J Behav Health 2013; 2(3):269-278 *ISSN: 2146-8346*

GESDAV

Journal of Behavioral Health

available at www.scopemed.org

Original Research

Wellbeing and correlates of wellbeing: Using maslow's 5 needs hierarchy to evaluate wellbeing

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Received: October 11, 2012

Accepted: February 02, 2013

Published Online: June 26, 2013

DOI: 10.5455/jbh.20130202125320

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Key words: Subjective Psychosocial Wellbeing, Quality of Life; Religiosity, Gender, Race, Education, Subjective Social Class, Bourne's Model, Maslow's Need Hierarchy

Abstract

Introduction: Since the World Health Organization's definition of health in 1948, researchers have continued to search for an Operationalization that is keeping with the holistic definition of health, wellbeing.

Objective. The purposes of the current work are (1) to examine the correlates among some predisposed variables and subjective psychosocial wellbeing (SWB) of Jamaicans, (2) to model factors that influence SWB, (3) to determine the predictability of those selected predisposing conditions on SWB, and (4) to ascertain whether SWB is better proxy of wellbeing than Bourne's Model.

Method. Analysis of the data is by bivariate and multivariate analyses, and it is taken from a nationally representative survey of 1,338 Jamaican adults who are 18 years or over. The survey was conducted between July and August 2006 by the Centre of Leadership and Governance, department of Government, the University of the West Indies, Mona-Jamaica.

Findings. The findings indicate that religiosity is positively correlated with SWB as well as ethnicity, education and social class, with gender being negatively related to SWB. It can be generalized, using multiple regressions, that religiosity, race, gender, education and social class can explain 7.7% of the variance in SWB of Jamaicans. Religiosity is found to be a weak predictor of subjective wellbeing (SWB), (1%), with race contributing 0.4% and gender 0.3% being among the least suppliers to the model.

Conclusion. The utilization of subjective psychosocial wellbeing is not a good evaluation of wellbeing compared to Bourne's Model, which offers an insight into how health must be defined.

INTRODUCTION

Some studies have sought to analyze health from a subjective perspective by way of general personal happiness, self-rated wellbeing, positive moods and emotions, agony, hopelessness, depression, and other psychosocial indicators [1-7]. Despite the importance of quality of life (or wellbeing) to the existence of humans, few scholars in the Caribbean have written on this pivotal issue, such as Powell, Bourne, & Waller [8], Hambleton et al. [9], and Bourne [10]. No Caribbean intelligentsias have examined modeling what constitute subjective wellbeing of people, using Maslow's Needs Satisfaction Hierarchy. Pacione [11] contended that one way of measuring quality of life is using the complex formulation of hierarchy of needs of Maslow has these cover a broader range of individual's domain of satisfaction. However, no study in Caribbean, in particular Jamaica, that has used this approach to proxy wellbeing (or quality of life. Thus, this study fills this gap by modeling subjective psychosocial wellbeing of Jamaicans. The purposes of the current work are (1) to examine the correlates

among some predisposed variables and subjective psychosocial wellbeing (SWB) of Jamaicans, (2) to model factors that influence SWB, (3) to determine the predictability of those selected predisposing conditions on SWB, and (4) to ascertain whether SWB is better proxy of wellbeing than Bourne's Model. Bourne developed a wellbeing model that operationalize wellbeing from economic resources and health conditions [10].

Conceptual Framework

Grossman [12] developed an econometric model that evaluates wellbeing and it is establishes health as a function of many variable. Smith and Kington [13] expanded and modified the Grossman's model, which reads:

$H_t = f\ (H_{t-1}, G_o, B_t, MC_t, ED)$.

In which the H_t – current health in time period t, stock of health (H_{t-1}) in previous period, B_t – smoking and excessive drinking, and good personal health behaviours (including exercise – G_o), M_c,- use of medical care, education of each family member (ED), and all sources of household income (including current income). Grossman model encapsulates biologic conditions, psychologic and socioeconomic factors.

