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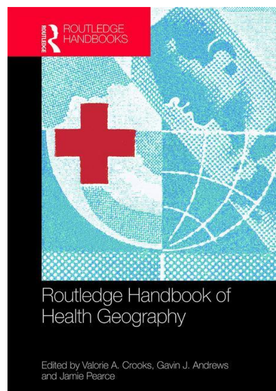

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18

WELL-BEING IN HEALTH GEOGRAPHY

Conceptualizations, contributions and questions

Meryn Severson and Damian Collins

The World Health Organization's definition of "health" as "a state of complete, physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948, p. 100), expanded the concept of health beyond medical matters to encompass a wide range of human experiences. Well-being subsequently became a popular idea with varied applications, coming to be understood as a policy goal, a purchasable commodity, a desirable status and a valuable analytic lens for scholars interested in diverse aspects of health and health care (Fleuret and Atkinson, 2007; MacKian, 2009).

The emergence of the sub-field of health geography in the early 1990s, alongside a broader socioecological turn in conceptualizations of health, led geographers to consider holistic ideas of emotional, social, and physical contentment (Kearns and Andrews, 2010). Concurrently, well-being emerged as a focus in geographical research. However, the term "well-being" itself remained loosely defined and understood, both within and beyond disciplinary boundaries. While we know what well-being is not – it is "not merely the absence of disease or infirmity" (WHO, 1948, p. 100) – what does it consist of? And why is it important?

This chapter seeks to answer both of these questions. In the first section, we outline the varied conceptualizations of well-being in health geography and some of the challenges associated with its application. In the second section, we illustrate the relevance and significance of well-being in health-geography research. We then conclude with questions for future well-being research in health geography.

Conceptualizing well-being

Components of well-being

Fundamentally, the concept of well-being entails a positive focus on various dimensions and experiences that contribute to human potential. The strength of the idea derives from its breadth and holistic nature, encompassing various aspects of quality-of-life, both material and subjective. However, diverse experiences and dimensions of "well-being" make the definition of the term difficult to nail down, as highlighted in Table 18.1:

These definitions focus on the combination of physical health and positive subjective or emotional experience (e.g., happiness, state-of-mind) at the individual level. Several also incorporate material aspects (e.g., prosperity, needs, welfare), which imply a connection to social and economic conditions. These conditions arise partly from the experiences of individuals and households as they engage in economic activity and

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Table 18.1 Select definitions of "well-being" in health geography

Definition
"a good or satisfactory condition of existence; a state characterized by health, happiness, and prosperity. The state of feeling healthy and happy" (MacKian, 2009, p. 235)
"an experienced state of being, in terms of healthiness and happiness" (Kearns and Andrews, 2010, p. 309)
"a longer-term state-of-mind (and body, if not spirit) . . . often regarded as synonymous with quality of life" (Kearns and Andrews, 2010, p. 311)
"a state of positive mental and physical health and welfare, attained or obtained in some way by fulfilling personal needs" (Andrews, Chen and Myers, 2014, p. 214)

perform work in particular places, and partly from larger socioeconomic systems that shape the distribution of opportunities and affluence. These systems play critical roles in the complex mechanisms that give rise to the socioeconomic determinants of health and the uneven distribution of well-being across the population. To the extent that increasing affluence allows for greater satisfaction of needs, it contributes to individual and collective well-being (Fleuret and Atkinson, 2007). However, in some cases it can have detrimental impacts on well-being, as when economic growth is generated through environmental degradation (MacKian, 2009). Additionally, material needs can vary between places, and, as such, the significance of wealth and income is contextual (Fleuret and Atkinson, 2007).

In important respects, quality-of-life is produced and experienced collectively – in terms of both material and interpersonal needs. Adequate income, meaningful employment, social support, and community integration have strong positive effects on health status, as powerfully illustrated by the Whitehall II study of more than 10,000 civil servants working in London, England (Ferrie, 2004). Thus, the concept of well-being necessarily encompasses both personal and collective components; being well is experienced at multiple scales, from the individual, to institutions (e.g., schools and employers) and neighborhoods, to the national state (Kearns and Andrews, 2010; MacKian, 2009).

