten toes, feels himself well in comparison with the colleague who has lost some of them. But the one who lost his big toe feels himself unwell not necessarily because he has lost it, but because his intact foot is the key component of his ability to earn a living. "Subjective component" sometimes means that an individual is not free to follow his or her own well-being for the sake of the well-being of others.

It is worth pointing out that in dissimilar microsocial environments people have many different motives for not behaving in concordance with their own individual well-being. These motives can change rather than be changed. The attempt to change the motives of people for the sake of their well-being from outside their proper social environment could have unexpected results.

4. 'Measuring the well-being' is questionable in regard to its inexactness[8]

For making 'well-being' measurable, the comparisons of different subjects, circumstances, matters of fact etc. are indispensable. The ways for measuring and estimating a particular state of well-being vary. A person can compare his/her states *l, m, n* of well-being at instant *I* or during period *P* at the same time with his/her own states *l', m', n'* of well-being at instant *I'* or during period *P'*.

The states of well-being can be compared in the following way. An examiner will compare the states l, m, n of well-being of that person at instant *I* (or during period P) with the examiner's states *l', m', n'* of well-being at instant *I'* or during period *P'*. Further, the investigator can compare the states of well-being of that examinee with the states of well-being of an another examinee. In addition, it is

[8] In sociological research the concept 'measuring well-being' is quite clear concept. See a brilliant analyse of that topic in (Ringen 1995).

possible for the examiner to compare the state of the examinee at that time and in those conditions with his own.

Nevertheless, it will remain an open question, which method of comparing and/or measuring different well-beings of one and the same person (1) and the well-beings of different persons (2) is the most reliable as the basis of estimation of individual well-being. Those comparisons always contain some elements of evaluation, which cannot be accepted by a more or less rigid theory of health economics or welfare economics. Because mental states are observable to the person only and not immediately observable from outside, the comparisons of the mental states presume immediate participation of the subject of those mental states.

To be measurable, the personal subjective well-being must have some features, which are understood by the interviewer and the interviewed person as akin and identical. The investigator must have some evidence on the subjective well-being of that person. The intensity of personal preference and the degree of pleasure could be suitable measurable indicators of subjective well-being, because different people can have more or less identical experience concerning those characteristics.

From the statement "*mental state of pleasure and degree of intensity of personal preference are the subjects when measuring and/or comparing well-being*" does not unfortunately follow that the comparison of the states of well-being is possible without fail. Some states can be the states of illusory well-being. Cocaine and marihuana are widespread personal preferences. A smoker of marihuana can have pleasure without being happy. In other personal preferences the degree of pleasure and the intensity of personal preference are neutralising each other. A woman giving birth can be both in pain and also happy.

Further, an interviewed person can misunderstand the vocabulary of the interviewer. For example, the interviewer is asking questions about health care. The interviewer may have in view the respondent's well-being related to hygiene, infections and/or health promotion. But the respondent has in mind his/her emotional or financial relation to the family doctor or doctor's office. If that person expressed her actual feelings and used wrong words, a misinterpretation of the data can also happen in the process of categorisation. That kind of reciprocal misinterpretation is more frequent in the case of local language transition process.

If both the interviewer and the person interviewed are able to use advanced English terms, then misunderstanding can hardly take place. But I see it often in the society in transition with the language in flux where the incidents of misunderstanding are quite common.

The second reason of reciprocal misunderstanding is the existence of two strategies concerning 'well-being' in health circles. (Seedhouse 1994:43). Many health promoters use the general expression 'well-being' extensively in their theoretical discussions and their political pronouncements. A causal relationship between well-being and the measures of health promotion is optimistically assumed (an optimistic strategy). A number of others consider themselves to be in advantageous position. They believe that they have a special competence to

distinguish between 'objective' and 'subjective' well-being (a hard-line strategy). The point of hard-line strategy: 'objective well-being' is always 'true well-being' while 'subjective well-being' can be either true or false. (Seedhouse 1994:43)For example, according to an optimistic view, the success in reducing the use of tobacco is the same as the growth of objective well-being. The physiological and mental suffering as a consequence of giving up smoking is not called a true reduction of well-being. Some mental and physical states are interpreted as states of well-being by a related person, but not by a hard-line health promoter. If a person does not agree with that interpretation he is claimed to be in error.