According to Smith & Kington [13], using $H_t = f\ (H_{t-1}, P_m\ G_o, B_t, MC_t\ ED, \bar{A}_t,)$ to conceptualize a theoretical framework for "stock of health" noted that health in period t, Ht, is the result of health preceding this period ($H_{t-1)}$, medical care ($MC_{t)}$, good personal health ($G_{o)}$, the price of medical care (P_m), and bad ones ($B_{t)}$, and a vector of family education (ED), and all sources of household income ($\bar{A}_t$). Embedded in this function is the wellbeing that individual enjoys (or not enjoys)

The concept of health according to the WHO is multifaceted. "Health is state of complete physical, mental and social well, and not merely being the absence of disease or infirmity" [14]. From the WHO's perspective, health status is an indicator of wellbeing [14]. Wellbeing for some, therefore, is a state of happiness – positive feeling status and life *satisfaction,* satisfaction of preferences or desires, health or prosperity of an individual, or positive effects. "When discussing the notion of what makes life good for the individual living that life, it is preferable to use the term 'wellbeing' instead of 'happiness" [15], which explains the rationale for this project utilizing the term *wellbeing* and not *good health.*

METHOD

Design and Sample

The CLGS (Centre for Leadership and Governance Survey) is a national survey that was conducted by the Centre of Leadership and Governance that is within the Department of Government, University of the West Indies, Mona-Jamaica between July and August 2006 [8]. It is a descriptive cross-sectional study, which collect data from noninstitutionalized Jamaicans on their political culture in addition to their perceived psychosocial state. The sample was selected from the fourteen parishes of Jamaica using a multistage area probability sampling approach. Each parish was called a cluster, and each cluster was further classified into urban and rural zones, male and female, and social class. The final sample was then equally randomly selected from the 14 clusters. It has a sample population of 1,338 respondents, with a sampling error of approximately ± 3%, at the 95% confidence level (i.e. CI) [8]. Face-to-face interviews were used to collect the data on an instrument, which took about 90 minutes. The overall response rate was approximately 95%. The results that are presented here are based solely on Jamaicans' opinion of their political orientation. Descriptive statistics will be used to analyze the data.

Measure

Subjective psychosocial well-being (SWB). This is the self-reported psychosocial state of an individual, which include- state of health, feel secure about being able to afford necessities, love, warm, friendship, self-esteem, and self-actualization (Kashdan 2003). The index is constituted by summation the mean of five Likert scale variable ranging from 0 to 10. Using Cronbach alpha for the five-item scale, reliability is determined at 0.841 (or $\alpha = 84\%$).

NB: subjective psychosocial wellbeing = $\Sigma\ SWB_{i,}$

where i represents each individual, and $0 \leq SWBi \leq 10$.

Findings: Results and Analysis

Table 1 presents information on the socio-demographic characteristics of the sampled population. The overall response rate for this survey was 96.9% (n=1,297), of which, 55.7% are females (n=723) compared to 44.3% males (n=574). The average age is 34 years and 11 months ± 13 years and 6-month, Range: 69 years. The majority of the sampled population are middle age people- [ages 26 to 59 years] - 60.5% (n=810), with 33.3% (n=445) being youth (ages less than 26 years) compared to 6.2% (n=83) who are elderly (ages 60 and older).

Table 1. Socio-demographic characteristics of sample, n = 1,297

Count (Percent)	
Gender	
Male	574 (44.3%)
Female	723 (55.7%)
Age	mean age is 34.95 yrs.
	mode age is 19 yrs.
	SD 13.6 yts.
Educational level	
Primary level and below (no formal to - 6 yrs)	60 (4.6%)
Secondary (include all age grades 7 to 9 yrs.)	653 (50.6%)
Vocational (skills training)	239 (18.5%)
Tertiary (include colleges, university - MSc. & BSc).	291 (22.5%)
Professional (Post University education)	4S (3.7%)
Subjective Social Class	
Working class	766 (59.0%)
Middle class	476 (36.6%)
Upper class	57 (4.4%)
Ethnic background	
African, Black	1023 (76.7%)
Mixed (Brown)	178 (13.4%)
European, white	106 (0.8%)
Other	26 (2.0%)
Religiosity	
Never	53 (4.0%)
Less than once per year	72 (5.5%)
Once or twice per year	161 (12.3%)
Several times per year	266 (20.3%)
Once per month	103 (7.9%)
Once per fortnight	69 (5.3%)
Once per week	249 (19.0%)

Multivariate Analysis

To study the relationship between subjective psychosocial wellbeing (SWB) and particular predisposed variables.

Using primary survey data, Table 2 presents the results from the econometric exercise. Of the twelve identified variables, six of them were statistically significant (i.e. $P < 0.05$). **T**he six account for 17% of the variability in SWB (i.e. in that the goodness of fit of the regression is very low – using R-squared coefficient, 0.169 or 16.9%). This indicates that trust together with the sociodemographic variables explains approximately 17% of the variability in subjective psychosocial wellbeing.