Dichotomies in well-being

Fleuret and Atkinson (2007) provide three theories for understanding well-being. The *theory of needs* stems from the work of Maslow and the connection between material affluence and well-being. Here well-being is an outcome of consumption, objectively and universally delineated by needs. However, needs are related to context and circumstances, leading to the second approach: *the relative standards theory*. This approach focuses on the contextual components of well-being, positing that "well-being is therefore linked to individual happiness and conditioned by the individual's perception of the context in which he or she is living" (p. 109). However, this approach's focus on the subjective experience neglects consideration of the physical aspects of well-being. A third understanding of well-being is the *theory of capability*, which seeks to integrate the material aspects of the theory of needs with the subjective aspects of relative standards through the idea of capabilities. Capabilities are "a range of attainable and valuable functionings including sets of skills and power" (p. 109). Here, we see a connection between well-being and understandings of health as a resource for everyday life, and a positive set of capacities that enable the fulfillment of human potential (WHO, 2017). However, approaching well-being in this way can be difficult, due to the problem of operationalizing capabilities (Fleuret and Atkinson, 2007).

These three theories illustrate a set of dichotomies that constitute well-being – health and happiness, material aspects and dimensions of human experience, objective and subjective, universal and contextual, and individual and collective. There is a particularly fundamental divide between *subjective well-being*, associated with dimensions of human experiences and context at the individual level, and *general or objective well-being*,

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associated with universality and material aspects at the collective level (MacKian, 2009). However, such tensions do not necessarily detract from the utility of well-being as a concept. Rather, they illustrate the breadth of the term and "the various linkages to a range of domains of human experience" (Kearns and Collins, 2009, p. 27). Additionally, while it is often simpler – for example, in research – to focus on a single aspect of well-being, operationalizing the concept in this way loses sight of its breadth and holistic nature.

Health and well-being

Health geography's focus on well-being reflects a sub-disciplinary move away from a biomedical focus on individual diseased bodies and spaces of medical intervention. At a more epistemological level, it also indicates a rejection of the Cartesian dualism, which separates body and mind. These shifts, combined with a concern for socio-spatial context, mean that well-being is by no means the sole (or even primary) domain of biomedicine (Kearns and Andrews, 2010; MacKian, 2009). From one perspective, a strength of the term "well-being" as a focus for inquiry, and a goal of interventions, is that it is difficult to medicalize due to its breadth and diversity. From another perspective, "well-being" can be understood to imply "a progression away from being ill or impaired [and thus] the natural positive outcome that medical intervention seeks to achieve" (Kearns and Collins, 2009, p. 19). Evading medical capture of the term is, thus, far from assured. This is particularly evident with regard to common ways in which well-being is measured, which often focus on life expectancy, mortality rates and incidence of disease, rather than more positive subjective dimensions, such as contentment, life satisfaction or capability (Fleuret and Atkinson, 2007; Kearns and Collins, 2009).

One tool for addressing this disconnect is the WHO-5 index, which was developed in 1998 to enable measurement of subjective well-being. It consists of a questionnaire with five positively worded statements, including "In the last two weeks, my daily life has been filled with things that interest me" and "I have felt active and vigorous," which respondents are asked to rank on a scale of 0–5. This index helps operationalize positive notions of well-being, at the same time as it reduces inherently subjective experiences and states to numbers. Moreover, it does not include direct questions about social well-being (WHO, 2017). As well-being is conceptualized at multiple scales, it should also be measured at multiple scales, from individual markers of health to indicators of national well-being. Measures of the latter now extend beyond primarily economic indicators such as gross domestic product to include more social and quality-of-life aspects, as in the Human Development Index and the Happy Planet Index (Fleuret and Atkinson, 2007; MacKian, 2009). Thus, operationalizing and measuring well-being continues to be an area for growth.

With respect to operationalization of the term "well-being," the example of the New Public Health movement is instructive. It focuses on enhancing population health by empowering and expecting individuals to take responsibility for their own well-being (Kearns and Collins, 2009). Through emotionally charged and persuasive messages about nutrition, exercise, sun exposure and smoking, for example, well-being is presented as "both a status and feeling, [which] can be achieved through individuals being responsible for and assisting themselves mentally and physically" (Andrews, Chen and Myers, 2014, p. 212). It also links to neoliberalism via the responsibilization of the individual and the associated rise of a well-being industry to enable healthy choices – at least for those who can afford them (MacKian, 2009). In New Public Health, well-being is an inherently political project, one in which hopes and fears, and visions of dystopia and utopia, are operationalized to propel certain actions and preempt possible health harms (Evans, 2010).

So, what can be said about well-being? At its core, the term points to a sense of completeness and balance in varied aspects of life, including the emotional, social, material and physical (MacKian, 2009). It is also the positive sense of having potential and ability within each of these dimensions of human experience (Kearns and Collins, 2009). It is possible to have a sense of well-being while living with a chronic illness or disability (Coleman and Kearns, 2015), and, as such, physical health is not the dominant component of well-being (Kearns and Andrews, 2010). Well-being also implies an embodied experience of *being well*, which is anchored in place and context. Thus, it invites geographic research into the places and spaces of well-being

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(Kearns and Andrews, 2010). In the next section, we explore the significance and influence of well-being in health-geography research.

