CHAPTER 2

MIGRATION AND QUALITY OF LIFE:
A REVIEW OF LITERATURE

‘… an acceptable quality of life requires respect, options, reasonable security and a sense of living up to potential’ and that ‘… quality of life ought to come in all sizes for all people’ and further that......

‘… facile, contemporary phrase “quality of life” is still a puzzle. Practically everyone seems to know what it means, but no-one can adequately define, classify or measure it’ – Weisman 1979: 123.

‘… that there is another world of human experience which is not quantifiable, nor statistically significant, but perhaps of enormous significance in ultimate terms’ – Paterson 1984: 2381.

2.1 INTRODUCTION

The survey of literature and review attempted here has two major parts, namely, (a) a review of literature on migration in all its relevance to the present study, especially living and working conditions of migrants in cities, push and pull factors, migration in developing countries, migration research at the international, national, state or regional levels, and urbanization, (b) another review of literature on quality of life in general and on the aspects considered in the study such as overall and impressions of quality of life among people and particularly migrants to cities, urban environment, health,
education, housing and basic infrastructures, employment, economy and livelihoods, recreation and safety in the city.

2.2 INTERNATIONAL MIGRATION AND THE INDIAN DIASPORA

India has one of the World’s most diverse and complex migration history. Since the 19th century, the ethnic Indians have established communities on every continent as well as on islands in the Caribbean and the Pacific and Indian Oceans. The composition of flows has evolved overtime from mainly indentured labour in far-flung colonies to post-war labour for British industry to high-skilled professionals in North America and low-skilled workers in the Middle East. In addition, ethnic Indians are in countries like Kenya and Surinam and from there have migrated to other countries, a movement called secondary migration.

According to the most recent assessment by the UN Population Division, in 2005, there were 191 million people living outside their countries of birth, which is about 3.0 per cent of the world’s population. The Tamil Diasporas, for example, is 20 million strong, living in 110 countries of the world, even as the ethnic group lives in countries such as Sri Lanka, Malaysia and Singapore in sizeable number. This number has almost certainly increased further as transport communications continue to encourage mobility. Although most migrants live in the richer countries of Europe and North America, including 38 million in the US and 10 million in Germany, a 2006 report by former UN Secretary-General Kofi Annan suggested that about one-third of the global migrants have moved from one developing country to another.
2.3 MIGRATION THEORIES

Existing migration theories may broadly be divided into four major categories:

- Theories on General Principles;
- Classical and Neo-classical models;
- Socio-Economic theories; and
- Migration and Development Models.

Theoretical formulations for the general principles of migration are found in the pioneering work of Ravenstein (1885). His seven generalizations, which he claims as the ‘seven laws of migration’, are related to the patterns and distance of migration, migratory streams, motives and characteristics of migrants. Many of his observations are still quite relevant. Stouffer (1940) developed the theory of intervening obstacles. For him, the factors that influence decision to migrate are the ‘plus’ and ‘minus’, both at the place of origin and at the place of destination. Lee (1966), combining the previous works of Ravenstein (1885); Herbert (1938); Stouffer (1940), formulated a more coherent theory of migration. According to him, Migration as causation needs to be viewed within the framework of factors associated with the area of origin, area of destination, intervening obstacles and migrants themselves.

In the late 1950s and the early 1960s, rural-urban migration was seen as a desirable and even a positive phenomenon that allowed transfer of surplus agricultural labour force to the growing industrial sector (Lewis 1954; Fei and Ranis 1961). Todaro (1969), who was one of the principal exponents of the neo-classical economic perspective, considered migration as a ubiquitous phenomenon. This model was based on economic factors, which
explained the relationships between migration, expected income differentials and urban employment. During the 1970s, however, another theoretical approach came to the fore, which in relation to both internal and international migrations, strongly criticized the purely economic models developed up to then, related it exclusively to the behaviour of migrants and their motivations.

According to McGee (1971), six main features of rural-urban migration emerge from his studies:

- The largest cities tended to attract the greatest number of migrants though not necessarily growing as fast as the newer industrial cities.

- Rural-urban migration was generally short-distance migration with the one proviso that the larger the city, the greater distance from which it would attract migrants.

- In terms of migration differentials three main features can be observed: (a) During the earlier part of the revolution the migration pattern tended to be made up of single seasonal workers. This changed to a pattern of family migration during the ‘main’ phase of the industrial revolution, although during the later parts of the industrial revolution, single migration was more characteristic. (b) Migrants tended to be concentrated into what have been called the ‘migration prone’ age groups between 15-35 years although this pattern was not so clear during the family phase of rural-urban movement. (c) The sex differentials of the migrants varied considerably from country to country and phase to phase of the industrial revolution. During the earliest phases it was largely male dominated, but later it was evenly balanced between males
and females and finally passing into a phase where migration was dominated by females.

- There was a tendency for certain cultural groups such as the Irish to figure prominently in the rural-urban movements.

- Finally, if the simple, ‘push-pull’ framework of motivation for migration is accepted, it seems clear that the ‘pull’ factors of increasing opportunities for employment in the new industrial cities and large towns acted as a far more important motivating force than any ‘push’ factors such as the decline of agricultural employment opportunities.

### 2.4 RURAL-URBAN MIGRATION AND THE LARGER CITIES

Most evidence suggests that the larger cities of Southeast Asia today are attracting a greater proportion of the rural migrants than the smaller cities. It is true that evidence on the growth rates of the larger cities suggests that they are not growing as fast as the smaller cities in many cases. But this growth pattern must be seen in the context of increasing suburbanization and the establishment of satellite towns on the fringes of many of these larger cities. For instance, while the population of Manila City grew by only 66,000 between 1948 and 1960, the population of Metropolitan Manila increased by almost million people. Care should be taken in viewing such a process as similar to the pattern of conurbation which occurred in urbanized areas such as Manchester and London during the industrial revolution, for the process of urban expansion is advancing into agricultural land and incorporating agricultural villages, not the merging of urban areas. Thus although the growth rates of some of the larger cities may be slowing down, in the total metropolitan areas there can be little doubt that the rate of increase exceeds other urban areas.
2.5 PART-1 LIVING AND WORKING CONDITIONS OF MIGRANTS TO CITIES

Living conditions for migrants are tough and can remain that way for decades. Poor immigrants usually stay in slums or in less secure accommodations. The report of the Working Group on Watershed Development for the Tenth Plan states that 50 per cent of the population in Mumbai and 40 per cent in Delhi live in slums. Roughly 500,000 people migrate into Delhi every year mainly to work in the 95,000 factories or as workers in tea shops, as vendors and drivers (Deshingkar 2010). Of the 400,000 going into the 1,500 illegal colonies and 1,000 slums in the city (Sinha 2003), with very poor access to clean water, sanitation or electricity, even those who earn a reasonable income face constant threats of eviction, disease, sexual abuse, underpayment and police harassment.

