Sociological Perspectives on the Quality of Life Correlated with the State of Health

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Abstract: The structural transformation of the society is based on changing the quality of life of the population. Scientific and technological development has led to the emergence of a number of elements of post-industrial civilization. The term quality of life refers to the subjective perception of living conditions, being an integration of the perception of the facilities that social progress brings to individuals within society. The article aims to make a synthesis of specialized sociological literature - mainly Romanian - referring to the quality of life correlated with the health status of the population.

Keywords: *Quality of life; well-being; determinants of health; indicators.*

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Introduction

The structural transformation of the society is based on changing the quality of life of the population. Scientific and technological development has led to the emergence of a number of elements of post-industrial civilization. Switching to this type of civilization involves changing the lifestyle. The concept of *quality of life* has emerged through the awareness of the existence of risks generated by the economic model of society (Wakker, 1994). The concept of quality of life has been used in criticizing the contemporary society, which is seen as directed towards exacerbated consumption. The term was launched by A. Schlesinger and K. Gaibraith (De Jouvenel, 1971), and developed by Bertrand de Jouvenel. The term refers to the subjective perception of living conditions, being an integration of the perception of facilities, which social progress brings to individuals in the society (Apostol, 1975: 199).

The concept has been developed to be treated from different perspectives: philosophical, sociological, political, as well as from the perspective of public policy analysis. We have chosen to deal with this topic because of the high level of actuality and the fact that we are interested in the means of evaluating and measuring the satisfaction of life.

The article aims to make a synthesis of specialized sociological literature - mainly Romanian - referring to the quality of life correlated with the health status of the population.

I. Quality of Life

Sociological studies on the quality of life bring together research in disparate areas, to which they provide a gnoseological coherence. In defining the concept of quality of life, it is to be considered a resumption "from another perspective of the concept of happiness" (Zamfir, 1982).

The term *quality of life* was used for the first time in the 1970s, with reference to ecological disasters, ocean pollution, and strictly to the stranding of marine mammals, dolphins and whales. The concept has been developed, being treated from different perspectives, philosophical, sociological, political, as well as of the public policy analysis. Due to the evaluative capacity on the real state of satisfaction with one's own life, the concept has been particularly popular in most social sciences, not just in sociology. In Romanian sociology, a series of studies on the quality of life emerged from the end of the 1970s. If during the communist period the majority represented ideological exercises of communist propaganda, the

group of sociologists gathered around the Institute of Research on Quality of Life within the Romanian Academy allowed, after 1990, for valuable sociological research in the field of quality of life and measuring public policies, especially social and health policies to be conducted.

1.1 Sociological dimensions of the quality of life

The criteria taken into account in the quality of life research highlight the objective conditions that determine the life of an individual, group or community, as well as the way social actors self-assess their living standards from a subjective perspective.

The following dimensions of the quality of life are defined in the literature:

- *emotional well-being* - generally, in measuring this dimension of quality of life, subjective indicators of the quality of life are used: happiness, self-esteem, sense of identity, sense of security, wealth of spiritual life;
- *interpersonal relationships* - which can be measured by subjective indicators, such as: social support, affection, friends and social contacts;
- *material welfare* - measurable by objective indicators: appropriate income, employment, job security, possession of property (movable / immovable), property, proper food and social status;
- *personal affirmation* - measurable by subjective indicators: professional fulfillment and promotion;
- *physical well-being* - in terms of health, quality medical care, physical mobility, adequate nutrition, health insurance, availability of leisure time, pleasant leisure time;
- *independence* - defined as autonomy, the presence of clearly defined values, the ability to make decisions, the possibility of making personal choices, self-control, self-driving in life;
- *ensuring fundamental human rights* - the right to a fair trial, the right to vote, the right to property, privacy, access to education and culture, etc.

From a sociological point of view, the concept of quality of life is an evaluation concept. It does not refer to any class of objects, or social phenomena as descriptive concepts, but to their evaluation. Practically, instead of describing the social phenomena and the mechanisms of their production, the sociology of the quality of life measures how good or bad they are for individuals, and how they are perceived by social actors. In a sociological analysis of the quality of life, it is necessary to take into account its two concepts, and how they are combined in the perception of individuals when referring to their own lives, how the evaluation process takes place, how the various criteria are applied to evaluate the different

components of life. Sociologists distinguish a range of areas in which life can be measured: property, lifestyle, family, work, leisure, participation in social-political life, access to culture. These domains are divided into simpler components, which can then be streamlined into indices and indicators.