The significance and influence of well-being in health-geography research

Within health geography, well-being is a significant and influential concept, centered on the place-based resources and experiences that support health and quality-of-life. In this section, we document some of the major contributions of health geography to understandings of well-being, as developed in three areas of research: spaces of well-being; therapeutic landscapes; and emotion, place and well-being. Each of these themes is explored in turn.

Spaces of well-being

The relationship between place and mental and physical health is central to inquiry in health geography (Kearns and Andrews, 2010). Fleuret and Atkinson (2007) identify three key ways in which this focus enables health geographers to contribute to the study of well-being: "a socio-economic focus on spatial and social injustice"; "an environmental approach . . . and the therapeutic virtues of the landscape"; and "a social welfare approach in which the consequences of vulnerability in terms of health and quality of life are studied" (p. 107). Reflecting a broadening of interest beyond institutional sites of medical intervention, health geographers have studied the rise of landscapes of well-being in the context of community and home-based care (Kearns and Collins, 2009). There is increasing recognition of the informal care work and *caringscapes* that contribute to well-being (Kearns and Andrews, 2010). These "spaces of care are therapeutic environments produced by, for, and through the interest of one person in the well-being of another" (DeVerteuil and Evans, 2009, p. 291). They include sites as varied as drop-in centers and homeless shelters, as well as traditional hospital-based settings, provided they offer "refuge, support, and essential resources" (p. 291).

Fleuret and Atkinson (2007) conceptualize spaces of well-being as informed by four other spaces: spaces of capability, integrative spaces, spaces of security and therapeutic spaces. Spaces of capability focus on experiences of well-being and self-fulfillment, which may be hindered by factors such as (dis)ability, aging and stigmatization. Integrative spaces include those domains and experiences with positive links to well-being and health, such as social contacts, while also identifying the processes that produce spatial and social inequalities. Spaces of security include social, spatial and individual supports that contribute to well-being. Lastly, therapeutic spaces, which have been a major focus of well-being research, are those environments that positively contribute to well-being. This four-part conceptualization reflects the multidimensional nature of well-being itself, as well as the way in which it is positioned outside of biomedical knowledge and medical spaces.

Therapeutic landscapes

Therapeutic landscapes positively impact well-being in a myriad of ways, including via stress relief, social connections, security and belonging – an overall sense of restoration and renewal (Duff, 2011). Here, landscapes are understood as "the complex layerings of history, social structure, symbolism, nature, and built environment that converge at particular sites" (Kearns and Collins, 2009, p. 19). Some landscapes – most often those with considerable natural value – are widely understood as enhancing human well-being. For example, bluescapes – which include river, beach and island environments – "are commonly interpreted as possessing restorative benefits since they offer opportunities for stillness, reflection and respite" (Coleman and Kearns, 2015, p. 207). However, as Duff (2011) warns, this idea that there is something innately health-promoting about these natural landscapes contributes to the exclusion of built and urban environments that can contribute to well-being.

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Additionally, the idea that it is the essence of places that is restorative neglects the activity that occurs in those places. Coleman and Kearns (2015) write that "therapeutic experiences cannot be presumed but rather are the product of peoples' diverse and complex relations with place" (p. 206). They support this argument in their study of bluescapes and older adults residing on a New Zealand island, highlighting the ways in which well-being is produced via emotional connections to the water and the island. These emotional connections were also expressed in the complex relations around staying or leaving the island as participants' health declined, with many to choosing to stay because of their sense of connection. Critically, it is "the experience of place rather than the place itself that is generative of well-being" (Coleman and Kearns, 2015, p. 216).

Emotion, affect and well-being

Health geographers' engagements with well-being are increasingly concerned with the emotions and affects generated through human encounters with place. In broad terms, emotions refer to the feelings experienced and expressed by individuals, while affects refer to shared, non-cognitive capacities. Both specific emotions and the more diffuse and collective energies and intensities that constitute affects are routinely mobilized in initiatives to promote forms of well-being (Evans, 2010). However, Andrews, Chen and Myers (2014) contend that well-being should be conceptualized as an affective environment, rather than as the result of a given intervention or the product of experience. From this perspective, well-being is "the environmental action, then feeling of that action, prior to meaning" (p. 219). Under this approach, well-being is temporally short, whereas in previous approaches it was understood as having some endurance or state of being (Kearns and Andrews, 2010).