Migrant workers have no access to subsidized grains at their destinations and spend a sizeable proportion of their wages on basic food supplies. Spending on rents is also substantial. Probably, the most serious cost of migration is children’s schooling. When entire families migrate, children stay behind to do household chores while the parents work. Data from the Andhra Pradesh villages show that while 15 per cent of the migrating households had children out of school, against 10 per cent of the non-migrating households.

Given the difficulties encountered by the illiterate and under-informed migrants in accessing provisions that have been made for them by the state, there appears to be a need for support from elsewhere. A number of civil society organizations have taken up public distribution system from the contractors and the government officials to ease the situation.
Parents of female rural-urban migration in India have received little attention by either researchers or planners. While some data do exist in the census and National Sample Survey (NSS) reports, they have not been utilised very extensively and also tend to yield very limited information. Andrea Singh (1983) in a paper of hers examines patterns of female migration to the major cities of India, especially among the urban poor who include disproportionate number of rural migrants. Her major goal has been to illuminate some of the social and cultural factors which affect decisions to migrate and also influence the consequences of migration for women. While economic factors are obviously basic to migration decisions, socio-cultural factors give migration streams particular shapes in the Indian setting.

Most studies of rural migration have emphasized the positive economic benefits which accrue to the village because of remittances by the emigrants. The women’s oral tradition of the Eastern U.P. region, however, included many references to men’s emigration to the cities, most of which have negative connotations. Some examples of this folklore are found in Saxena (1977: 175-178). The common themes are the women’s opposition to the husband leaving for a job in the city, her feeling of wasting her youth and beauty and her fears about her husband’s health and faithfulness. Aside from the emotional problems resulting from separation of husband and wife, the literature suggests that a woman left behind may be adversely affected in other ways as well. Although the majority of emigrants in Saxena’s study sent sizable amounts of money on a regular basis back to their families in the villages, only a handful sent remittances directly to their wives and children. Money is usually sent to the senior male members of the matrilineal joint family (for example, the emigrant’s father), and most of this money has been channelled into debt repayment, agricultural investments, and marriages (Saxena 1977:132-135). The normal practice apparently is to send a single remittance to the joint family with instructions regarding how much should be
given to the wives and children of the emigrants; however, there is no indication of how much of this is actually turned over to the wives and children directly.

Another important contributing factor is the absence of agricultural activity in the new habitats. A majority of the migrants from the rural areas of Kashmir was of owners of agricultural lands and orchards. They were engaged in productive work in one or the other form.

The reasons for the low active workforce among Kashmiri migrants in Jammu have been summarized as under:

- fairly large student/child population;
- less participation of women in the economic activities;
- unsuitable/unsatisfactory jobs for the educated;
- lack of job opportunities;
- the problem of unemployment; and
- out-migration of educational workers.

Apart from the above, another important contributing factor is the absence of agricultural activity in the new habitats. Majority of the migrants belonging to rural areas in Kashmir was of owners of agricultural lands and orchards and were engaged in productive work in one or the other form.

The economy of any society depends on the strength of its workforce. On the basis of types of activities performed as well as modes of production, activities of the workforce can be classified as under:

(a) primary economic activities;
(b) secondary economic activities; and
(c) tertiary economic activities.

The primary group includes several occupations of which the most important is agriculture. It includes fisheries, forestry, hunting, mining and quarrying. Primary economic activity is totally absent among the Kashmiri migrants living in different parts of Jammu. Although most of them were, directly or indirectly, involved with the primary sector in the Kashmir Valley, after migration, it has been an altogether different story: a search for a piece of land for shelter, leave alone agriculture.

In the secondary economic activities, the society is mainly associated with the production of material goods and includes small-scale industries, household industries, extractive industries, manufacturing industries and also the construction work. At the time of survey, 21 out of the total workforce of 258 persons were engaged with the secondary economic activities. Tertiary economic activities are composite and include those activities which are not productive of material goods and so embrace commerce, transportation, storage and communication, banking and insurance and service workers (public and private) of all types. The tertiary activities are an index of the socio-economic status and well-being of any society/community.

2.5.1 Push and Pull Factors of Migration

The plight of the urban resident in finding a better living and work may be addressed by a question as to why there is a heavy migration to urban areas. Very little is known about the factors which impel residents of rural areas and villages to make their way into the large cities. There is a great deal of controversy as to whether they are pushed toward the urban areas because of circumstances over which they have no control, or whether the compelling
reason for moving to urban areas is the *pull* which the urban area exerts over those who live elsewhere (Moore and Smelber 1970; Todaro 1969).

The push versus pull controversy is difficult to differentiate. It is quite clear that both push and pull factors have an impact upon the movement of rural and village population into urban areas. The evidence seems to indicate that it is the push of existing rural circumstances which suggests to the rural resident that things might be better in the urban area. Quite diverse factors affect migration to urban areas. If, for example, the land tenure system results in progressive fragmentation of land via multiple inheritance, or if the family structure is such that primogeniture causes younger sons to be displaced by the senior son who inherits all, then the capacity to survive either is reduced or virtually ceases to exist and additional candidates for migration, perhaps to urban area, are the result.

### 2.5.2 Migration in Developing Countries

It was not only the rural population that was caught up in migration from one place to another and particularly toward urban areas. There were also international migrations, to and among urban areas such as the movement of rather large number of Indians from their homeland to various parts of South, and Southeast Asia and to Hong Kong, the migration of Indians to South Africa, and the migration of Chinese into Hong King, Rangoon, and Bangkok. More recently international migrations have been sparked by the partition of India and Pakistan and establishment of the state of Israel, taking quite different kinds of migration to urban areas in newly developing countries. While migrations on an international scale have often involved considerable distances, a majority of intra-country migration appears as relatively short-distance moves.
It would be helpful for predictive purposes to be able to refer with confidence to laws of migration to urban areas in newly developing countries. The fact is that very little is presently known about the migration patterns, although studies in process may reveal a much higher level of information than has been available. There is some evidence, for example, to suggest that migration occurs first from rural or village areas to small towns and then to bigger and bigger towns. However, there is also considerable evidence that this step-by-step migration may not take place, but rather that rural migrant’s move first to small cities and then to big ones as may be observed in the case of Brazil. This has been disputed by Harley L. Browning, who believes that migration does not proceed in this stepwise fashion. If there are any laws of migration to urban areas, they are likely to vary somewhat from country to country, depending upon the circumstances of migration. For example, the sizable influx of migrants to certain mining centres in South Africa involves a complex set of relationships and patterns of modern migration which might not be characteristic of other countries where migration takes place so heavily for purposes of working in extractive industries. There is evidence of seasonal reverse and multiple migration streams.