Table 2. Regression analysis: Subjective Psychosocial Wellbeing and some explanatory variables

	Unstandardized Coefficients		Standardized Coefficients	95% Confidence Interval	
	B	Std. Error	Beta	Lower Bound	Upper Bound
Constant	6.555	.250		6.065	7.045
Age	.005	.005	.038	-.004	.014
Religion & religiosity	-.045	.027	-.055	-.098	.008
InterTrust	.438	.119	.119***	.205	.671
Governance	-.522	.133	-.128***	-.782	-.262
socialcl1	.677	.123	.183***	.435	.918
socialcl2	.795	.301	.086**	.205	1.385
Sex	.137	.116	.039	-.090	.364
Index of Political Participation	-.043	.016	-.091**	-.075	-.012
Area of Residence	.185	.159	.037	-.127	.498
Race	-.188	.203	-.030	-.587	.210
Trust Gov't	-.015	.206	-.002	-.419	.389
Unemployed	-.930	.189	-.162***	-1.302	-.558
Income	.059	.012	.164***	.034	.083

N=840
R squared = 42.7%
Adjusted R squared = 16.9%
F statistic [13, 826] = 14.15, p value = 0.001 < 0.05
Residual Error = 1.6
*, **, and *** represents a p value < 0.05

Interpersonal trust (i.e. InterTrust) is dummy variable, 1=trust and 0=otherwise
Sex is a dummy variable, 1=males and 0=female
Social support is a dummy variable:
where sociaicl1=middle class, 0=other; where sociaicl2=upper class, 0=other
Referent group being lower class
Trust in government is a dummy variable, 1=Trust, 0=otherwise
Unemployment status is a dummy variable, 1=yes, 0=otherwise
Race is a dummy variable, 1= Caucasian (or white) and 0=otherwise
Area of residence is a dummy variable Kingston and St. Andrew, 0=Otherwise
Governance is a dummy variable, 1=benefits of most equally, 0=otherwise

In this paper we are concerned about a comprehensive measure of wellbeing (or quality of life) and so we used all five-item from the Maslow's needs hierarchy. This was accomplished in the above results. Having established the statistically association between subjective psychosocial wellbeing and some predisposed variables, we wanted to examine the role of the same explanatory variables found above and their influence on perceived health of the individual. This interest became apparent when we observed from decomposing the data (Table 3) that self-reported health status was below the average subjective psychosocial wellbeing.

Table 3: Decomposing Subjective Psychosocial Wellbeing Index

Table 3. Decomposing Subjective Psychosocial Wellbeing Index

Subjective Psychosocial Wellbeing Index category	N	Mean ± Standard deviation
Perception of Health Status	1,315	6.33 ±2.6
Perception of Basic Necessities	1,302	5.75 ±2.7
Perception of Love. Warm, and Friendship	1,311	7.78 ±2.3
Perception of Recognition and respect from other	1,310	7.71 ±2.0
Perception of self-actualization	1,306	6.74 ±2.3
Total - Subjective Psychosocial Wellbeing Index	1,319	6.9 ± 1.7

To study the relationship between self-reported health status and particular predisposed variables (Eqn. [4], and we used multiple regression to estimate the following linear regression (Eqn. [5]). In equation (Eqn.) 5 only the parsimonious variables were in the final model.

$H_i = f\ (R_e, R_a, G, E, S, A, X, PPI, AR, Y_i, U, T_g, Ti, \varepsilon i)$ [Eqn. 4]

where equation 4(i.e. Eqn. 4) is self-reported health status of person i, (i.e. Hi) is a function of religiosity, R_e; race or ethnicity, R_a; Educational attainment of the individual, E; Age, A; self-reported social class, S; sex, X; interpersonal trust Ti; trust in government, T_g,; Political participation, PPI; income of person i, Y_i; area of residence, AR; unemployment, U; sex of respondent i, Xi; governance of the country, G and a residual error, ε_i. From function (2), using the coefficients in Table 4, the result is a linear function (2):

Table 4 presents the results from the econometric exercise. Of the twelve identified variables, six of them influence SWB (i.e. $P < 0.05$). It is observed that interpersonal trust influences self-reported health status of each person. Interpersonal trust was not the only variable this is statistically significant, but so are social class, unemployment status (or employment status), income and perceived governance of the society. Comparatively between the two models, social class, income and interpersonal trust account for more of the model in subjective psychosocial wellbeing (53%) compared to the health status model (40%). Importantly what accounts for this 13% difference are (1) income's contribution to self-reported health status is lower than that of overall subjective psychosocial wellbeing. As income's contribution to latter model is 18%, while it is 10% to former model (i.e. self-reported health status).