The researcher Erik Allardt (Allardt & Uusitalo, 1994) has built a model of welfare dimensions, which has greatly contributed to the development of today's research on the quality of life. Allard conceives welfare as having two major components: the objective observable and the perceived one. The observable objective component has two levels of necessity: fundamental (life standard) and complementary (quality of life).

Welfare	Happiness
1. Possession - income, education, professional activity, health, housing;	4. Attitudes of dissatisfaction - perceived antagonisms, discrimination, unfairly perceived privileges, income satisfaction;
2. Affection-attachment to the community, to family, friendship;	5. Attitudes of satisfaction - perceived happiness, perceived satisfaction of needs.
3. Self-affirmation - individual prestige, political resources, activity;	

Allard conceives welfare as having two major components: the *objective observable* one (welfare) and the *perceived* one (happiness). The observable objective component comprises two levels of necessity: fundamental needs (life standard) and complementary needs (quality of life). He argues that "satisfying needs is simply defined by the material or non-material resources possessed by an individual and centered around the concept of living standards. However, not all needs can be defined based on the possession of material resources. The necessities of love, solidarity, etc. are not defined by material resources, but by the way people connect to each other. Also, the needs of social and political participation, or those representing the universe of alienation, are essential" (Allardt & Uusitalo, 1994: 330).

By the concept of quality of life we understand that the activities, living conditions, relationships, subjective states, etc. relate to these needs (necessities, requirements), human values and aspirations. Human needs, values and aspirations are criteria for assessing the quality of life. As everything related to human being and subjectivity, the needs are not easily defined, measured quantitatively, or satisfied, varying from one individual to another depending on the position he occupies in a social system, individual values or those of the group or society in which it is integrated.

1.2 Quality of Life Indicators

Usually, the quality of life implies the existence of differentiation criteria based on which the quality of life of an individual or community is appreciated. Thus, three levels of indicators are highlighted: economic indicators that allow the codification of the economic conditions of individual or social welfare, social indicators measuring the social conditions of well-being, as well as the proper indicators of the quality of life, dealing with the reactions subjective of people in the face of economic and social phenomena.

Any indicator of the quality of life should be the synthesis of a status indicator and an indicator of assessment criteria, of human needs. Depending on the type of evaluation criteria, we will have absolute or relative quality of life indicators. If the universal evaluation criteria are used, we are talking about absolute indicators. Particular, variable assessment criteria will be related to relative quality of life indicators.

1.3 Social determinants of health-state

In the current sociological literature, two general trends on inequalities in access to health services (Mihăilă, 2006) predominate: the influence of socio-economic status (SES) and the influence of the social environment (Teodorescu, 2011).

1.3.1. Social position as determinant of health-state

The social position is an important factor in the analysis of the quality of life related to the state of health of the population, this determinant including variables such as: age, gender, socio-economic status (educational level, occupation, income). Pop (2010) believes that social status is important factors in determining health, living and working conditions that people can choose, or the opportunity to choose a healthy lifestyle and quality health care services.

1.3.2 Income as a determinant of health-state

Income is a universal factor in determining health inequalities, both at the individual and at the societal level (Pop, 2010). Voicu (2013) highlights the inter-relationship between material well-being and health, highlighting the role of health as an important resource for individual development, enabling participation in the labor market and providing the necessary income to meet the needs" (Pop, 2010).

1.3.3 Education as a social determinant of health-state

The educational level (Precupețu, 2008) influences the life strategies developed by individuals in order to maximize their quality of life implicitly in order to maintain good health (Scripcaru, Damian, Sandu, & Ioan, 2014; Voicu, 2013).

1.3.4. Age as a social determinant of health

Along with aging there is an impairment of health. The lifestyle adopted by a person has an important impact on his / her health:

- through risk behaviors,
- nutrition characteristics, practicing physical exercises,
- the way of spending leisure time,
- stress limitation,
- behaviors to prevent various diseases (Precupețu, 2008).

