How to Value a Life Without Limits:

Quantifying Suffering With Quality-Adjusted Life-Years in Social Anxiety Disorder

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In this issue of JCP, Patel et al[1] examine comorbidity and health-related quality of life (HRQOL) among those with social anxiety disorder (SAD) using a nationally representative survey. The authors used survey-weighted regression analyses to determine significant factors associated with quality of life among those with SAD, finding multiple significant associated comorbid psychiatric disorders. The authors also found specific feared situations in SAD, which were negatively associated with HRQOL. The authors highlight the importance of considering comorbid (or multimorbid) conditions in the treatment of SAD and hope that their work may inform future clinical care and psychiatric epidemiologic research. The authors' work opens a platform for a much broader comparison of human suffering attributable to psychiatric disorders, a platform which with further research may allow better comparison to disorders outside of psychiatric illness. This can be accomplished through the use of quality-adjusted life-years (QALYs), a metric which can help psychiatrists and other clinicians better understand the impact of our work across specialties while placing a patient-centered value on our clinical care.

QALYs are the most commonly used measure of health-adjusted life-years and are often used in assessing the cost-effectiveness of health care interventions.[2] One QALY represents a year lived in a state of perfect health. One's HRQOL, as noted in Patel et al's article,[1] takes into account both self-reported physical and mental disability through survey data; this patient-reported disability can readily be translated to QALYs through measure-specific conversions to determine years of quality-adjusted lifespan lost to illness or gained through definitive treatment in a given patient.[3] Converting diseases to quality-adjusted lifespan effects in this way is useful because it allows the characterization of disability and burden of disease across a variety of conditions, both psychiatric and medical, as reported previously elsewhere.[4,5] This characterization gives physicians 3 incredible abilities: (1) the ability to benchmark the suffering associated with a condition, (2) the ability to compare degrees of human suffering across different conditions, and (3) the ability to quantify how our care improves patients' lives.

In psychiatry, where experiences are difficult to quantify yet impairments are often profound, the QALY is a particularly important tool. The QALY allows psychiatric clinicians to highlight that the opioid use disorder we treat reduces our patients' quality of life over 2 times as much as their diabetes (−0.16 vs −0.06 QALYs per year).[4,6] It shows that generalized anxiety disorders (GADs) and major depressive disorder (−0.10 QALYs per year and −0.09 QALYs per year), while not quite as severe as opioid use disorder, are associated with over twice as much suffering in our patients than their obesity (−0.04 QALYs per year).[7,8] Psychiatric illnesses, which are often chronic, are associated with an incredible amount of suffering. Yet psychiatrists provide the equally incredible abilities to mitigate this suffering through clinically validated pharmacologic and nonpharmacologic interventions; further work is needed to illustrate that scaled to the incredible benefits we can provide to our patients, psychiatric services receive comparatively little government funding.

Inquiry into the effect of anxiety disorders on quality of life is not new.[9] There is sufficient literature available to allow meta-analysis of HRQOL in anxiety disorders,[10] including individual components of quality-of-life scores. Of these anxiety disorders, SAD may be associated with relatively more severe long-term disability than other types of anxiety disorders.[11] More recent research, such as Patel et al's work in this issue,[1] has added nuance to our understanding of HRQOL in those with anxiety disorders, highlighting the role of concomitant contributors such as psychiatric comorbidities to quality of life in anxiety disorders, with an eye toward treatment of these concomitant conditions.[12,13] Other work[14] highlighting treatment as a differentiator of quality of life in those meeting criteria for psychiatric disorders could be easily applied to those with GAD, even within the same dataset that Patel et al used. A uniting feature of this past work is a focus on just 1 (benchmarking and characterization) of the 3 main abilities QALYs can give clinicians.

While recent work on HRQOL in psychiatric disorders has delineated

specific predictors of quality of life, a return to the roots of the concept may yield particularly impactful future research across the fields. Specifically, comparing degrees of human suffering across different conditions, net of standardized sociodemographic factors may be useful in highlighting the benefit of psychiatry to the health care system and society more broadly. Treating oftentimes smoldering and stigmatized mental illnesses is how psychiatrists provide value to society, value largely captured by patients, caregivers, and other societal stakeholders rather than health systems as reimbursements for psychiatrists lag, and psychiatry is seen as a "money loser" by health care leaders.[15,16] The ability to quantify how much our care improves patients' lives gives psychiatry a concrete *raison d'etre*, an ability to attract the additional attention and funding we clinicians need. In a society that places substantial value on reducing human suffering, psychiatry's patient-centered effects, quantified in the QALYs we help give back to our patients, may be the best way we have to articulate our value.[17]

QALYs have several notable limitations that we would be remiss without mentioning. In particular, as an averaged measure, they cannot capture the substantial variation in the lives of those with persistent and chronic disabilities and do not capture the full spectrum of human suffering.[18] This claim made by detractors is no small part of why QALYs have recently been proposed to be banned from use in determining US federal payment for health care, and the National Institutes of Health has funded development of next-generation measures of HRQOL[19]; other countries, most notably the United Kingdom, have continued to embrace QALYs and consequently have emerged as leaders in psychiatry for cost-effectiveness research as their health care systems face budgetary shortfalls.[20,21] QALYs cannot capture all the value we provide, especially beyond our patients and to society at large. Finally, as a patient-centered metric, QALYs do not take into account systemic benefits to treatment, including increased employment and engagement with society, reduced burden on the health care system, and reduced reliance on downstream services, all of which are even more difficult to quantify than subjective HRQOL.

It is undoubtedly reductionist to simplify human suffering to numbers; these numbers, however, can help us make better decisions for our patients. QALYs, while flawed, are the least bad widely used measure we have to quantify both the human suffering we seek to alleviate and how the value we provide to our patients compares to our colleagues in adjacent medical and surgical fields. This measure is a valuable tool to justify why the work we do each day providing psychiatric care is so needed, particularly as clinical budgets are squeezed in the pursuit of ever-greater efficiency in health care. In a field often defined by heterogeneity and limited biomarkers of disease, this quantification helps us define our value to patients and society. Future work is needed to better quantify the impact psychiatrists have on the communities we serve.

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