It appears also that there is a certain amount of floating migration, composed of people who wander from one city to another, desperately trying to make a place for themselves. Deshmukh noted in his Delhi study that ‘no less than 65 per cent of the migrants had tried their luck first from 6 to 15 other towns or even more.

Before the start of rural economic reforms in 1978, rural-urban migration of any sort was tightly restricted and indeed, with only minor exception, prohibited. The introduction of the household responsibility system in farming means that surplus labour, previously disguised by commune work rules, became available for new farm and non-farm activities.
In the 1980s, peasants began to sell their products in the reopened urban food markets and new grassroots rural industries responded to the demand for consumer goods. The growth of rural industry was the outstanding phenomenon of the 1980s. The employment grew by 13 per cent per annum in the 1980s in response to market disequilibrium, but by less than 3 per cent per annum in the 1990s as equilibrium was established and competition from the reforming urban economy intensified. Instead, rural-urban migration was the outstanding phenomenon of the 1990s. This redirection of rural labour absorption was assisted by the abolition of urban food rationing, acceleration of the urban reforms that had commenced in 1985, and - as the one-child family policy took lagged effect - a deceleration of urban labour force growth. The rapid growth of the urban economy compared with the slow growth of the urban-born labour force meant that there was an increasing need for rural workers in the urban economy. Temporary migration expanded to meet that need.

Historically, most migration from rural to urban areas was undertaken by men who travelled for temporary non-agricultural work. By the 1990s, however, a lot of migrants sought to settle permanently in the urban areas, and there was also an increase in the flow of women migrating independently to work in urban areas, especially in the garment factories. Migrants can be a result of changes in land use patterns (Ruffer and Masud 2010). Rising population density, proportional inheritance rules and highly liquid markets have reduced average plot sizes and margins of profitability. The fragmentation and division of land leaves many households without enough land to earn a living, encouraging migration or involvement in non-farm activities. A study on migration in Dhaka shows that most migrants belong to one of three categories: students (37 per cent), day-labourers (10 per cent) or the unemployed (15 per cent). There are a few studies analyzing the economic activities of migrants, although research has
shown that 21 per cent of those unemployed migrated while only 5 per cent of the students did, unemployment therefore seems to be a more powerful factor in determining migration than continuing education.

Rural-urban migration should be viewed from three perspectives - those of the migrants themselves, their prospective employers, and the government - anyone of which might wish to promote or resist migration (Knight, Song and Jia, 1999). Many rural people have a strong economic incentive to migrate, having few productive opportunities in the village. Some are put off by the transaction costs involved, including lack of information and contacts as well as the cost of movement and hence the importance of the village and the migrant networks in facilitating the migration.

2.5.3 National Research

One feature of rural-urban interdependence that has received considerable attention in the rural-urban linkage literature is rural-urban migration. Typically, as a country develops, urban economic growth takes place, which entices people to leave the countryside in search of new opportunities in urban areas. Following the economic booms of Japan, South Korea, and lately China and Thailand, rural-urban migration not only improved the well-being of the migrants, but also improved the land-labour ratio in the agricultural sector, enabling non-migrants to raise their labour productivity and income. For example, the increase in land/labour ratios in Japan and South Korea, and more recently in China, was the result of the net flow of rural labour to the urban and rural non-farm sectors.

According to Rajagopalan (2010), migration from rural to urban areas is driven by two factors: education and employment. The facilities for primary, secondary and higher education available in urban India are
incomparably more to those in rural India. To make a fair comparison, however, one would need to focus mainly on literacy and primary education, which are considered necessary for every citizen of the country.

2.5.4 State or Regional Research

Urban populations in India are concentrated in the six most developed states, namely, Maharashtra, Gujarat, Tamil Nadu, Karnataka, West Bengal and Punjab where rates of urbanization remained the same or increased during the 1990s. On the other hand, urbanization rates slowed in the backward states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh (the BIMARU’ states). Overall, there has been a slowing in the growth rate of urban populations from the record level of 3.8 per cent per annum in the 1970s to 3.1 per cent in the 1980s and further to 2.7 per cent in the 1990s, and the slowing has been greater in the smaller towns (Deshingkar 2010).

Analyses of the 2001 National Census and 1999-2000 NSS data show a slowdown in permanent or long-term rural-urban migration rates despite increasing inter-regional inequalities (Kundu 2003). Kundu (2003) has calculated that rural-urban migration has declined by 1.5 percentage points, even allowing for a decline in the fertility rate, increase in urban boundaries and the emergence of new towns.

2.6 PART 2: QUALITY OF LIFE RESEARCH

This review of the literature looks at the meaning of the concept 'quality of life', the use to which it has been put in various branches of social sciences, its meaning in particular, and the instruments already developed for its measurement and their relevance to Quality of Life (QL) Research in India. The review concentrates mainly on the quality of life of people and, in
some much broader contexts, of education, health, livelihoods, hope and happiness.

Quality of life is an active arena for interdisciplinary research, attracting scholars from planning, geography, sociology, political science, economics, and other disciplines. Helburn (1982:445) has asserted that because 'quality of life' as a policy goal is attached to place, it is a goal of which spatial scientists must be cognizant, and to which planners and geographers can make important contributions. Cutter (1985) drew attention to the subject of quality of life in her monograph, ‘Rating Places: A Geographer’s View on Quality of Life’. Awareness of spatial and temporal variations in the quality of life can enable policy makers and planners to monitor changes and to devise more effective policies to address persisting inequalities (Hemmasi 1994, 1995). Numerical and statistical methodology for creating comparative equality of life indexes is still evolving. Techniques for developing composite quality of life indexes include simple rankings of places, calculation of standard scores, scaling methods, and factor or principal components analysis (Dasgupta and Weale 1992, Park 1985, Hall 1984, Tata and Schultz 1988, Stover and Leven 1992, Ram 1982).

2.6.1 The Concept of ‘Quality of Life’

In a fascinating review of the myriad of ideological uses and abuses to which the concept of ‘quality of life’ can be put, Edlund and Tancredi (1985) postulate five different meanings of the term ‘quality of life’. They believe that the meaning is dependent on the user of the term, on his understanding of it and on his position and agenda in the social and political structure. Quality of life can be viewed as fulfilment, the ability to lead a 'normal life', the social usefulness of an individual, from a rational objective point of view, or from the subjective, individualistic point of view. They give examples of the use of the various view points in research and conclude:
It is to be hoped that we have shown that not only are all of these meanings thoroughly different and ideologically distinct, but that their basic assumptions are often obscured and not immediately evident.

The possibilities for other definitions and ideological uses of the phrase ‘quality of life’ are simply endless.

Hornquist (1982) believes that human needs are the foundations of the concept and that quality of life is the degree of need satisfaction. He outlines six spheres of life in which there are needs to be met—physical, psychological, social, activity, marital and structural (that is, in the political field, and in dealings with justice and the authorities).