Table 4. Regression analysis: Self-reported Health and some explanatory variables

	Unstandardized Coefficients		Standardized Coefficients	95% Confidence Interval for B	
	B	Std. Error	Beta	Lower Bound	Upper Bound
(Constant)	6.218	.400		5.433	7.002
Age on your last birthday	-.013	.007	-.063	-.028	.002
Religion & religiosity	-.002	.043	-.002	-.087	.083
Dummy Trust	.424	.190	.076*	.051	.797
Dummy Governance	-.470	.212	-.076*	-.887	-.054
socialcl1	.739	.197	.132*	.353	1.126
socialcl2	1.163	.481	.083*	.218	2.108
Sex	.534	.185	.099*	.170	.897
Index of Political Participation	-.023	.026	-.033	-.074	.027
Dummy Area of Residence	.324	.256	.043	-.178	.826
Race	-.319	.325	-.033	-.957	.319
Trust Gov't	-.237	.330	-.025	-.884	.410
Unemployed	-.999	.303	-.115*	-1.594	-.404
Income	.050	.020	.091*	.011	.089

N=839
R squared = 9.2%
Adjusted R squared = 7.8%
F statistic [13, 825] = 6.456, p value = 0.001 < 0.05
Residual Error = 2.6
* p value < 0.05

Interpersonal trust (i.e. InterTrust) is dummy variable, 1=trust and 0=otherwise
Sex is a dummy variable, 1=males and 0=female
Social support is a dummy variable:
where sociaicl1=middle class, 0=other; where sociaicl2=upper class, 0=other
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Race is a dummy variable, 1= Caucasian (or white) and 0=otherwise
Area of residence is a dummy variable Kingston and St. Andrew, 0=Otherwise
Governance is a dummy variable, 1=benefits of most equally, 0=otherwise

Limitations to the Model

This model:

$SWB = \alpha + b_1 R_e + b_2 R_a + b_3G + b_4E + b_5S + e_i$ …is a linear function

There fore we are unable to distinguish between (1) the wellbeing of two individuals who have the same typology and (2) wellbeing of an individual that may change over short time intervals that does not affect the gender parameter. As such in attempting to add further tenets to this model in order that it is able to fashion a close approximation of reality, the following modifications are been recommended.

Each individual's wellbeing will be different even if that person's valuation for quality of life is the same as someone else who share similar characteristics. Hence, a variable P representing the individual should be introduced to this model in a parameter α (p). Secondly, an individual's wellbeing is different throughout the course of the year and so **time** is an important factor. Thus, we are proposing the inclusion of a time dependent parameter in the model. Therefore, the general proposition for further studies is that the linear function should incorporate **α (p, t) a parameter depending on the individual and time.**

Another important delimitation of this model is its low explanatory power, and that this can be due to use of five variables compared to Bourne's model (2008) that used some 12 factors. Hence, the use of the psychosocial wellbeing as an evaluate measure to assess wellbeing is inconclusive at this time.

DISCUSSION AND CONCLUSION

One of the rationales for this research is to critique the two paradigm of measuring wellbeing. Paradigm one is to evaluate the subjective assessment of wellbeing and paradigm two Bourne's model that coalesce the subjective and the objective evaluation of quality of life. The current study examines subjective quality of life by way of using Maslow's Need Satisfaction. Some scholars argue that the use of psychosocial needs satisfaction to evaluate quality of life (or wellbeing) should be preferred to any other cosmology as it encapsulates fundamentally all elements of human's existence, and so is closer proximity of quality of life than GDP per capita, self-reported health or happiness [1-5].

An economist writing on 'objective wellbeing' summarized the matter simply by stating that "…one can adopt a mixed approach, in which the satisfaction of subjective preferences is taken as valuable too" [16], which is the premise upon which this paper will adhere in keeping with this multidimensional construct, wellbeing. Camfield [5] in looking at wellbeing from a subjective vantage point notes that Diener [1] argued that subjective wellbeing constitute the existence of positive emotions and the absence of negative ones within a space of general satisfaction with life. According to Camfield [5], Cummins' perspective subsumed 'subjective and objective measures of material wellbeing' along with the absence of illnesses, efficiency, social closeness, security, place in community, and emotional wellbeing, which implies that "life's satisfaction" comprehensively envelopes subjective wellbeing.