Affect is dynamic and diverse, changing between people and over time (Duff, 2011). This variability is highlighted in Coleman and Kearns' (2015) analysis of how bluescapes impact aging and well-being, in which participants expressed a deep sense of connection with the water and the island that changed over time and with their experiences. For example, one participant commented how after her husband passed away, the island felt isolating but the water helped with her grief.

Emotions and well-being can also be connected through music and soundscapes. In some instances, this connection is explicit, through lyrical focus on the topic or through support for events like LiveAid. More generally, soundscapes and well-being interact primarily through emotion. For example, the internalization of lyrics and creation of soundscapes "transports [individuals] from their current situation, to help them forget, feel better, and hope" (Kearns and Andrews, 2010, p. 185). Listening to music is often a social event, particularly in the shared experience of attending concerts, which can contribute to feelings of community integration and support and, thus, emotional well-being. The intersection of emotional and health geography offers a particularly rich milieu for investigating the meanings and experiences of well-being in diverse places.

Directions for future research

In this section, we identify three areas for future health-geography research into well-being. First, geographers are already undertaking important work linking the places in which we live and work with the social gradient of health (Kearns and Collins, 2009). Implicit in this research is a recognition that well-being – in terms of overall contentment and quality-of-life beyond satisfaction of basic material needs – is something the relatively privileged can afford to work on. Greater income and wealth often bring with them the time and resources to dedicate to nutrition, exercise, supplements, work-life balance and more (MacKian, 2009). At the same time, neoliberal discourses can place the blame for poor health on individual choices, downplaying or denying the influence of socioeconomic factors (MacKian, 2009). In studying well-being, researchers must continue to highlight the inequalities and inequities that impact well-being at both the individual and

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population levels (Kearns and Andrews, 2010; Kearns and Collins, 2009). This is important, in part, to counteract the individual as the locus of New Public Health imperatives and to inform policy goals of increasing well-being across all sectors of society.

Conceptually, well-being is linked to both happiness and health (MacKian, 2009). However, there are times when these two ideas conflict, and, as such, it is important that there be a "realization that not all that contributes to personal well-being is necessarily good for one's health in a medical sense . . . for example, overtraining [or] taking performance-enhancing drugs" (Kearns and Andrews, 2010, p. 315). Moreover, hedonistic activities, such as drug use, smoking and poor eating, can create at least short-term feelings of contentment and satisfaction, often at the expense of long-term physical and mental health. This creates tension in the idea of well-being. Do these activities produce (genuine) well-being? What separates pleasure from well-being? Moreover, some things that contribute to health, such as physical activity, can in certain instances contribute to negative emotional states. So too can New Public Health campaigns, which are often focused on fear (Evans, 2010) and the private well-being industry that promotes well-being as a consumption-based status (MacKian, 2009). Geographical analyses of well-being need to grapple with these conflicts and tensions and, in so doing, develop further accounts of how health benefits and health risks can be co-present in landscapes and place-based experiences.

Lastly, the term "well-being" is nuanced, complex and difficult to translate and study in different languages (Fleuret and Atkinson, 2007). While the holistic, integrated concept of well-being is relatively new (or rediscovered) in the Western tradition, it has long existed in other traditions, such as among the Maori in New Zealand and Indigenous peoples in Canada (Kearns and Andrews, 2010; Kearns and Collins, 2009). However, under neoliberalism, well-being is increasingly linked to individual responsibility and choices (MacKian, 2009). Given these diverse interpretations and histories, well-being appears as "a relative notion that is socially and culturally constructed and as a result takes on different meanings depending on the context, [which] amounts to stating that the WHO definition of "health" cannot be universal as it is subject to the effects of place" (Fleuret and Atkinson, 2007, p. 111). How can well-being research better account for diverse contexts that influence how the idea itself is understood? How can cross-cultural analyses of well-being be undertaken? Is well-being necessarily a universal goal, as the WHO definition of "health" appears to suggest?

Conclusion

In this chapter, we have reflected on the concept of well-being and its rising prominence in health geography. Well-being is a more complete and broad concept than health, combining varied indicators of quality-of-life and aspects of human experience and connecting multiple disciplines and domains of life. However, issues of definition and measurement remain challenging. Here we see an enduring legacy of the Cartesian dualism: the "divorce in Western rational scientific thinking [between body and mind] that has resulted in subsequent confusion about what well-being is and how to comprehend, measure, or enhance it" (MacKian, 2009, p. 235). Recognition of the impacts of place on physical, emotional and social well-being have given health geographers a prominent position in the study of well-being. Research around therapeutic landscapes and the partial relocation of health care from the hospital to the community and the home invite continued geographic research. While the scholarship around well-being has increased with widespread adoption of the socioecological model of health, there are still areas for additional research, particularly around inequalities, contradictions and context.

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