Berg, Hallauer and Berk (1976) attempted to elicit from 150 health workers the relative importance they placed on 50 abilities or functions. From their position of health, they rated consistently high cognitive, emotional and social functions. The ability to use one's mental abilities, to think clearly, to see, to love and be loved, to make decisions for oneself, to maintain contact with family and friends, to live at home, and to walk, were assigned the largest average values. This chapter makes some interesting points about the relative importance placed on various functions by different individuals, and asks the unanswerable question 'How much is the quality of life reduced when one could no longer climb a mountain if one elected to do so?'. The need to focus on the conceptions of the individual is stressed, to determine what his concerns are and how they relate to his experience of well-being.

Ziller (1974) also favours the phenomenological approach, assuming that quality of life is in the eye of the experience. In an exploration of the concept as it applies to life after coronary artery bypass surgery, Cohen (1982) puts forward the theory that quality of life is based on the capacity of the individual to realize his life plans. He explains that while some elements
are prized by us all, some are prized to a special degree by each patient. He suggests that it would be useful for patients to state, prior to surgery, what changes they hope for, and to ascertain, in follow-up, to what extent their goals are realized.

Andrews (1974) defends the development of perceptual indicators, that is, measures of what people feel, as valid reflections of society's concerns. He addresses their weaknesses pointed to by some commentators and concludes that none of the weaknesses is sufficient to invalidate the development and use of perceptual indicators. He believes that quality of life is the extent to which pleasure and satisfaction characterize human existence. He believes that without data from perceptual measures it becomes difficult to decide which potential objective indicators deserve measurement. Bond and Lader (1974) used visual analogue scales to measure subjective feelings in normal subjects and report on an example of their use. Sackett and colleagues (1977) report on the development of a health index questionnaire designed to measure the social, emotional and physical functions of a population. Campbell (1976) promotes the use of subjective indicators, believing that objective indicators are surrogate indicators.

Liang and Colleagues (1982) criticize the use of objective indicators in rheumatology, taking the measures further away from clinical relevance. They too believe that functional capacity is relative to patients' goals, expectations, priorities, social supports and other factors. They also warn against an obsession with statistical soundness that may cloud the objective of finding measures that are patient-oriented and clinically useful.

Abbey and Andrews (1985) have collected data from 675 respondents. Their results have shown strong support for the hypothesis that psychological concepts relate to perceptions of life quality. Internal control, role performance and social support were important for good quality of life.
Kirshner and Guyatt (1985) make a plea for developing instruments to measure quality of life with a goal clearly in mind, and that the existing instruments should be limited by their suitability for the specific purpose they are being used for. A recent study by McKenzie and colleagues (1986) found that the sickness impact profile (also see Bergner and others, 1981) was unable to detect within-patient improvements and deteriorations accurately, limiting its use for following individuals over time. The classic dilemma of scale assessment is that, since no absolute standard exists, the evaluation of scale performance is always of one scale against another. The recommendation of Anderson and colleagues (1986) is that instruments administered by the interviewer rather than self-administered are necessary for sufficient reliability and validity on the grounds that the latter lead to under-reported dysfunction. This leads us back to the subjective nature of this construct and the question 'who is experiencing the quality of life we are attempting to measure?'

In a review of the current status of quality of life research, Schipper and Levitt (1985) acknowledge that the most difficult phase of evaluating quality of life is defining what is to be measured. They feel that it is most important to understand that quality of life is a continuous variable, an on-going response to events affecting the patient. They identify four central components consistently considered substantive elements of quality of life: (1) physical/occupational function, (2) psychological state, (3) sociability, (4) somatic discomfort — but they are unclear as to the relative importance of each in the overall quality of life. In an earlier paper Schipper (1983) talks of the difficulties of measuring a construct based on the patients’ perspectives, which are emotional and personal. Although with each step out of the laboratory the variables become harder to control, he feels that a gain in relevance is worth a sacrifice in precision. He suggests that:
‘We tread on new and unfamiliar ground. Quality of life studies will force us to come out from the comfort of technological medicine into a world that is less concrete and less controllable, but more human. The relevance and validity of some of our most trusted measures will be reassessed. Out of it we will be better physicians, more sensitive to the vigour, complexity and adaptability of the human soul’.

In their review of studies using quality of life criteria, Najman and Levine (1981) point out that there seems to be little understanding of the association between the objective conditions of life and the subjective perceptions of the patients and that the use of objective indicators alone produces results totally unrelated to the feelings and experiences of the patients studied. Those who use objective indicators alone, they warn, may simply be projecting their own values and priorities on the patients they are studying.

2.6.2 Definitions of Quality of Life

Quality of life has no single uniform definition (O'Boyle 1997). Cummins (1997) summarized 60 quality of life definitions. Hughes and Hwang (1996) have examined 87 studies on what constitutes quality of life and identified 44 definitions. A group of international researchers, who have done primary research on quality of life in the field of intellectual disabilities, developed a consensus related to the conceptualization measurement and application of quality of life (The Special Interest Research Group on Quality of Life 2000). They underscored that the key characteristics of all definitions are:

(a) General feelings of well-being;

(b) Feelings of positive social involvement; and
(c) Opportunities to achieve personal potential.

Many more definitions of and theories concerning quality of life are explained in the literature. Campbell (1976) believes that 'quality of life is a vague and ethereal entity, something that many people talk about but which nobody very clearly knows what to do about', while to Fayos (1981) it is 'the ability of patients to manage their lives as they evaluate it'. Shaw (1977) produces a mathematical equation, stating that:

‘Quality of life (QL) is a product of the patient’s natural endowment (NE) and the efforts made on his behalf by his family (H) and society (S), that is QL = NE x (H + S)’.

William Easterly (1999) brings together, from a variety of sources, 81 indicators of quality of life for the years 1960, 1970, 1980, and 1990 for a large number of countries worldwide. The indicators range across even areas, namely:

- Individual rights and democracy;
- Political instability and war;
- Education;
- Health;
- Transport and communication;
- Inequality across class and gender; and
- ‘Bads’ – indicators of the prevalence of crime, terrorism, pollution, work injuries, and suicide. (The bads are scaled so that a diminution is positively correlated with growth).
This innovative study considers both cross sectional and time series relationships to real GDP per capita of these indicators. Although there is a strong cross sectional association between these indicators and real GDP per capita, the time series relationships are quite mixed.

Easterly (1999) finds that the effect on the indicators of exogenous shifts over time - those due to factors other than economic growth - is quite strong compared with the effect of economic growth. Using three different econometric techniques to assess the role of GDP per capita versus exogenous factors in explaining the change in the various indicators, he concludes that GDP per capita has an impact on quality of life that is significant, positive, and more important than exogenous factors only for from 6 to 32 out of the total of 81 indicators, depending on the technique of analysis.

