Module:
Mental Health in the Community

Week 3
The epidemiology and burdens of mental disorder

Topic 2
The burden of mental ill-health for the individual – Part 2 of 2

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Lecture transcript

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I'm going to go on to talk about some concepts which are, essentially, about how we measure the impact of illness, disease, disorder, on the individual and on society, as a whole. And these concepts are quality of life, health-related quality of life, QALYs and DALYs. And I'll go on to explain these in a little bit more detail in a moment.

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So, what's quality of life? Quality of life, Centres for Disease Control tell us is, 'A broad multidimensional concept that usually includes subjective evaluations of both positive and negative aspects of life... [A]lthough the term 'quality of life' has meaning for nearly everyone and every academic discipline, individuals, and groups can define it differently... [H]ealth is one of the important domains of overall quality of life, there are other domains as well - for instance, jobs, housing, schools, the neighbourhood. Aspects of culture, values, and spirituality are also key aspects of overall quality of life that adds to the complexity of its measurement.'

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How do we approach quality of life? I, myself, and a colleague, Jerome Carson, have identified six approaches to quality of life, broad approaches.

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The first is the objective indicators approach, and that relates to income, living conditions, access to resources, and participation in occupational and social roles. So that, for example, we can look at people with a diagnosis of mental disorder, and look at their income, where they live, what sort of resources they get, and their participation in occupation, social roles. And we can see they're all significantly impacted in people with a mental disorder diagnosis.

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The second approach is needs satisfaction. Now that's based on Maslow's hierarchy of needs, from the most basic human needs - food, sex - to higher order needs, such as self-actualisation (which, I think, means that the highest quality of life is found on a beach in California).

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The next approach is subjective well-being, and that can be measured, either in terms of current hedonic state (my happiness), or reflect overall life satisfaction and satisfaction within particular life domains.

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The next construct is psychological well-being. That includes ideas such as moral, self-esteem, self-efficacy, and a sense of autonomy and control.

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Another approach is that of the capabilities approach, which was developed by the welfare economist, Amartya Sen. And this focuses on what people are actually able to do in order to achieve outcomes that they value. In this model, poverty, ignorance, and oppression result in capability deprivation.

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The final construct is so-called health-related quality of life.

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So what's health related quality of life? One definition is, 'A person's subjective perception of the impact of health status, including disease and treatment, on physical, psychological, and social functioning and well-being'. The English National Institute for Health and Care Excellence provides an alternative definition. So health-related quality of life is, 'a combination of a person's physical, mental, and social well-being'.

Other well-recognised measures of health-related quality of life, are notably the SF-36 and the EQ-5D, though neither, incidentally, is great at assessing the impact of mental illness on one's life. Health-related quality of life's an important construct, partly, because medicines regulators require evidence of impact on health-related quality of life before licensing new medications.

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Now another important idea is the Quality-adjusted Life Year, or QALY. This is a measure of the value of health interventions. And it's calculated by multiplying survival in life years with the utility associated with a particular health state. So full health rates as 1, and death rates as 0.

Given appropriate outcome and cost data of an intervention, for example, a hip replacement or coronary bypass operation, in terms of QALYs and the cost of the intervention per QALY gained can be calculated. In principle, one could choose to do X instead of Y because X provided more QALYs per unit cost than overall ambition to use scarce resources to maximise health gain. So would you get more bangs for your buck by doing hip replacements or coronary bypass operations? In practice, NICE uses a cost per QALY of about £30,000 as a cutoff for approving an intervention as cost effective.

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Now an allied construct is the Disability-adjusted Life Year, and that joins together 'years lived with disability', which is calculated by the prevalence of a disorder times the disability weight for a condition, with 'years of lost life' (impact premature mortality). So disability-adjusted life years are the years of lost life plus the years of lost disability. The disability weight is the conceptual opposite of utility. So perfect health gives a weight of nil (0). Extreme ill health, a weight of one.

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If we look at the economic aspects of mental disorder, we can look at it from the perspective of the individual. So poverty, reliance on the state or families, subsistence in housing, potentially avoidable distress, pain and suffering, which, in principle, could be monetised, and stigma. For society, conventionally, we think about the treatment care costs, social security costs, and costs due to lost productivity.