The open question about the relations between a 'true' and a 'false' well-being is not only derived from procedural difficulties of the process of measuring 'well-being'. It turns the concept of well-being into a matter of unlimited conceptual analysis.

Utmost priority of the concepts of 'well-being' and 'quality of life' in the WHO papers has brought about too high expectations of well-being. It inspires very many people around the world. But it also gives cause to exaggerated hope. The division of well-being into true and false is one of the derivatives of that unjustified hope on well-being.

Looking for a way how to cope with the problem of status and division of well-being, the following solution has been offered:

People are taken as agents who seek well-being through the choices they make in life. They are assumed to be able to know what is good and what is bad for them. Choice is the key element in their proposed action. In a more general theory of well-being, choice in itself is most valuable. Any serious measuring of well-being cannot come from outside the set of choices the people themselves make. What exactly people choose is less important than one's ability to choose whatever one desires. People live well or badly to the degree where they can make their choices themselves. In the predominant theory of well-being (Ringen, 1994) the choice is focused not on what they do, but on what they could do. The same perspective is prevailing at the 'capabilities approach' as developed by Sen in its emphasis on freedom (Sen 1992). I agree there is a gap between the concept of well-being as a theorist of health promotion (S. Downie), a sociologist (S. Ringen) and an economist (A. Sen) interpret it. Nevertheless, a health promoter's goal in general lines is the same as that of an economist: to extend the ability of an individual to be autonomous and self-determined. It would be a politically accepted principle to encourage the political concern for individual well-being, but at the same time preserve a domain of personal authority, adhering to the 'pursuit of happiness' principle (Ringen 1995:5). According to that liberal principle the whole question of how to live was left to people themselves; and the role of others, be it an examiner who wants to measure well-being or a politician who wants to improve it – was limited to the domain of personal opportunities[9].

[9] Choice is specified as exercised by persons in social settings. The first assumption is that people want to choice, the second that some choices are more valuable than the other are. Choice made

The view of S. Ringen, "My perspective ... is not utility but freedom, and the question here is hence whether there may be a problem of too much choice in respect to freedom" (Ringen 1995:5) is correct aa for the realities of one's everyday life. But the whole field of health care and health promotion cannot be covered with the attitude – the more choice, the better. One cannot prove that the multiplication of choices per se is the best strategy for protecting health, preventing diseases, curing them and adding extra autonomy and self-determination in every place and country.

It is easy to demonstrate that in many particular health care and health promotion situations the model – the more choice the more well-being – is not correct. In both the personal and institutional life most professional decisions have to be made during a limited period of time. If there is a number of obstetricians in a small city, this does not necessarily improve the well-being of the woman who intends to have an abortion or give birth to a child. Even if she would gain as for her privacy and mental well-being due to the availability of many competing doctors, an obstetrician's clinic having a small number of patients presumably has more cases of malpractice and is more expensive. Gains and losses of that particular person depend on her opportunity to decide on the cost and choose information. An unlimited choice does not improve her well-being at all in that particular situation. Unfortunately there is no exact measure about how much choice secures one's well-being.

Comparing the harm, cost and benefit of smoking, we face similar problem. People smoke because they feel they increase their well-being by doing so. The 'hard-liner' says that one's objective well-being does not improve through the enjoyable smoking of an expensive cigarillo. Are both right?

A lot of smokers die at the age of retirement. With that they save the community ten years of pension costs (and also the health insurance costs, which will generally increase in advanced age). It would therefore be quite sensible to ask whether a smoker ought to be freed from paying excise tax on cigarettes. Nevertheless, it is quite obvious that if a smoker dies as soon as he retires, he will both save society much money and improve the measurable well-being of society.