There are only three of the 81 indicators in all three econometric methodologies ‘for which growth is the primary life-improving and significant determinant: calorie intake, protein intake, and telephones’ (Easterly 1999). Two of the three relate to consumption and the third, to communications density. He concludes that ‘the evidence that life gets better during growth is surprisingly uneven’ (Easterly 1999). A similar conclusion comes from two papers by Charles Kenny (2005a, 2005b) that consider both quantitative and qualitative evidence, limited in range, but extending over a substantially longer time period.

What conclusion emerges from this survey of objective quality of life measures? The answer is that so far as objective indicators of material living levels are concerned, economic growth does raise quality of life. But there are significant ‘bads’ associated with this consumption such as rising pollution and obesity. With regard to where people live, economic growth is clearly responsible for the strong centralization of population in urban places, but whether this is taken as an improvement in quality of life research is
debatable. When it comes to social and political indicators, an examination of historical experience reveals noticeable timing differences in their improvement from that in GDP per capita, and raises serious doubt that economic growth has been the primary factor in quality of life advances in the social and political realms.

One determinant of quality of life, public policy, often plays an important causal role independently of economic growth. A simple illustration is provided by another quality of life indicator, per capita cigarette consumption. In the United States, following the introduction of the cigarette in the late nineteenth century, per capita consumption rose nearly 80-fold from 1900 to the early 1960s. This trend is partly a reflection of rising income associated with income growth, and partly of the impact on consumption of new goods generated by technological advances associated with economic growth. But since its peak in the early 1960s, per capita consumption has steadily declined, and by 2000 consumption was down by one-half from the early 1960s and back to the level prevailing at the start of World War II.

This decline is due to the break through in knowledge that established the adverse effect on health of cigarette smoking, and the dissemination of this knowledge via public health policies and the health industry. Cross sectional data underscore this conclusion. A plot of male adult smoking against GDP per capita does not however reveal a strong positive association across countries. To the naked eye, there is no clear relationship, and a fitted regression reveals a slightly negative, but statistically significant association. This result is because the high income countries are those which have first acted vigorously via public policy to curtail smoking. With this graph, plotted with 1960s data, the more common consumption pattern
prevails, that is, high levels of GDP per capita associated with higher prevalence of smoking.

An implication of the finding above is that bad associated with economic growth - air pollution, obesity, and the like - are amenable to correction with appropriate public policies. But what smoking illustrates more generally is the important role that public policy may play in influencing quality of life. The cigarette experience is a contemporary example of the central role of public policy in promoting health and life expectancy.

The great breakthroughs in health knowledge came with the sanitation movement and validation of the germ theory of disease in the middle and latter half of the nineteenth century. This knowledge led to the development of a new technology for controlling contagious disease, and this technology was very largely implemented by public policy through the establishment of a public health system (Easterlin 2004, Chapters 6, 7). In like manner, the disjunction between the advance of schooling and growth of GDP per capita is a reflection of the important and independent role played by governments in establishing universal schooling. If social and political indicators of quality of life are, at present, positively associated with GDP per capita, it is often because the countries that first implemented the new production technology underlying modern economic growth were also the first to introduce, often via public policy, new advances in knowledge in the social and political realms.

2.6.3 Objective and Subjective Dimensions of Quality of Life

Indeed, researchers have agreed that quality of life is multidimensional and includes both subjective and objective dimensions (Halpem 1993; The Special Interest Research Group on Quality of Life, 2000; Testaand Simonson 1996; Vinayakam and Sekar 2013). Another
international group of researchers (Schalock et al 2002) has adopted Schalock's eight domains and specified sub domains as follows (The Special Interest Research Group on Quality of Life 2000):

- Emotional well-being: safety, stable and predictable environments, positive feedback;
- Interpersonal relations: affiliations, affection, intimacy, friendships, interactions;
- Material well-being: ownership, possessions, employment;
- Personal development: education and facilitation, purposive activities, assistive technology;
- Physical well-being: health care, mobility, wellness, nutrition;
- Self-determination: choices, personal control, decisions, personal goals;
- Social inclusion: natural supports, integrated environments, participation; and
- Rights: privacy, ownership, due process, barrier-free environments.

In general, quality of life has been defined using a combination of both subjectivity and objectivity, which is however controversial (Halpem 1993). This controversy is neither unexpected nor it deserves careful attention, for human beings are rarely objective. Those who argue for the objective conceptualization of quality of life feel that quality of life is the sum of the objectively measurable life conditions experienced by an individual. Their contention is that subjective satisfaction is nothing more than a response to those conditions (Stark and Goldsbury 1990). There are some
others who argue that a person's expressed satisfaction with life is the dispositive criterion as each individual or family differs in what they enjoy, desire from life, or find important (Edgerton 1990; O’Boyle 1997). Some researchers do accommodate both perspectives (Felce 1997; Schalock et al 1989; Stainback and Stainback 1989). Schalock (2000), on the other, has suggested that some domains and indicators (for example, emotional well-being) are more amenable to personal appraisal, while others (for example, material well-being) are not: in other words, they are better suited to objective assessment.

Quality of life embraces multiple dimensions of human experience that affect well-being. It is captured in both objective and subjective dimensions. The objective indicators are those external to the individual and encompass measures of material living and its components, as well as family life, physical and mental health, work, environment, and the like. The measures relate both to circumstances whose increase raises quality of life, such as level of nutrition or life expectancy, and also to bads, like pollutants and crime, whose increase lowers quality of life. Subjective measures, on the other hand, are self-reports of personal wellbeing, as obtained in surveys of happiness, general life satisfaction, prevalence of positive and negative moods, and the like (Easterlin and Angelescu 2007).

2.6.4 Measuring Quality of Life

It is often difficult to measure quality of life. Almost all measurement tools have multiple domains, with multiple items in each domain. A number of measurement methods have been used for assessing quality of life, for example, for persons with disabilities, including surveys and questionnaires (Cummins et al 1994; Ferrans and Powers 1985), interviews (Park 1985; Lehman 1988), vicarious interviews, and vicarious surveys (Ouellette-Kuntz and McCreary 1996). Most other researchers have
put in efforts at involving the persons with disabilities, but they have
depended on a vicarious response. In some tools, parents or siblings were the
major vicarious respondents for the measurement (Becker Diamond and
Sainfort 1993; Ouellette-Kuntz and McCreary 1996).

As individuals are unique, the uniqueness of each individual is at
the heart of how quality of life is measured, especially when they are highly
diverse as well. At the individual level, a prominent measurement
consideration is whether the person has a disability or not. Schalock (2000)
has argued that quality of life for persons with disabilities encompasses the
same indicators that are important to persons without disabilities. On the other
hand, Hatton (1998) has asserted that the experiences of persons with
disabilities are restricted because of the limits imposed by disability
conditions; and the limited experiences do result in different indicators of
quality of life. Hence, specific attention needs to be paid to the uniqueness of
each individual, in conceptualizing and constructing a valid measurement for
quality of life (Borthwick-Duffy 1996).

