

# People and Health

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## What quality of life?

The WHOQOL Group

*The present article outlines the development of a questionnaire for assessing the subjective quality of life in health care settings, and explains the relevance of this instrument to treatment decisions, research and the training of health care professionals.*

Work by WHO on the conceptualization and measurement of people's subjective quality of life began in the mid-1980s. This soon led to a project (1,2) on the assessment of quality of life in health care settings, now involving 25 centres globally.

Consultations were held with medical and social scientists representing developing and developed countries, and the views of patients and healthy persons were solicited. Quality of life was defined as individuals' perceptions of their position in life in the context of the culture and value systems where they lived and in relation to their goals, expectations, standards and concerns. It is, of course, coloured by physical health, psychological state, level of independence, social relationships, environmental factors and personal beliefs.

On this subjective basis, a description of a person's quality of life should not reflect the opinions of health professionals or family members. The definition is not concerned with objective measurement of people's condition

or what they possess. Thus, income is not a factor in either absolute or relative terms, but the degree of satisfaction which people feel about their income is taken into account. Similarly, the number of hours which people sleep is not considered, whereas any problems they perceive in connection with their sleep are regarded as matters of consequence.

Assessment of the quality of life should be based on a broad range of criteria, not on a single issue such as pain. Where pain is experienced the quality of life should be assessed by exploring what impact it has on the individual's independence and psychological, social and spiritual life, rather than by focusing exclusively on the pain itself. Clearly, positive aspects of life also have to be taken into consideration.

The centres conducted qualitative research so as to learn how people in different cultures wanted their quality of life to be assessed. There was a remarkable amount of agreement as to the facets and questions thought appropriate in widely varying cultures.

A questionnaire was administered to some 4800 subjects, both men and women, in a variety of health care settings; well subjects were included for purposes of comparison. Analysis of the results made it possible to produce a 100-item core questionnaire, compri-

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**Domains and facets in the instrument for quality of life assessment**

<b>Domains</b>	<b>Facets</b>
Physical	Pain, discomfort Energy, fatigue Sleep, rest
Psychological	Positive feelings Thinking, learning, memory, concentration Self-esteem Bodily image and appearance Negative feelings
Level of independence	Mobility Activities of daily living Dependence on medication or treatments Working capacity
Social relationships	Personal relationships Social support Sexual activity
Environment	Physical safety and security Home environment Financial resources Health and social care: availability and quality Opportunities for acquiring new information and skills Participation in and opportunities for recreation/leisure Physical environment (pollution, noise, traffic, climate) Transport
Spiritual	Spirituality/religion/personal beliefs

sing four questions for each of 24 facets (see table), together with four questions on the overall quality of life and perceived health. This instrument has already been developed at centres in Australia, Croatia, France, India, Israel, Japan, the Netherlands, Panama, the Russian Federation, Spain, Thailand, United Kingdom, USA and Zimbabwe; it is undergoing development in Argentina, Brazil, Canada, China, Germany, Hong Kong, Italy, Norway and Sweden. This is the most cross-culturally valid instrument of its kind. Using the appropriate versions it should be possible to conduct quality of life studies at single or multiple sites.

The indicators of outcome chosen to monitor health care tend to have an influence on how that care comes to be organized. The use of mortality rates tends to drive services in a certain direction. It is hoped that the use of quality of life indicators can encourage a more holistic approach to service delivery – something which is sometimes lacking. Assessment of the quality of life can be used as an outcome measure in research on the relative benefits of different treatment methods. For example, radiotherapy and radical surgery may have equal efficacy against a particular kind of cancer, but if the subjective quality of life of patients is significantly better with one method it should be preferred.

Such assessments can provide a key parameter in cost-benefit studies and can thus contribute towards achieving optimal resource use. In

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general a consideration of the subjective quality of life is likely to lead to an improvement in the quality of health care.

The most important potential application, however, is perhaps in sensitizing health care professionals to look beyond diseases, disabilities and symptoms. The instrument can help to identify the ways in which disease affects people and to find suitable interventions. It can also encourage health care professionals to

focus attention on the positive aspects of people's lives and how they can be strengthened.

A short version of the instrument, containing 26 items, has recently been developed which is more suitable for use in clinical practice and in research where repeated assessments have to be made. It is also intended to produce add-on modules for the assessment of quality of life in specific populations, such as refugees, children, and people with cancer or AIDS. ■

### References

1. **Orley J, Kuken W.** *Quality of life assessment: international perspectives.* Berlin, Springer-Verlag, 1994.
2. **The WHOQOL Group.** The World Health Organization Quality of Life Assessment (WHOQOL): position paper from the World Health Organization. *Social science and medicine*, 1995, **41**: 1403-1409.

## **Palliative care instead of euthanasia**

*With the development of modern methods of palliative care, legalization of voluntary euthanasia is unnecessary. Now that a practicable alternative to death in pain exists, there should be concentrated efforts to implement programmes of palliative care, rather than a yielding to pressure for legal euthanasia.*

- *Cancer pain relief and palliative care.* Report of a WHO Expert Committee. Geneva, World Health Organization, 1990: p. 55 (Technical Report Series, No. 804).