Health values and attitudes are also significant because the health behavior is being influenced (Zanden & Wilfrid, 1990).

1.3.5 Social Vulnerability

From the perspective of the social determinants of the quality of life, Șoitu, Rebeleanu, and Oprea (2013) state that an individual should not be considered inherently vulnerable, thus being transformed by a number of additional factors, among which are mentioned: "poverty, inadequate housing, receiving services of inferior quality, unjustified legal regulations, manifestations of power and inequality at the level of family, society - including institutions, structures, hierarchies, policies, measures".

Fig. 1: The dynamic relationship between SES and Health

Source: Adler and Stewart (2010)

Four main mechanisms underpinning the status of Economic and Social Status (SES) – health (Teodorescu, 2011):

1. **Differentiated access to health care services** - explains 10% of premature mortality – (Rădoi, Ionescu, & Cojocaru, 2015):

- increased interest from specialists
- although in practice inequalities in access to health care can not be completely eliminated, *social programs* can improve the conditions under which disadvantaged people benefit from better health care (Teodorescu, 2011).

2. **Exposures to the environment** (explains 5% of premature mortality)

- Studies have highlighted the importance that living in toxic, polluted environments has on health;
- Environmentally disadvantaged communities have a lower health level.

3. **Unhealthy behaviors** (contributes to explaining 40% of premature mortality)

- Behavior such as smoking, lack of physical activity, unhealthy food, affects the immune, cardiovascular and respiratory systems, promotes the occurrence of chronic diseases and cancer;
- Unhealthy behaviors are particularly characterized by low SES, influenced by external factors such as access to certain types of food, physical education programs in schools, advertising in the food industry, leisure time activities, etc.

4. **Distinct exposure to stress**

- From the perspective of public health, stress is an external feature, a negative impact event requiring individual adaptation;

- From a psychological point of view: stress is a condition that occurs when the person does not cope with psychological or physical demands, which exceeds his or her own management resources;

- Physiologically: stress corresponds to the state of activation of the sympathetic nervous system or of the hypothalamus-pituitary gland, with effects in changing blood pressure, pulse, skin conductivity, cortisol level;

- Stress may be positive or negative:

□ emphasizes **the role of contextual, group or environmental factors** in which the individual integrates;

□ the **role of the community / neighborhood** that affects health not only through the SES characteristics of the individuals comprised of it - calculated by the average of the income levels, the percentage of the unemployed, the level of education (Damian et al., 2017) etc. -, but also by the

environmental characteristics itself: the presence of supermarkets, vegetable and fruit markets, leisure facilities, sports infrastructure, crime rate ...

□ The concept of "**behavioral justice**" - Adler and Stewart (2010) - refers to the health problems resulting from the differentiated access to the resources needed for healthy behavior due to the characteristics of the residence environments.

Marmot believes that the failure to meet fundamental human needs such as autonomy, empowerment and individual freedom can be causes of precarious health. Increasing the health level can be solved by improving **social and environmental conditions** and promoting **individual control**. Social change, in the sense of increasing freedom, would lead to the reduction of health inequalities by facilitating individual and community involvement in decisions that may affect life (Stiggelbout et al., 1994).

1.4 Objective and subjective indicators of the quality of life

There are substantial differences between the two types of indicators. There is a difference in structure in the first place. The objective indicators refer, according to Elena Cosmina Pop, to the state of life, as well as to the conditions in which life is developed and components of individuals (Pop, 2010). To measure the quality of life, the researcher can use existing social indicators at the community level or create new indicators (Sandu, 2016).

1.5 Quality of life correlated with health-state

In contrast to general quality of life studies, health-related quality of life analyzes the extent to which the health condition and the therapeutic processes influence the state of well-being or maintain it within the limits of a relative normal. Health-related quality of life studies are used in the assessment of health programs, the construction of health policies, but also in current clinical practice. Quality of life indicators are considered less objective than those of morbidity and mortality in the analysis of the effectiveness of health services, but closer to patients' perception of well-being and thus more relevant in measuring the subjective efficiency of health programs and medical health care, especially with regard to people with chronic diseases and in the field of palliative care.