2.6.5 Migration and Quality of Life

Age at immigration has been a consistent and a most crucial factor
affecting socio-economic well-being, quality of life, and overall life
satisfaction among immigrants in the host country (Angel et al 1999;
Balgopal 1999; Boyd 1991; Gee 1999; Wong 2001). For example, the study
by Angel et al (1999) on Mexican immigrants in the United States has shown
greater economic dependency among those who immigrated after
50 compared with those immigrating at younger ages. Among the factors,
living arrangements and quality of life have received greater attention in

2.6.6 Global Quality of Life Research

Quality of life, as an interest and concern, is a subject of great importance and is exemplified in our current concerns for environment and for benefit-burden ratio in medical treatments (Walter and Shannon 1990). But globally it is an outcome indicator added to social, as well as health, service programme development (DHSS 1989). It has been added to the Worldwide Healthy Cities Programmes and defined as spanning the visual arts, recreation, employment, transport, housing, environmental and conservation issues, health and other indicators of what has been labelled as 'the social temperature'. The Organization for Economic Cooperation and Development (OECD) has agreed on a list of quality of life related social concerns of member states, including health, command over goods and services, employment and quality of working life (Andrews 1973). The salience of quality of life across disciplines has resulted in the recent emergence of generic quality of life questionnaires (Evans and Cope 1993), and quality of life questionnaires for use in health care evaluation (Chubon 1987; Patrick et al 1988; Siegrist et al 1993).

Quality of life research spans a range of topics, from quality of life in the last year of life (Lawton et al 1990) to quality of life in urban environments (Rogerson et al 1989). It has a usage across many disciplines - geography, literature, philosophy, health economics, advertising, health promotion and the medical and social sciences (for example, sociology and psychology). It is multidimensional and, theoretically, incorporates all aspects of an individual's life. It has also been defined as (a) the `output' of the inputs of the physical and the spiritual (Liu 1974); (b) the degree to which a person
accomplishes life goals (Cella and Cherin 1987); and (c) quantified crudely as a formula in which quality of life is a product of one's natural endowment and the effort made on one's behalf by the family and society (Shaw 1977). The meaning of quality of life is thus dependent on the user of the term, his or her understanding of it, and his or her position and agenda in the social and political structure (Edlund and Tancredi 1985).

In non-experiential social indicators research, quality of life encompasses all circumstances of life, for example housing, leisure activities, work, and the environment (Campbell et al 1976; Wingo and Evans 1978; Kaplan, 1993a). Experiential social indicators research on the other includes subjective well-being (Elster and Roemer 1993). There are several meanings of the term ‘quality of life’ in social research, ranging from individual fulfilment to the ability to lead a ‘normal’ life (Edlund and Tancredi 1985; Fowlie and Berkeley 1987). Early on, Dalkey (1972) has first derived a list of quality of life domains from graduate students, and then used the Delphi technique with a panel of people to rework the students' lists. The final list included: novelty (newness, surprise, variety), health (physical well-being, feeling good), dominance (superiority, power, control, aggression), self-respect (self-confidence, self-understanding), challenge (stimulation, competition, ambition), freedom (individuality, spontaneity, unconstrained), comfort (economic well-being, good things, relaxation), affection (love, caring, relating, understanding), security (peace of mind, stability, lack of conflict), achievement (sense of accomplishment, meaningful activity), status (prestige, social recognition, positive feedback) and involvement (participation, concern).

Discussion of quality of life dates back to Plato and Aristotle (Hagerty and colleagues 2004). Within the academic literature, centres of health care field, including nursing, medicine and health promotion (King and
Colleagues 1997; Haas 1999) have been the centres focusing on quality of life studies. Haas (1999) refers to a literature review that identified more than 4,000 articles published about quality of life related to health that were published within the four-year period from 1993 to 1997.

Psychology literature on quality of life forms a large subset of the health literature. Quality of life is also the subject of academic debate in economics, particularly in the related field of happiness studies, a research area shared with psychologists and sociologists. Most of this literature considers the effect of medical interventions on the quality of life, or subjective well-being of individuals or groups of individuals with shared characteristics.

Quality of life and well-being are 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 quality of life of populations (Rapley 2003). 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 quality of life within and between communities, cities, regions and nation states. Major studies of quality of life, for example, have been sponsored by organisations such as UNESCO, the OECD, and the World Health Organization (WHO) (Parmenter and Donelly 1997; Schalock 2004).

Quality of life 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, founded and edited by Alex Michalos. Since then the volume of academic articles concerned with quality of life and well-being issues has steadily increased. Schalock (2004) reports that since 1985 alone over 20,900 academic articles have appeared in the international
literature containing the term “quality of life” in their title. 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 wellbeing.

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. The Scottish team’s literature search (Galloway 2005) produced a final selection of 244 articles, the majority academic but with a significant minority drawn from commissioned consultancy work and reports by public sector agencies.

2.6.7 Rural - Urban Environment and Quality of Life

Urbanization is a positive or negative change in quality of life is debatable. There are analysts who praise the benefits of urban life, such as opera, theatre, and spectator sports that require a large population base to sustain them. But surveys suggest that a fair proportion of urban people would prefer a rural environment (Fuguitt and Zuiches 1975; Fuguitt and Brown 1990). Suburbanization of the 20th century with the advent of motor vehicles is arguably a reflection of this preference to live in a more rural-type of setting. Representative social indicators of quality of life such as life expectancy and education also exhibit a strong cross sectional correlation with GDP per capita.

Life expectancy at birth is the average numbers of years a group of individual’s can expect to live. It is determined by considering a fictitious generation that at every age from birth until the age of the maximum life span has a risk of death observed at that age in the year when the indicator is
calculated. It is often taken as a proxy, more generally for health. The high positive association of life expectancy with GDP per capita, coupled with higher levels of food, clothing, and housing consumption made possible by higher income, leads naturally to the inference that ‘wealthier is healthier’ (Pritchett and Summers 1996). However, increased pollution and adverse dietary changes may also accompany economic growth, raising doubts about the simplistic association of greater health with higher income. Indeed, in the nineteenth century, the concentration of population in cities and towns, induced by modern economic growth, increased exposure to disease (Schofield and Reher 1991). Some experts assert flatly that ‘low mortality for all will not come as an unplanned spinoff from economic growth’ (Caldwell 1986).