Diener [2] in an article titled 'Subjective Wellbeing: The Science of Happiness and a Proposal for a National Index' theorizes that the objectification of wellbeing is embodied within satisfaction of life. From the theorizing of various writers, it is clear that wellbeing is multidimensional, multidisciplinary and multispatial. Some writers emphasize the environmental components of subject matter [11, 17], psychosocial aspect [18] and from a social capital vantage point [19-21].

This study examines the cosmology of Maslow's Needs Satisfaction as a proxy of quality of life and found that Bourne's model is a better evaluative approach than former. Bourne's Model (that coalesce physical functionality with material resources) explanatory power was significantly greater than using Maslow's Needs Satisfaction – that is, an R-squared of 39.3% to that of 16.9% respectively. When Maslow's Needs Satisfaction Index was decomposed and self-reported health status was taken out of the general index, the explanatory power fell to 9.2%. Scholars like Diener, Cummins; Caldwell, and Arthaud-day have argued people know best as to what affect them and this is so, but this cosmology is not comprehensive as they have postulated. Owing to the fact that subjective assessment of wellbeing (or quality of life) omits material resources that are undeniably a fundamental aspect to human's existence. Hence, Bourne's Model is better approach to the evaluation of quality of life rather Maslow's Needs Satisfaction that is still subjective in nature.

Another rationale for this paper is identification of explanatory variables and their single and collective contribution to subjective psychosocial wellbeing. The literature has shown religion or religiosity influences quality of life through positive thinking, social support or restricted social behaviour. From theologians' perspective, spirituality and religiosity are critical components in the lifespan of people. They believe that man (including woman) cannot be whole without religion. With this fundamental concept, theologians theorize that man cannot be happy, lowly depressed or feel comfortable without a balance of spirit and body [38]. In order to acquire a state of personal happiness,

self-reported subjective wellbeing, some pundits forward a construct that people are fashioned in the image of God, which requires some religiosity before man, can be happy or less stressed. Religion is, therefore, according to some scholars is associated to wellbeing [22-24] as well as low mortality [25]. Religion is seen as the opiate of the people from Karl Marx perspective but Theologians, on the other hand, hypothesized that religion is a coping mechanism against unhappiness and stress. According to Kart [26], religious guidelines aid wellbeing in that through restrictive behavioural habits which are health risk such as smoking, drinking of alcohol, and even diet. In this research religion or religiosity did not influence subjective psychosocial wellbeing or self-reported health status. We must forward there that there is a bivariate statistical association between religiosity and subjective psychosocial wellbeing, but when all the explanatory variables are included, religiosity cease to impact on subjective psychosocial wellbeing.

On the issue of sex, the literature extensively looked at this variable and had established that a statistical relation exists between it and quality of life. But, using subjective psychosocial wellbeing we found no statistical difference between the quality of life of males and that of females. However, in respect to self-reported health status there is a sex difference. Men reported a higher subjective health status compared to their female counterparts. What explains this significant difference between being unrelated in subjective psychosocial wellbeing and related in subjective health status?

The World Health Organization [27, 28] forwarded a position that there is a disparity between contracting many diseases and the gender constitution of an individual. One health psychologist, Phillip Rice [29], in concurring with WHO, argued that differences in death and illnesses are the result of differential risks acquired from functions, stress, life styles and 'preventative health practices'.

Biomedical studies showed that there are gender specific diseases. The examples here are prostate cancer (affect only men) and cervical cancer (plague only women). Rice believed that this health difference between the sexes is due to social support. According to Rice [29], this can be explained by epidemiological trends. Lifestyle practices may justify the advantages that women enjoy compared in men concerning health status. However, a survey done by Rudkin found that women have lower levels of wellbeing (i.e. economic) than men [30]. This finding is further sanctioned by Haveman et al [31] whose study reveal that retired men's wellbeing was higher than that of their female counterparts, because men usually received had more material resources, and more retired benefits compared to women ages 65 years and older. Thus with men receiving more than women, and having a more durable possession than women, their material wellbeing is higher is later life.

Females have a high propensity than males to contract particular conditions such as depression, osteoporosis and osteoarthritis [27]. Herzog [32] noted that "…it appears that older women are more likely to be impaired by their health problems, while older men are more likely to die from them." A study that was conducted by Schoen et al. [33] on a group of adolescents reveals something different from that which was reported by WHO [28]. They found that males are more likely than females to feel stressed 'overwhelmed' or 'depressed', and they attributed this to limitedness of men's social networks.