The term health-related quality of life refers to the extent to which significant aspects of personal life are influenced by health and health-related interventions, such as medical care.

The concept of quality of life in health derives from the general one of the quality of life that brings together research on wellbeing, satisfaction,

etc. OMS correlates the quality of life with the way individuals perceive their social situation, relate to cultural values and their own standards and aspirations (WHO, 2008).

The World Health Organization (WHOQOL) identifies 6 areas with 24 dimensions of quality of life, proposing 100 items for health-related quality of life analysis. Thus, we analyze:

- Physical health status, seen as a state of vigour or fatigue, pain or discomfort, sleep, or rest.
- Mental health status, in terms of the personal appearance of the affective, positive or negative state, self-confidence, self-esteem and cognitive abilities: concentration, thinking and learning. Adherence to treatment seems to be correlated with positive affective status.
- Degree of independence analyzed in terms of availability for physical mobility, daily activity, degree of dependence on drugs and medical devices. The dimension of independence can generally be correlated with the value of the degree of social autonomy of the individual.
- The state of social health is viewed as an interpersonal relation to the social support the individual enjoys and the sexual activity that the individual carries out.
- The individual's living environment in terms of financial resources, freedom of movement, housing, work satisfaction, quality and accessibility of medical services, quality of social assistance services, quality of leisure time, education and access to professional training and the quality of the physical environment.
- Quality of spiritual life understood as belonging to religion and religious practices according to one's own preferences (Lupu, 2006).

Figure 2: Conceptual Framework of the Committee on Social Health Determinants

Source: Pop, 2010

Iustin Lupu (2006) analyzes the quality of life in medicine in the form of physical, mental and social well-being and the ability of patients to perform their usual tasks. The assessment of the quality of life and its variations is useful in medical practice to understand the significance of the disease and especially the chronic disease on individuals, and on the other hand to evaluate the effectiveness of the therapeutic act in terms of the effect of the treatment from the point of the patients and of the determination of their needs for physical, mental and social support throughout the period of illness (Lupu, 2006). The author presents among the utilities of studying the quality of life of patients, the possibility of informing him or her about the significance and possible effects of various medical procedures.

1.6 DALY and QALY and the concept of quality of life

In the late 1960s, healthcare specialists developed "cost-utility analysis" using Quality Adjusted Life Years – QALY (Dragomirișteanu, 2017; Miyamoto, 1999; 2000; Miyamoto & Eraker, 1985). The ethical support of "cost-utility analysis stems from classical utilitarianism, namely to produce maximum health gains for the largest number of people" (Toader, 2010). Utility-based judgments result in the calculation of QALY (years of life adjusted for quality of life) or DALY (years of life adjusted for present disabilities), and to maximize benefits or minimize costs for a large number of individuals (Mihăilă, 2006). "In the *cost-utility analysis*, *utility* refers to the value of a particular state of health and can be measured by the preferences of individuals or societies for a particular combination of health levels" (Paveliu, 2013). *Cost-Benefit Analysis* "takes into account the quality of life when comparing costs and consequences, and the measure used is called QALY (quality adjusted life-years)" (Mihăilă, 2006). The **QALY concept** was first used in 1968 in a study of chronic renal failure. **QALY** is a "concept that measures average health status over a year on a scale of 0-1" (Torrance, 1986). A healthy year of life is worth a year, but a year of suffering and poor health is less than 1. Death is considered to be 0 (Dolan, 2000).

"In principle, QALY can have a negative value if a person's quality of life can be considered worse than if he died. Corollary: A therapeutic intervention deserves being beneficial if it generates **positive QALY** and the cost of obtaining **QALY is as low as possible**" (Oprea & Gavrilovici, 2015).

QALY offers a common unit for:

- Evaluating the degree of benefit obtained from a variety of interventions in terms of quality of life for the patient;

- measuring the level of health gain resulting from medical interventions and, when combined with the costs associated with interventions, can be used to assess their relative economic value (Mihăilă, 2006).