### 2.6.8 Health and Quality of Life

Quality of life was introduced by Medline in 1975, and accepted as a concept by Index Medicus in 1977. This was followed by acknowledgement and acceptance by various scientific bodies (Bech 1992). Since the 1970s, however, there has been an explosion of interest in the subject, with an increasing number of citations of quality of life in the medical literature. Both journal and review articles on quality of life now appear regularly in the medical literature (de Haes and van Knippenberg 1985, 1987; Cella and Tulsky 1990; Aaronson et al 1991b). There has also been a proliferation of study groups, conferences and special journal issues (for example, Advances in Nursing Science in 1985; Journal of Chronic Diseases in 1987; Psychotherapy and Psychosomatics in 1990; Medical Care in 1990; Social Science and Medicine in 1995).

It is because health is the most valued state of existence (Rokeach 1973; Kaplan 1993a), and there has been a rapidly expanding literature on health-related quality of life’. Life expectancy at birth in the developed world
has increased over the past 150 years, although most of the increase has taken place during the first half of the 20th century. Expectation of life, and expectations of a morbidity-free life at older ages, has also increased and has led to international attempts at measuring health expectancy (Bone 1992; Robine et al 1992). Debate has also been focusing on health care costs in relation to ‘health gain’ or benefit from the treatments and interventions that are contracted for (Normand and Bowling 1998).

Early empirical social research on quality of life in studies in the United States has estimated well-being, satisfaction or happiness, and what people meant by ‘the good life’ (Gurin et al 1960; Bradburn and Caplowitz 1965; Bradburn 1969). Lawton (1983) was the first to propose a theoretical model of quality of life as ‘the good life’, defined as psychological well-being, perceived quality of life, behavioural competence and the ‘objective’ environment.

Health-related quality of life is patient-based and is therefore subjective but focuses on the impact of a perceived health state on the ability to live a fulfilling life (Bullinger et al 1993). From a health or disease perspective, quality of life has focused on the impact of disease and treatment on disability and daily functioning (Kaplan 1985). As a double-sided concept, it incorporates both positive and negative aspects of well-being and life. It is multi-dimensional, incorporating social, psychological and physical health (Morris et al 1986; Sherwood 1977). Grant and Colleagues (1990) define quality of life as ‘a personal statement of the positivity or negativity of attributes that characterize one’s life’.

In an excellent review of the literature of the quality of life of cancer patients, de Haes and van Knippenberg (1970) conclude that:
• The definition of quality of life is mostly lacking and a wide variety of operationalizations can be discerned;

• Little attention is given to intervening variables, whereas demographic variables have been proved to be associated with the quality of life of the population at large;

• The number of patients in these studies is small;

• The reliability and validity of the instruments is not always evident, and

• Practically no attention is given to theories explaining the origins of the quality of life of patients.

2.6.9 Education and Quality of Life

In most countries, schooling was already well advanced before the take-off into modern economic growth. The contrast with the patterns for life expectancy and fertility is noteworthy. Whereas the demographic indicators for these countries typically lag the onset of modern economic growth, a considerable growth of schooling has occurred in a number of countries before the take-off into economic growth, because the initial expansion of schooling occurred rather slowly. It is noteworthy to see a similarity that the pattern for education shares is common with those for life expectancy and fertility, namely, the advent of rapid improvement in the indicator often does not occur concurrently with that in GDP per capita. For education, the simple association between economic growth and quality of life evident in the cross section is not reproduced in the time series data (de Haes and Knippenperg 1985).
2.6.10 Housing and Basic Infrastructures and Quality of Life

Quality of life embraces material subsistence; as such there can be little doubt that modern economic growth has brought about a major long term improvement, because the food, clothing and shelter available to the average household have risen at rates never before known. A sense of the enormous transformation in material living levels, qualitative as well as quantitative, can be readily obtained from a simple contrast of living conditions in the late-eighteenth-century with the situation today. Everyday life two centuries ago was most akin to what we currently known as ‘camping out’. At that time, among the rural population (95 per cent of the total), housing typically consisted of one-storey houses with one or two rooms and an attic under the rafters. Frequently, there was no flooring except the hard earth. A fireplace with a chimney provided heating and cooking. Toilet facilities consisted of outdoor privies. Water and wood had to be fetched. Transportation consisted of a horse and wagon (Brady 1972; also Lebergott 1993, 1996).

The qualitative change from that world to the United States’ current panoply of consumer goods – cars and planes, electrical appliances and running water, tele-communications and computers, pharmaceuticals and health care, and the phenomenal array of food and clothes – is literally incredible. If quality of life is identified with the amount and kinds of goods available to the average consumer, then there can be little question that economic growth has wrought a phenomenal advance. Writing more than three decades ago about living levels in the United States, economic historian Dorothy Brady (1972: 84) made this point simply and effectively: “Today, the great majority of American families live on a scale that compares well with the way wealthy families lived 200 years ago.”
2.6.11 Economy, Employment, Livelihoods and Quality of Life

Literature relating economic growth to quality of life examines cross sectional (point-of-time) relationships, usually how countries at different levels of real GDP per capita differ in regard to various quality of life indicators, where GDP per capita or a variant thereof is taken as an index of the level of economic development (Easterlin and Angelescu 2007).

Data in these studies relate to recent experience, the past few years, or the latest decade, or at most the last 40 or 50 years. In these cross sectional studies, positive correlations are taken as signifying causal relations between economic growth and quality of life. On the other, a limited set of studies of economic growth and quality of life has been on time series evidence. These studies throw light on the extent to which changes in quality of life accompany the process of modern economic growth (UNDP 2006; Hagerty and Veenhoven 2006).

Higher income allows people to satisfy their needs better and as such consumption is higher in richer countries. This pattern is indeed observed in cross sectional data. From the data for 64 countries, the following quantitative differences in consumption among countries, for individual goods that cover the entire range of goods included in consumption expenditure and GDP, emerge: Per capita consumption in the five richest countries averages 26 times that of the five poorest. In practical terms this translates into economic differences in the necessities of life on the order of 10 fold for food, 25 fold for clothing, and 73 fold for shelter. Differences in food consumption translate into sizeable nutritional differences, as reflected in energy and protein intake, and fruits and vegetables consumption per capita. The difference between rich and poor is even more pronounced further up the pyramid of material needs and the consumption of durables. Radios, cars, and television sets are all much more plentiful in higher income
countries. While cars and TV sets are luxuries in most Third World countries, they are part of everyday life in the richer ones, where the question is often not whether a household owns one but rather how many (Easterlin and Angelecu 2007).

One of the main characteristics of modern economic growth is the introduction of new goods. The consumer durables such as cars, radios, and TV sets were new goods in the first half of the 20th century. Those at the start of the 21st century are cellular phones and the internet. These even newer goods are already becoming common place in developed countries. In poorer areas of the world, however, they are for most persons a thing of the future (Ronald Inglehart 1988: 1203, for a view different from this). Higher income is also accompanied by an increase in the so-called bads, showing that economic growth is not costless. The most prominent bad is pollution. Cross sectional relationships between GDP per capita and carbon dioxide emissions indicate to a high positive correlation. This is hardly surprising given that cars, a salient feature of high-income consumption, are among the main sources of such emissions (Shafik 1994). Holtz-Eakin and Selden (1995) suggest a diminishing marginal propensity to emit carbon dioxide.