This idea is dissenting from the dominating view on smoking. But if free choice is the primary value and the cornerstone of attaining one's well-being, we must agree with this conclusion. If so, the measurement of individual well-being causes much more problems than the social one.

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between strategies of personal behaviour (e.g. to sit and smoke instead of doing exercises) is vital choice, but a choice between different whiskies a trivial one.

5. Dissimilar social environments concerning well-being

Some concepts on social processes are language-dependent and/or culture-dependent. My thesis is that 'well-being' is a language-sensible and value-sensible concept in comparison with other WHO concepts of that conceptual family[10].

I introduce three abbreviations with the aim of shortening my arguments. Those are: *Society 1 (S1), Society 2 (S2), and Society (S3). S1* will designate contemporary wealthy democratic society, which is communicating in WHO official language[11]. *S2* will denote a post-socialist society, say Estonian, and its local national language in transition. *S3* will signify a contemporary continental wealthy democratic society.

Via the integration of S2 into the European Union (into S3) the role of interpretation of the EU- and WHO-concepts upon local language will probably decrease. Conceptual analysis of the components of the EU and WHO vocabulary is an element of that integration. There are no exact methods, which could help to prognosticate how much time the process of integration takes before the linguistic differences of local languages cease to influence the communication between the established societies and the EU-newcomers. At present, different groups of societies and languages actually influence local societies and their languages, including the Estonian (S2) language in different ways.

How I justify the activity of a S2 theoretician in the field of the theory of well-being?

It is quite an intriguing question why a S2 theoretician ought to deal seriously with the local theory-making in well-being if there actually is no well-being in the sense of S1 and S3 concept of well-being in S2. How to justify my own activity in that field, if all recorded increase of well-being of S2 derives from the import of productive ideas, conceptual networks, models of social structure, financial resources, medicine, medical equipment and many other means, which are worked out in S3 and S1?

A quasi-rational justification would be the following: here are theoreticians of 'well-being' and there is a widespread actual well-being, and there are the institutions related to the well-being in S1 and S3. If S2 wants to gain more or less similar well-being it must set up the same institutions dealing with the same aspects of well-being as the S1 and S3 institutions and officials.

A *preferably rational justification*: Communication between S1 and S2 is hardly possible, if the communication partners do not understand the mentality of each other and if they do not comprehend the forces, which motivate and lead the partner into action. An assimilation of S2 into S3 and S1 may hardly be satisfying for either because of the S3 and S1 public attitude, because of S2's need of

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[10] i.e.'quality of life', 'health promotion', 'health education', 'prevention', 'health advocacy', and 'health legislation'

[11] Great Brittain and the United States.

identity, if S2 as a junior partner does not make as intensive efforts as S3 and S1 do with the aim of bridging the gap between S1 and S2. Conceptual analysis is one of those efforts.

It is worth pointing out that any S2 has the ability to make others believe that it is taking on or it has already taken on the fundamental conceptual networks of S1. Pretending to accept the S1 concepts leads S1 and S3 to believe that the conceptual networks are already homologous between the WHO and EU (S1, S3) and S2. This ability of S2 to pretend that the conceptual analysis is already completed misleads not only the S1 experts but also the S2 persons themselves.

The ability of S2 to make successful conceptual analyses, including the analysis of 'well-being' may be regarded as a proof that S2 is able to recognise and emulate the rational thinking, which is characteristic of S1.

Emulation of the conceptual networks of S1 by S2 will be regarded by the S1 experts as a kind of guarantee that S2 has already become capable of repeating the social political practices of S1, including those which had brought S1 to its contemporary state ofwell-being. There is no doubt that this action facilitates the S2 access to the foundations created by the established societies.

6. Why is that concept fuzzy?

I assemble two groups of basic statements on 'well-being'.