QALY is an aggregate index that considers both quantity and quality of life, taking into account the number of years added after an intervention. Each year is given a weighting factor on a scale from 0-zero (death) to 1-one (perfect health) which, in case of a disability, reflects the quality of the added years of life. Perfect health is hard, but not impossible, to define itself. The idea is that there is a worse state of health than death, and that therefore negative values on the health spectrum should be possible (some researchers have included negative values in the calculations). QALY is calculated as the arithmetic product between life expectancy and a measure of quality of life over the years to come. The additional assessment of the quality of life can be achieved by applying questionnaires (Mihăilă, 2006).

The idea of using QALY as a unit of measure of the benefit generated is simple: the time spent in perfect health is weighed against factors corresponding to the real health status.

- For one year of perfect health, 1 QALY is generated, but one year spent in a health condition characterized by factor 0.5 represents the equivalent of one half of QALY (Mihăilă, 2006);

- QALY is primarily used in cost-utility and cost-effectiveness analysis.

For example, in the case of a cost-utility analysis, an intervention that generates 4 years in a health condition characterized by factor 0.75 generates 1 QALY more than an intervention that generates 4 years of health characterized by a factor of 0.5:

Intervention I1: 4 years, 0.75, generates 3 QALY.

Intervention I2: 4 years, 0.50, generates 2 QALY.

The additional QALY generated by Intervention 1 is: 1 QALY.

For cost-utility analysis, the following calculation formula is used:

$$\text{ratio cost utility} = \frac{(\text{cost I1} - \text{cost I2})}{(\text{no QALY generated by I1} - \text{no QALY generated by I2})}$$

Years of life adjusted for disabilities / Potential life years adjusted for incapacity / Dependency-adjusted life expectancy. DALY is a synthetic

indicator that takes into account both the years lost through premature death and the years of life lived in incapacity. A DALY can be seen as a full year of health lost, and the present disability is seen as "the difference between the current health status of the patient and an ideal status in which he would live up to an advanced age with no illness" (*Health gap*). ***DALYs is a loss and consequently the value of the indicator has to be minimized*** (Anand, 2004; Arnesen & Norheim, 2011; Fox-Rushby & Hanson, 2001; Kamm, 2004).

The concept was "developed in 1993 by the *World Bank and the Harvard School of Public Health*" (Mihăilă, 2006) as a method of estimating the overall burden of the disease and as a result indicator in cost-effectiveness (Vanhook, as cited in Mihăilă, 2006) analyzes. The burden of the disease is calculated as the sum of all DALYs values attributable to premature mortality. A year of 1000 healthy people has the same value (expressed in DALY) as a year of life:

- 9524 people with tetraplegia,
- 2660 blind people,
- 1686 people with Down syndrome without cardiac malformation,
- 1499 people suffering from deafness.

While DALYs are a loss and consequently must be minimized, QALYs is a gain and must be maximized. In the DALY approach, years represent disabilities weighted on a scale of 0 (no disability) to 1 (death). In the QALY approach, scale values are reversed: the weighted quality of life (also called utility) equal to 1 means a perfect state of health, while the value 0 is synonymous with death.

II. Measuring the Quality of Life

II.1. The Human Development Index (HDI - United Nations)

The Human Development Index is a standardized questionnaire focusing on the most significant aspects of human well-being. The three dimensions of HDI analysis are health, expressed by life expectancy at birth, education, expressed through the average of adult education years, living standard, expressed in gross national income. For each field a composite annual index is calculated, aggregated based on the geometric mean of the scores obtained at each of the indicators.

Figure 3. HDI Components

Source: Toader, Iancu, and Olteanu, 2017

The HDI index of 2015 classifies countries into four major categories:

- a) very high (HDI value ranging from 0.944 to 0.802),
- b) high (HDI ranging from 0.798 to 0.702),
- c) average (HDI value between 0.698 and 0.555),
- d) low (HDI value varies between 0.548 and 0.348).

In this ranking, the first places are occupied by Norway, Australia and Switzerland, and the last places are the Central African Republic and Niger.

