

Opinion

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## **The Quality Adjusted Life Year: A Social Technology**

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In every OECD nation, alarm bells are ringing that the costs of welfare services, only just affordable now, will force retrenchments of current commitments as the proportion of the aged creeps toward 15 percent of total population.

This demographic fact, a consequence of lowered birth rate and increased longevity is a menace so serious that it has been identified as a “crisis” of the one remaining legitimate form of the industrial society. Fascism, and lately socialism, have been discredited because they are repressive. The welfare state, though not a utopia, nevertheless maintains a floor of decency and humanity that extends, at least in principle, to all. But what will happen if the minimum needs cannot be met?

The Quality Adjusted Life Year (QALY) holds out some promise of resolving this dreaded conflict in the most costly of welfare services, health. It is a comprehensive system that its advocates claim resolves the many conflicts of values between users, payers, and providers.

Payers – insurers, the insured, and governments - have been placing more and more pressure against higher costs by demanding that providers show that services are cost-effective. Prior to the development of QALY, providers were frustrated by the absence of data for evaluating probable outcomes of a contemplated treatment regimen. They now have in QALY a management tool enabling them to anticipate the impact of medical care on the patient’s health; health itself has been quantified as a measure of the quality of life that the patient may enjoy thanks to the treatment. This evaluation process is called “outcomes management”.

Outcomes management is a technology of patient experience designed to help patients, payers, and providers make rational choices based on comparative data about the effect of treatment choices on the patient’s life. The unifying concept of outcomes management is the measurement of physical and mental functioning, and patient well-being, which together comprise “quality of life”. QALY advocates believe that they have a uniform, objective set of life measures is psychometric instruments such as the Sickness Impact Profile and Index of Well-being.

The concept of an objective measure of quality of life is breath-taking. Of course we make estimates of this sort constantly, but by our estimates express fleeting impressions or a basket of prejudices, some unconscious. The prevailing “metrics” of life quality hitherto have been art, religion, and philosophy, which express the intangible aspects of human existence. The judgment on these efforts by Objective

Science is long since in: they are one and all expressive of subjective states; the same goes for all value judgments. Thus it is very big news, of Nobel dimensions, that Objective Science has discovered an objective measure of the intangible. It is even bigger news that this measure is obtained by aggregating and comparing questionnaire scores – that humble instrument in the armamentarium of sociologists, market researchers, and psychologists.

These questionnaires present several dozen questions about the patient's mood states, dependency, mobility, mental functioning and social engagement. The closer the respondent's answers approach nil value, or a negative state in the case of moods, the lower the respondent's life quality ranking will be. One wonders: do the authors of these questionnaires really believe that their own perception of life quality can be encompassed by such a survey? Will patients give truthful answers when they become aware that the questionnaire is a scaling device that will be used to decide whether or not they receive treatment? Are truthful answers valid for patients who may respond during an episode of sickness depression? How would a Mahler or Nietzsche, who were tormented by illness all their adult lives, respond to such a questionnaire? Would they refer the interrogator to their creative works, in which their nuanced appreciation of the quality of life is expressed? What calculus of life's pleasures can be assigned to the intellectually handicapped and the chronically mentally ill?

QALY's psychometrics applies market research or consumer choice psychology to life and death decisions. Its function as a social technology is to entrench in public policy the concept that the value of life can be objectively graded on a numerical scale; and to use the objectivity so obtained to ration medical services. But unlike market research, where respondents are free not to participate, these questionnaires are administered in the medical context. Patients know that they are expected to cooperate, and that means accepting the quiet but palpable intimidation of medical authority. Thus they are not free to reject the invasion of privacy they these questionnaires represent, nor even free to reject the threat to themselves that the use of questionnaire results may pose.

Consumer health groups are likely to black ban QALY as yet another step in the attempted medicalisation of social problems. In the United States, public mistrust of medicine is so wide-spread that medical practitioners commonly feel themselves to be in a state of siege. In Germany, a watershed of public vigilance was reached in the recent controversy over euthanasia.

QALY experts tout it as a "powerful tool" for resolving, objectively and fairly, the many "dilemmas" of modern medicine. But if as they contend values are subjective,

then the implementation of the measurement of life values as the criterion for resource allocation is also a subjective choice and is accordingly trapped in the inherent contentiousness of values. By highlighting competition for scarce resources, QALY may achieve the opposite of what is intended. One would not be surprised if it proves to be more socially divisive than abortion and more damaging to doctor-patient relations than malpractice.