Studies have revealed that the classification of many diseases affect a particular gender. In that, for particular chronic viruses, the primary contributor to death is ischemic heart diseases that substantially are a man rather than a women's disease. In a research conducted jointly by the University of Michigan in the United States and the Bureau of Health Promotion in Taiwan on elderly Taiwanese, between 1989 and 1993, of 4,049 people of 60 years and beyond, a number of socio-economic determinants were studied concerning mortality. From the findings, age is positively related to health conditions, with female, married people, primary level education and post-primary level graduands negatively related to health conditions [34].

Embedded within Zimmer, Martin and Lin's [34] findings are the direct relationship between ageing and health conditions compared to an inversely relationship that exists between health conditions and females, primary and post-primary level graduands and married people. It is clear from the included socio-economic factors mentioned previously that males who are older than sixty-years have a higher propensity to be ill than females. Health conditions, therefore, is influenced by marital status (i.e. married people). This reality represents a situation, where married people are less likely to particular health condition than those who are in common-law, visiting relationships or single. A noteworthy finding is the direct relationship between poverty and health conditions. Embedded within this socio-physical situation is the difficulty of the poor to seeking and afford proper preventive care in comparison to the rich or those in the middle-class, therefore making them vulnerable to poor health conditions.

From the various studies presented, within the socio-demographic reality of longer life for female, there is a paradox in that living longer implies that there is a higher probability of preventative and curative costs of

care. It should be noted here that a study conducted by Franzini et al. [35] on native Mexicans in Texas found that females had worse mental and self-reported health than their male counterparts, but not physical health. Franzine et al's work contravenes many findings on gender and health status. Another study on *socioeconomic determinants of mortality in two Canadian provinces* found that household income and education were significant in predicting mortality. When gender was introduced within the model, the association dissipated [36].

A study conducted by McDonough and Walters [37] revealed that women had a 23 percent higher distress score than men and were more likely to report chronic diseases compared to males (30%). It was found that men believed their health was better (2% higher) than that self-reported by females. McDonough and Walters used data from a longitudinal study named Canadian National Population Health Survey (NPHS). The study was initiated in 1994, and data were collected every second year for a duration of six years. The information was taken form 20,000 household members who were 12 years and older.

A research carried out by a group of economists revealed that "…women are slightly more likely to report higher levels of life satisfaction than men (mean=78.3, compared with 77.1 for men…" [38]. Based on the nature of the study, '…subjective wellbeing and ill being', the reported wellbeing (measure by life satisfaction) of women is higher than that for men but that males have a higher financial wellbeing than females [38]. Thus, the difference in this study owes cultural background of Jamaicans. Males in Jamaica like many African nations are culturalized not show emotions or any sign of weakness, and sickness (or ill-health) is a sign of weak. Thus, males will substantially attend doctors when that is the last resort – i.e. at the critical stage of the dysfunctions oftentimes not before that excess in response to their wives' or girlfriends' insistence.

Within the construct that length of time in unemployment or employment affects quality of life, why was age not statistical significant in this research although the literature suggested otherwise. In the bivariate association (single correlation coefficient table) there was a statistical relation between wellbeing and age, but this disappears on entering the other variables. A part of the justification for the disparity are (1) the proportion of people older than 60 years in the dataset (6.2%, or n=83) and (2) cultural background of the sampled respondents. Some 33% of the sampled population in this study are youth (ages 25 years and younger), and that younger people are less likely to report health matters because they see themselves as invincible and that they place lower importance on health and wellbeing as do men.

CONCLUSION

In summing, the utilization of subjective psychosocial wellbeing (i.e. the linear additive of Maslow's

Needs from the 5-Need Hierarchy) despite the perspective of Michael Pacione that this is a complex

alternative paradigm which captures human's diverse need, this is not a good evaluation of wellbeing compared to Bourne's Model. His model encapsulate material resources and physical

functioning as it former's explanatory power is lower than that offered by Bourne. This is primarily

concerned about (1) identification of variables that are factors of subjective psychosocial wellbeing

of Jamaicans and their explanatory power, and (2) a comparative approach between subjective psychosocial wellbeing and composite wellbeing developed by Bourne. In addition to the discourse

on the models, despite the low predictability of this paper, the current work is a premise upon which

further studies can commence; and that this should be investigated within those factors identified

herein along with those, which were omitted because of the delimitations of the used dataset.

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