EDITORIAL

Quality of Life Rediscovered: Implications for Clinical Outcome and Health Economics in Schizophrenia

Quality of life has emerged, over the past 2 decades, as an attractive and powerful concept that reflects a new image of health viewed from a biopsychosocial perspective. The concept has been applied as an important attribute in patient care, in clinical evaluative studies, and in health economic analyses. Although no one knows the exact origins of the idea of quality of life, the concept seems to have developed in the postwar era, reflecting the enhanced standard of living that accompanied economic prosperity in many Western societies following the end of the Second World War. These developments led to higher expectations, which included psychological fulfillment, happiness, satisfaction, and well-being (Awad and others 1997a). Such a broad concept of quality of life includes many issues related to health but also such nonhealth-related elements as employment, environment, and other life situations intended to make it useful as a health outcome. To be useful in medicine, the idea was narrowed to focus mostly on health-related quality of life.

In psychiatry and the mental health field, quality of life, particularly in schizophrenia, started as an extension of increased concerns about the plight of the chronically mentally ill who were discharged to the community as the result of deinstitutionalization in the 1960s (Lehman and others 1986). Because the community was ill-prepared for such an exodus from psychiatric hospitals, the living conditions of many discharged psychiatric patients deteriorated remarkably. Personal safety, poverty, social isolation, and many socioeconomic issues became major concerns and led to increased emphasis on the study of the quality of life of discharged psychiatric patients. Although initial studies were limited in scope and concerned themselves with the development of measurement techniques to identify patients' needs in the community, the concept was influential in attracting attention to the plight of chronic psychiatric patients living in the community. Unfortunately, during the late 1970s and early 1980s, such heightened interest was not sustained as it was in other areas of medicine, for example, cancer and arthritis. Several factors may have contributed to the diminished interest: lack of agreement on a definition of quality of life, lack of adequate conceptual models, questions about the reliability of patients' self-reports, and a scarcity of standardized measures appropriate for schizophrenia.

More recently, the notion of the quality of life of psychiatric patients was rediscovered and has quickly gained prominence in psychiatric practice. Many factors may have contributed to such a revival of interest (Awad 1995). Chronic illnesses are replacing life-threatening conditions, so the cost of care has become an increasingly important concern. Recent economic constraints and efforts to contain medical costs have also led administrators to seize the idea of quality of life as a tool in the redistribution of resources by comparing the outcomes of therapies and programs. While evidence-based outcomes in medicine have been steadily growing as a new movement, the recent rise in consumerism has forced a redistribution of the health care decision-making authority, with families and patient groups pressing for more participation in decisions about health care and having a clear expectation of better therapies. With the recent accelerated development of new psychiatric medications, specifically antidepressants and antipsychotics, the acquisition cost, which reflects the high cost of new drug development programs, has become a major economic concern.

The requirement to prove the cost-benefit of new antipsychotics has focused attention on the need for valid and reliable measures of quality of life of medicated patients with schizophrenia, as well as on the incorporation of the concept into health economic evaluations (Revicki and Luce 1995). Unfortunately, such heightened interest in quality of life has not been matched by focused research efforts to define the concept, its boundaries, its major determinants, or its important clinical correlates (Awad and others 1997b). Very little research has been directed toward exploring such basic issues, since more interest has been directed toward its application and its measurement. Important and basic issues that still require clarification include: Whose assessment of quality of life is relevant? Can we rely on our patients' self-reports? Are global ratings of quality of life sufficient? Can

they replace multidimensional measures that are generally more complex and require more time to complete? How will we meaningfully integrate quality of life assessments in pharmacoeconomic studies?

In this context, the papers in this issue, written by some of the most active researchers in the field, make a major contribution toward the clarification of the concept of quality of life and its application. The dedication of this issue of the *Journal of Psychiatry & Neuroscience* to topics on quality of life is a testament to the growth of the quality of life movement, highlighting the recent expanded interest in and underscoring the importance of the concept. It is expected that, over the next few years, the number of publications on quality of life will increase significantly. To ensure the quality of reports on this topic, authors and editors of journals need to adhere to certain standards of reporting. Authors need to include the definition of quality of life as applied in their studies. Reports have to state the rationale for choosing a particular quality of life scale and provide information about its psychometrics. Further, reports need to identify whether patients' self-reports have been included (Gill and Feinstein 1994).

Campbell and others (1976) wrote, "quality of life is a vague and ethereal entity, something that many people talk about, and which nobody clearly knows what to do about" (p 117). Since then, I believe the concept of quality of life has certainly made significant inroads in clinical practice, although we still need more emphasis on shifting our traditional conceptual approach from symptom improvement to the improved functional status of the individual. What matters in the end is how our patients not only feel but also function on medications. Unless a good deal of basic research can help to refine the concept and its measurement, however, all the present enthusiasm may fade away as a passing trend. If we allow this to happen, it would be a missed opportunity, since at last the concept of quality of life has provided a common language, which is relevant and easily understood by all professionals across disciplines and orientations, by patients and their families, by economists, by administrators, and even by politicians.

REFERENCES

Awad AG. 1995. Quality of life issues in medicated schizophrenics: therapeutic and research implications. In: Shriqui C, Nasrallah H, editors. Contemporary issues in the treatment of schizophrenia. Washington (DC): American Psychiatric Press; p 735–47.

Awad AG, Voruganti LNP, Heslegrave RJ. 1997a. Measuring quality of life in patients with schizophrenia. PharmacoEconomics 11:32–47.

Awad AG, Voruganti LNP, Heslegrave RJ. 1997b. A conceptual model of quality of life in schizophrenia: description and preliminary clinical validation. Quality of Life Research 6:21–6.

Campbell A, Converse PE, Rogers WL. 1976. Subjective measures of well-being. Am Psychology 31:117–24.

Gill TM, Feinstein AR. 1994. A critical appraisal of the quality of quality of life measurements. JAMA 272:619–27.

Lehman A, Possidente S, Hawker F. 1986. The quality of life of chronic patients in state hospital and in community residences. Hosp Community Psychiatry 37:901–7.

Revicki DA, Luce BR. 1995. Methods of pharmacoeconomic evaluation of new medical treatments in psychiatry. Psychopharmacol Bull 31:57–65.

Dr A George Awad, MB, BCh, PhD, FRCPC
Director, Psychopharmacology Program
University of Toronto
Toronto, Ontario, Canada