

Editorial

Massimo Moscarelli, MD Agnes Rupp, Ph.D.

The articles in this issue consider a modeling-based approach for reducing the burden of depression (**Andrews *et al.***, page 175), cost and outcomes in terms of antidepressants and continuity for depressed patients receiving antidepressant therapy (**Dobrez *et al.***, page 187), the contribution of psychiatric health toward explaining differences in post-service civilian wages, and the hours worked and employment probabilities among male veterans (**Savoca and Rosenheck**, page 199) and the consequences of state parity legislation in the US for psychiatric care (**Sturm**, page 209). This last article has stimulated a Commentary by **Zuvekas** (page 215).

Andrews *et al.* (page 175), present an approach for modelling, on the basis of epidemiological and service-use data on depression, the burden currently averted from current care for depression, the burden that is potentially avertable from an hypothetical regimen of optimal care and the cost/effectiveness of both current and optimal services for depression. This approach is aimed at informing the process of priority setting when resource allocation for depression is considered.

This issue stems from the claimed persistence of the burden of depression while a number of efficacious treatments (such as drug treatment, psychotherapy, ECT) are available, at least in the affluent world. The authors quote the 1999 Australian National Survey on Mental Health and Wellbeing indicating that it did not suggest that the burden of depression is decreasing, at least according to 1990 data.

Depression in the Australian environment is used by the authors as an example to illustrate a method whereby epidemiological and service use data can be related to the reduction in Disability Adjusted Life Years (DALY). DALY is the measure introduced by the World Bank/WHO study of the global burden of diseases, which estimates the years of healthy life lost by summing premature death and living with disability.

This measure is aimed at informing priority setting for resources allocation; its conceptual background refers to the analysis of individuals, groups and society utilities and preferences. Mental health professionals are expected to appreciate the difference between this measure and the psychiatric measures currently in use by physicians for evaluating mental disabilities. While the aim of psychiatric disability measures is to determine the various severity levels of disability, the aim of utility measures such as

DALY is to determinate, through various techniques, utility values assigned by individuals, groups or society to various severity levels of disability. This exercise is aimed at enabling the assignment of an economic value to the utility lost because of the illness (and to the utility of treatment that is able to reverse the loss, totally or in part).

The study obtains data on the services use and treatment outcome from a variety of secondary sources, including the Australian National Survey on Mental Health and Wellbeing, and on the efficacy of individual treatments from published meta-analyses. The direct costs were estimated from published sources.

The same procedure is used to model a hypothetical scenario of the maximum burden avertable from optimal care (a hypothetical population management strategy for depression for present coverage, to estimate the gains possible if all those already in contact with the health system received efficacious treatment). The cost-effectiveness scenarios of current and optimal services for depression are explored.

The study by **Dobrez *et al.*** (page 187) considers the cost and outcomes in terms of antidepressant-continuity for depressed patients receiving antidepressant therapy. The frequently recurrent nature of depression has suggested longer lengths of treatment in the acute phase and continuing antidepressant medication for some time after full remission of symptoms and the authors focus on an intermediate outcome: patients' tolerance and compliance with the medication regimen for a specified length of time. In addition to medical choice of antidepressants (TCA and SSRI) the authors consider other variables which may have an impact on the length of therapy, such as the initial site of care, the prescription by psychiatrists or non-psychiatrists, and the combination of drug treatment and psychotherapy. They may determine various cost/effectiveness scenarios in the care of depression.

The observational study uses retrospective claims of private health insurance database to identify if SSRIs as a first-line treatment for major depression may decrease patient's charges and maintain continuous therapy better than using TCA. The impact of both site of care and concurrent psychotherapy are analysed. The authors claim that SSRI substantially reduces the incidence of patients discontinuing pharmacotherapy while leaving charges largely unchanged. The initial provider specialty is not found relevant to the continuity of pharmacotherapy and the concurrent

psychotherapy creates a trade-off through reduced pharmacotherapy interruption with higher costs. The authors expect that further research on provider choice, concurrent psychotherapy and drug choice is needed to provide additional information on the effects of treatment choices on the cost/effectiveness of depression care.

The study by **Savoca and Rosenheck** (page 199) analyses the civilian labor market experiences of veterans in the US, and focuses on the impact of psychiatric health on employment and wage determination. The study uses the National Survey of the Vietnam Generation, a survey completed in the late 1980s of persons who were on active duty in the years of Vietnam War, 1964–1975. Three variable outcomes are considered: hourly wage rate, usual hours worked per week and whether subject is currently working.

Lifetime diagnoses of major depression, anxiety, substance abuse/dependence and posttraumatic stress disorder (PTSD) were constructed from the US NIMH Diagnostic Interview Schedule, administered by the survey. A distinction between veterans exposure to combat or to a low level of war zone stress is underlined, since among the latter the prevalence rates of mental disorders are similar to the estimates derived from the Epidemiological Catchment Area (ECA) study for the general population. Although one quarter of the veterans in the sample were exposed to high levels of war-zone stress, only those among them who also met diagnostic criteria for psychiatric disorders were at serious disadvantage in the civilian labor market.

The authors claim that all four types of psychiatric disorders have significant negative effects on the probability of employment and a diagnosis of combat-related PTSD significantly reduces both the likelihood of working and the hourly rate of pay.

The Sturm article (page 209) focuses on the exploration of the impact of state parity legislation, regarding the private insurance market in the US, enacted in 1996. The legislation was aimed at providing a parity of access to mental health services of the insured population equal to the access available to non-psychiatric medical services. At present, 26 states have passed the legislation.

The author claims that the debate among those who supported it (emphasising that those mandates are intended to bring the mentally ill back into the private insurance system) and those who opposed it (arguing that indirect consequences such as employers terminating insurance coverage in response to increased costs) was based on limited scientific information and old data. It did not enable a proper analysis of the legislation's impact on cost and utilization consequences due to parity enactment.

The study analyses national survey data from 1996–1998 and focuses on patients with mental illnesses to evaluate how their insurance status, insurance generosity and their perception of access to care have changed. Changes in these variables are contrasted between states with and without parity legislation. Three variables are analysed: change of insurance status, change in coverage, and change in access to get good health care when needed.

The author, reporting that the effects of state parity on the above variables are not significant (a slight number of mentally ill report improved insurance generosity and access to care, but there was also a higher number of mentally ill losing all insurance coverage in parity states), emphasises that while this study is far from being a conclusive evaluation, little research is still available to inform policy debates. The issue of the consequences of parity legislation in the US has stimulated a Commentary by **Zuvekas** (page 215).