Figure 4. Ranking according to HDI scores, based on figures for 2014

Source: Toader et al., 2017: 11

In 2015, Romania was classified as a country with "high human development" and ranked 52 of the 188 countries that were analyzed. In this ranking, Romania surpasses Bulgaria, but ranks behind Hungary, Poland and the Czech Republic, which fall into the category "very high human development" (Toader, Iancu, & Olteanu, 2017: 11).

Figure 5. Evolution of the HDI score for Romania

Source: Toader et. al., 2017: 11

II.2 Global happiness report

The World Happiness Report - WHR (Sustainable Development Solutions Network)

The report of global happiness was based on both quantitative indicators, statistical indicators taken from national reports and opinion polls, respectively.

The specific analysis was made on the basis of six variables, both objective and subjective, as follows:

- GDP per capita;
- Life expectancy at birth;
- Social assistance;
- Freedom to make choices in life;
- Generosity;
- Perception of corruption (Toader et al., 2017: 12).

According to the 2016 report, Denmark, Switzerland and Iceland ranked first, while Syria and Burundi were at the top of the list. Romania ranks 71 of the 157 analyzed countries. Romania has a score of 5,528, occupying a better position than Hungary and Bulgaria.

Figure 6. WHR score, average 2013-2015

Source: Toader et al., 2017

II.3 The Legatum Prosperity Index - LPI (Legatum Institute)

The Prosperity Index is a composite index based on nine sub-indices, which concern:

- Economic quality;
- Business environment;
- Governance;
- Education;
- The health;
- Safety and security;
- Personal Freedom;
- Social capital;
- The natural environment (introduced in 2016).

Romania ranks 50th out of 149 evaluated countries.

Figure 7. LPI score 2016

Source: Toader et al., 2017

In this index, Romania is on an upward trend, compared to 2001-2002. However, there has been a fall in 2010-2011 and a recovery since 2012.

Figure 8. LPI: Evolution of Romania's score

Source: Toader et al., 2017

II.4 The Happy Planet Index - HPI (New Economics Foundation)

The Happy Planet Index combines four elements, in order to highlight how people in different countries use environmental resources for a long, happy life (Toader et al., 2017: 14). HPI develops a welfare measurement mechanism based on sustainability indicators.

The HPI report of 2016 includes "objective (quantitative) but also subjective (qualitative) components" (Toader et al., 2017: 14) such as:

- The level of living experienced;
- Life expectancy;
- Inequality of results;
- Environmental footprint.

Figure 9. Ranking according to HPI scores

Source: Toader et al., 2017

The particularities of this index are represented by the introduction of the ecological footprint as a determinant of the sustainability index. Due to this factor, countries such as Luxembourg, with a high life expectancy and high living standard, but with a negative environmental footprint, occupy a penultimate place in the ranking. Romania ranks 55th out of 140 countries.

Figure 10. Romania's position in various reports measuring well-being

Source: Toader et al., 2017

II.5 Instruments for measuring the quality of life in relation to the state of health

One of the most common tools for health-related quality of life research is the SF 36 Health Survey, which is presented as a questionnaire addressing 8 dimensions of quality of life: physical functionality, limitations in the exercise of social roles due to health problems, physical pain, social

functioning, mental health status correlated with psychological stress and well-being from a psycho-social point of view, limitation of social roles due to emotional problems, vitality expressed as energy or fatigue, and general perception of health (Ware, as cited in Toader et al., 2017).

The tool measures the quality of life in both objective, physical dimension, as well as the subjective and psychological dimensions, allowing for correlations between the two. The tool has been translated and adapted to countries such as Japan, China, etc.

In our country, the instrument was applied to transplant patients, hemodialysis, renal failure aneurics (Sinescu et al., 2008), in the postoperative patient's quality of life study (Hartog, Dur, Tuinebreijer, & Kreis, 2009: 15). Sinescu et al. (2008: 7) show that SF 36 can be used to monitor patients with different pathological conditions and compare them with the status of the majority population.

The identification of deviations from the majority population scores highlights the specificity of the disease, while the proximity to the majority of the population scores highlights the effectiveness of the medical intervention.