The relation between environmental quality and economic growth is U-shaped that environmental quality may deteriorate during a period in which developing countries begin to industrialize, but at some point this deterioration is stopped and reversed as income rises (Portney 2000). Grossman and Kruger (1991) provide some supporting evidence of this U-shape in data on air quality in selected cities in developed and developing countries during the period 1977-88. The flipside of higher food consumption is another bad associated with economic growth: the detrimental diet choices that people in richer countries make is reflected in higher intake of fat. The result is new and growing health problems that these countries are facing,
such as obesity and high blood pressure (Offer 2006; Oswald and Powdthavee 2006). Taken together, there is cross sectional evidence that richer countries lead in the quantity and quality of consumption. The positive impact of greater consumption on quality of life is offset to some extent by negative effects brought about by that consumption, such as new environmental and health problems.

2.6.12 Recreation and Quality of Life

The conclusion is that empirical evidence demonstrating a link between cultural and sporting participation and quality of life/well-being is very thin on the ground.

- Safety and Quality of Life
- Satisfaction with Life Scale
- Hope and Life Quality

2.6.13 Subjective Happiness Scale

Assessments of well-being measure individuals’ happiness or satisfaction with life. For example, the Australian Unity Well-being Index is described as a “barometer of Australians’ satisfaction with their lives, and life in Australia” (Cummins et al 2003). Other researchers suggest that subjective well-being can be measured using self-rating questions about “happiness” and “life satisfaction” (Helliwell and Putnam 2004; Spiro and Bosse 2000:299). Helliwell and Putnam (2004: 1435) distinguish between these two terms, explaining that:

Generally speaking, self-ratings of ‘happiness’ turn out to reflect relatively short-term, situation-dependent (affective) expressions of mood,
whereas self-ratings of ‘life satisfaction’ appear to measure longer-term, more stable (cognitive) evaluations.

Evidence from psychology studies suggests that ratings of life satisfaction/dissatisfaction are a reasonably reliable indicator of how people feel about their lives, providing a good sense of individuals’ subjective well-being (Moum 1996; Sandvik and Seidlitz 1993; Layard 2003). On this basis, economists have generally come to accept life satisfaction as a useful measure of subjective well-being. However economists also accept the evidence from psychology studies that individuals’ expressions of life satisfaction reflect a number of different aspects of their self-perception, related to their life opportunities and outcomes.

2.6.14 Impressions of Quality of Life

In literature, there also exists confusion about what is quality of life, what contributes to it, and what are the outcomes of it (Hagerty et al 2001: 81). Taillefer et al (2003: 295) say that the confusing tendency of some authors results in considering everything a part of quality of life. In practice, however, making this distinction is not straightforward as different authors have arrived at different conclusions:

‘Happiness and a feeling of well-being will also result from QOL. When one rates his or her life as having quality, one will concurrently have a sense of self-esteem and pride regarding his or her life. It must be noted that a confounding scenario seems to be apparent with each of these consequences of quality of life in that each can contribute to, as well as result from quality of life’ (Meeberg 1993: 34)
As a result:

‘This means that in the current debate, there are some factors that exist both inside and outside the concept of QOL’ (Taillefer et al 2003).

How well quality of life and well-being are defined has important policy implications. The quality of life ‘movement’ has been received with wariness and even opposition by the disability campaigners (Keith 2001: 49). Keith and Schalock (2000) argue that quality of life can be used in three ways:

- as a ‘sensitizing notion that provides reference and guidance’;
- as a ‘social construct’; and
- as an ‘organising concept’ or ‘unifying theme’.

Or, in the words of Keith (2001): a systematic framework through which to view work aimed toward improving the lives of individuals.

Quality of life, thus, has a high public profile at times; for example, in regard to legal decisions over medical intervention to save very premature babies who could be profoundly disabled, or in prolonging the lives of people in a persistent vegetative state. In a different policy context, however, a psychological concept of quality of life 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 has brought a greater emphasis on the needs of individuals and the use of quality of life as an indicator of satisfaction with services. Because of the nature of the policy decisions being made, Rapley (2003: 81) argues that there are “serious ethical, conceptual and philosophical difficulties”
involved in studying quality of life, which researchers must take very seriously.

Every realm of public policy-making and service delivery in the developed countries is now influenced by notions of quality of life and wellbeing (Schalock 2000: 116; Schalock 2004: 203). Ager (2002) describes quality of life as: ‘a successful ‘meme’, a concept that has reproduced rapidly in response to conducive environmental conditions’.

2.6.15 Quality of Life Models

In a systematic review of quality of life models, the researchers have identified 3 different types, namely:

1. **Conceptual Model**: A model that specifies dimensions and properties of quality of life - the least sophisticated type of model.

2. **Conceptual Framework**: A model that describes explains or predicts the nature of the directional relationships between elements or dimensions of quality of life.

3. **Theoretical Framework**: A model that includes the structure of the elements and their relationship within a theory that explains these relationships - the most sophisticated type of model (Taillefer et al 2003).

2.7 CONCLUSION

This chapter has reviewed and appraised literature, as part of providing a knowledge and ideational background for the study, in two essential theme areas: migration research and quality of life research. In the
review, the focus has been on international, national and regional (or state) research in both migration and quality of life. In either, there is a good number of researches which give us insights and perspectives on the themes of this research. Particularly, migration to megacities such as Chennai has been a result of push and pull factors: rural people were pushed off their lands because of shortage of jobs and incomes; people from small and big towns were pushed off the urban milieus by the attractions of the big and mega cities; and megacities such as Chennai, due primarily to their industrial developments, including IT and automobile, for example, created jobs which the largely educated from the villages and the small towns could take advantage of, resulting in a continuous migrant stream to the cities. Migration research provides a clear-cut understanding of how rural-urban and urban-urban migrations have resulted in a large number of people concentrating in the cities, making the cities their home where their life and work underwent drastic changes. The perspectives that the studies provide may be summed as that which make the migrants dream about their life and work becoming better than they were back at home (origins).

The quality of life and work focus of the present study is essentially a means of understanding the migrants overall quality of life and overall impressions of quality of life and work as well as a comparison of the conditions now in the city in relation to those ‘before’ coming to the city. And so the review and appraisal of literature on quality of life emphasises the subjective and objective meanings of quality of life, focuses on the measures of quality of life and global, national and regional and local quality of life research; and draws the strands of quality of life in regard to the eight aspects of urban places, namely, rural-urban environment, health, education, housing and basic infrastructures, employment, urban economy, recreation and safety. The literature available to us throws much light on the two themes and makes possible the assembly of ideas and corroborations for the present study.