The antagonistic statements:

1. 'Well-being' is a concept which contains an abundance of different meanings no other term conveys.

2. It is an essentially ambiguous concept, which has a fluctuating content depending on who is using it, why, and where.

3. 'Well-being' is a simple, and in most cases an empty notion as many political terms are.

The statements on well-being as a complex of bodily and/or mental state and/or activity of the individual. It does not matter what kind of categorical status the notion of 'well-being' has; the point is that the actual maximising of individual well-being is claimed to be the aim of health promotion.[12]

It is quite clear that the statements 1, 2, and 3 need a conceptual analysis. Speaking about particular components of well-being, I presume that there exists a common basic level (or ideal prototype) of well-being in both my own mind as well as the minds of other persons who share the culture I live in or conform to.

Thus, different individuals discern various 'well-beings'. Nevertheless, they understand each other if they distinguish and label the following classes of well-

[12] If they are right, then the methods of health promotion are akin to the methods of maximising person's well-being. Consequently, there must be exact measures of the results of health promoter's effort: how much the well-being of the person has been increased due to the methods used in health promotion (Abelin et al. 1987).

beings: well-being = happiness, well-being = positive stress, well-being = enjoyable intellectual stimulation , well-being = tranquillity (Seedhouse 1994:48).

If the concept of well-being of the people of S1 and S3 differs from the one of S2,[13] the following question is justified: if people of S1, S3 and S2 have different concepts of well-being, do they have different perception of well-being as well? Maybe it would be correct to say that there are no differences in their perception, and only the examples on which they focus their attention are different?

According to modern psychological and anthropological views, there is enough evidence to suppose that the ability to experience either happiness, positive stress, enjoyable intellectual stimulation or tranquillity does not depend on the cultural background of the individual. Particular feelings and the concepts related to those experiences depend on one's cultural background, social development and psychological type. These determine whether one's feeling of happiness and well-being are based on one's gratifying relationship with one's partner, or on a wide network of satisfying social relations. Or it may be a chance to do interesting work, the good fortune to enjoy fine cuisine, excellent health, outstanding results in bodybuilding etc. Let us now seek the sources and grounds of positive stress. It is quite clear that sickness is a factor decreasing the ability for positive stress. But does one's positive stress derive from one's success in sport or from a demanding professional job or from constant self-motivation in science? Could one's well-being come from a continual intellectual stimulation, generated by the creative people around him? Maybe the person in question has been fortunate enough to study or work at a school with an exceptional selection of students? Can one's tranquillity come from one's position as a rich rentier? Or from life-long job without frustrating responsibility, or from a leisurely life in a country house?

These common-sense questions about the grounds of one's well-being reveal a substantial problem. It is easy to question but not easy to answer: is there a significant difference between the well-being from the point of view of public administration and the well-being that a health promoter has in view?

If there are significant differences between those "well-beings", the problem of the arrangement of particular components of well-being will arise. But if there is only one uniform well-being in the sense of well-being in health promotion and in communal organisation of society as well, the priority in grouping the particular components of well-being ought to differ from the first case.

There are some forms of life, which cause happiness and tranquillity, and those with positive stress and continual intellectual stimulation. They exist in established societies (in S1 and S3). In that respect the application of different concepts of well-being for describing the differences between S2 from S1 and S3 have enough ground. But seemingly similar concepts of well-being need a very balanced interpretation when attempting to introduce them into the realities of S2, which differ substantially from the realities of S1.

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[13] I do not claim that this assumption is wholly true in any particular case.

In S2, for example, the continual intellectual stimulation has often been related to the intensive states of distress and in a few cases to the well-being in the sense of S1 and S3. There is no Oxford-style pleasant environment for study and research. Thus, if there is a good environment for productive intellectual work it has to be regarded as an exception. It makes no real sense to seriously discuss a wealthy life-style of a rentier if there are only two hundred rentiers per one million people in S2.