These studies have highlighted the applicability of the instrument on the patients in chronic or terminal conditions. Between 1990-200, the SF 36 survey was calibrated for Romania by the Center of Urban and Regional Sociology, Course for patients with chronic kidney failure. The evaluation of the quality of life would measure the success of the therapeutic intervention. Barbara Resnick and collaborators (nursearling.com) uses the SF 36 instrument as a starting point in measuring the success of the therapeutic intervention and the medical act.

The authors start from the idea that unlike the health-state, the Health Related Quality of Life (HRQL) is an individual and subjective interpretation on the state of health and its impact on the individual's life, especially in terminal and chronic conditions that, while not restoring health, maintain the best state of health. The indicators of the quality of life may successfully highlight the efficiency of the therapeutic act and care which, while not restoring the health-state, it maintains a good social functioning state of accepting the individual condition and the subjective satisfaction over life.

Studies on the correlation between autonomy and the quality of life analyse the correlation between the informed choice and the dignity of the patient within palliative care, the relationship between family care and self-care, the needs and the quality of life of patients under family care.

Special emphasis is placed on the relationship between self-management and quality of life (Gibson, Beatty, Wang, & Cummings, 1995; Toader et al., 2017: 15) in the literature. The authors emphasize the importance of therapeutic education and patient involvement in self-care and the self-management of chronic illness and its correlations between increasing autonomy and quality of life for the individual.

The ability to express the informed consent is dependent on the degree of information, experience, education, culture, credits, mental health-state, level of intelligence, affecting the capacity to discern through medication, disease associated stress, chronic or terminal conditions, pain and resistance to pain.

All these dimensions of autonomy are at the same time indicators of the quality of the individual's life, thus considering the tests or questionnaires that measure the quality of life and which include these indicators as effective and in estimating the probability of an autonomous behavior, correlated with a real informed consent.

The indicators of the quality of life in SF 36 which can be correlated with the state of social and functional autonomy, are:

- the ability to perform current activities indicates functional autonomy in the sense of independence from external care;
- the mobility of the limbs increases the patient's dependence on the context of care.

There are evaluated indicators such as:

- extremity mobility;
- the ability to dress, put on shoes, sit and lift from the chair, to more complex activities such as phone use, shopping, etc.

The social functioning of the individual is correlated with indicators such as: number of social interactions the individual takes part in, including relationships with friends, family, the community, religious life.

The increased social interaction capacity of the individual enables him / her to have more freedom of choice as regards his / her own care, and at the same time a social and cultural mediation of the decisions to his / her own condition.

III. Quality of Life Related to Mental and Emotional Health

Diminishing mental capacity or altering it by the effect of illness, pain or therapy influences the ability of the decision on one's own state of health and the understanding of the condition they are in, and on the therapeutic alternatives.

The negative emotional state interferes with the capacity of the subject to make decisions questioning the authenticity of these decisions.

Conclusions

The concept of quality of life was developed by sociologists and economists, being treated from different perspectives such as philosophical, sociological, political, as well as the analysis of public policies. The term refers to the subjective perception of living conditions, being an integration of the perception on the facilities, that the social progress brings to the individuals in the society. If during the communist period most of the queries regarding the quality of life represented ideological exercises of communist propaganda, thanks to the group of sociologists gathered around the Institute of Research on Quality of Life within the Romanian Academy, especially Elena and Cătălin Zamfir (Zamfir, 1982, 1984), to carry out valuable scienological research on the quality of life and the measurement of public policies, especially social and health policies. The criteria taken into account in the quality of life research highlight the objective conditions that determine the life of an individual, group or community, as well as the way in which social actors self-assess their living standards from a subjective perspective.

In terms of quality of life, Romania, according to research conducted by the Institute for Research on Quality of Life (ICCV), Romania has been classified as "high human development" and occupies the 52nd place of the 188 countries that have been analyzed. In terms of *global happiness*, starting from indicators such as per capita GDP, hope of birth, freedom to make allegations for one's own life, but also the perception of corruption, Romania ranks 71 out of 157 analyzed countries. Romania has a score of 5,528, occupying a better position than Hungary and Bulgaria. Regarding the prosperity index, Romania ranks 50th out of 149 evaluated countries. Romania ranks 55th out of 140 countries in terms of subjective happiness, by reference to indicators such as the level of living experienced, the inequality of results, the environmental footprint, etc.

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