I tend to think that the people of S1 and S2 interpret the concept of well-being on the grounds of pleasurable intellectual stimulation in different ways. Further, the majority of the S2 population does not perceive well-being on the grounds of financial support in the same way as the S1 community does because in S2 there are no forms of life of the S1 and S3 individuals.

Significant differences in the ways of life of the people of S1 and S2 compel to alter the common view on translation and interpretation of the S1 concepts and on the emulation and application of the S1 ways of life by S2. In that case the interpretation does not mean a pure concept but the concept, which needs to be hypostasised into the ways of life of S2.

7. Conclusion

1. Given that philosophers have developed a variety of accounts of well-being, both subjective and objective in nature (see Elster et al. 1991), it might not necessarily come as a surprise that a clear view has not emerged in health circles (see Buchanan 1994). Thus, my intention here was to offer only some observations which the theory of well-being should take into account in order to allow practical relationship between well-developed Western conceptual field of well-being and its local variety in transition.

2. The interpretation of the S1 'well-being' into S2 real thinking language cannot be based on linguistic procedure only. It is obvious that the conceptual network developed by S1, which is needed to be put into the existence against the realities of S2, is targeted on the realities, which are brand-new or even lacking in S2.

3. Strict priority of order of particular components of well-being are not always possible. These priorities vary depending on the dissimilar types of social environment.

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References

Abelin, T., Brzezinski, Z. J and Carstairs, V. D. L. (1987) *Measurement in Health Promotion and Protection*, Copenhagen: WHO.

Acitelli, Linda, E. Douvan & J. Veroff (1997) "The Changing Influence of Interpersonal Perceptions on Marital Well-being among Black and White Couples". *Journal of Social and Personal Relations*, 14 (3), 291–304.

Bentham, J. (1988) *Principles of Morals and Legislation*. N.Y.: Prometheus Books.

Borman, C. L. (1993) "Race Differences in Marital 'Well-being'". *Journal of Marriage and the Family*, 45, 387–94.

Buchanan, I. (1994) "The purpose- process gap in health promotion". In *Health Promotion and Prevention*. Editors: Per-Erik Liss and Nina Nikku. Swedish Council for Planning and Coordination of Research (FRN), pp.52–60

Elster, J., J. E. Roehmer, eds. (1991) *Interpersonal Comparisons of Well-being*. Cambridge: Cambridge University Press

Gray, J. (1996) *Mill on Liberty: A Defence*. London, New York: Routledge.

Kickbush, I. (1989) *Good Planets are Hard to Find*. Regional Office for Europe: WHO.

Mill, J. S. (1991) "Utilitarianism Defence of Utilitarianism". In: *On Liberty and Other Essays*. J. Gray, ed. Oxford, New York: Oxford University Press, pp.131–201.

Mutran, E. & D. C. Reitzes (1984) "Integrational Support Activities and Well-being among the Elderly: A Convergence of Exchange and Symbolic Interaction Perspectives". *American Sociological Review*, 49, 117–130.

Nordenfelt, L. (1993) *Quality of Life, Health and Happiness*. Brookfield USA. Hong Kong. Singapore. Sydney: Avebury. Aldershot.

Nutbeam, D. (1985) *Health Promotion Glossary*. Regional Office for Europe: WHO.

Ringen, S. (1995) "Well-being, Measurement, and Preferences". *Acta Sociologica*, 38, 3–15.

Seedhouse, D. F. (1986) *Health: The Foundations for Achievement*. Chichester: John Wiley & Sons.

Seedhouse, D. (1994) "'Well-being': health promotion's red herring". In *Health Promotion and Prevention*. Editors: Per-Erik Liss and Nina Nikku, Swedish Council for Planning and Co-ordination of Research (FRN), pp. 43–51.

Sen, A. (1992) *Inequality Re-examined*. Oxford: Clarendon Press

WHO Health Promotion. (1984) *A discussion document on the concept and principles*. Copenhagen: WHO.