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Ode from the literature

Is it worth enhancing depression care in primary care?

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Affiliation?????

My Director of Finance asked me: Is there any benefit, in cost effectiveness, in enhancing the care of patients with depression in primary care? Surely the money would be better spent on something more concrete than the 'worried well'.

A quick answer from one paper. Enhancing the care of depression is known to be effective. It appears as one of the 'National Enhanced Services' in the new GP contract in the UK (nGMS). Various 'Local Enhanced Services' have also begun to appear around the country, as modifications to this. But is it all worthwhile?

This paper looks at the cost effectiveness of enhancing the care for depression, over a two year period. Twelve practices were examined, they were randomised to provide standard or enhanced care, using practice nurses to provide regularly scheduled care management over 24 months.

Two hundred and eleven adults, newly diagnosed with depression, were studied (73.4% of the eligible patients). Outcomes included blinded estimates of days free of depression impairment over two years, as well as health care costs over two years.

The enhanced care model used incorporated chronic disease management principles. The 'enhanced' teams were given brief training to provide acute and continuation phase treatment of patients suffering with major depression (as judged by DSM-III-R) criteria. The training emphasised regular scheduled contacts to encourage treatment (psycho- and pharmaco-therapy) uptake and adherence, to adjust treatment if needed, and to discontinue treatment when appropriate.

Enhanced care significantly increased the number of days free of depression impairment, compared to usual care (647.6 compared to 588.2 days, $P < 0.01$).

The incremental cost effectiveness ratio for enhanced care ranged from $9592 to $14 306 per quality adjusted life year (QALY). This compares very favourably with the quoted costs of smoking cessation (>$8000 per QALY), hypertension pharmacotherapy (>$14 000 per QALY), hypercholesterolaemia pharmacotherapy (>$18 000 per QALY), COPD reahabilitation (>$36 000 per QALY), or screening for depression (>$45 000 per QALY).

The number of incremental days free of depression impairment increased between the first and second year (23.0 vs 36.4, respectively, $P < 0.001$).

The incremental health plan costs decreased significantly between the first and second year ($568 vs –$12, $P < 0.001$).

How much can I trust this, the director asked? The level of evidence is 2b. (Individual cohort study or low quality randomised trials <80% follow up.)

Executive Summary for the stressed director. Treating depression along chronic disease management lines, using an enhanced model of primary care results in significant patient benefits. Furthermore it is very cost effective. PCT's and commissioners should consider making this one of their priorities for implementation. Go for it, this is a very good way to spend the NHS's money!

REFERENCE

1 Rost K, Pyne JM, Dickinson LM and LoSasso AT. Cost-Effectiveness of Enhancing Primary Care Depression Management on an Ongoing Basis. *Annals of Family Medicine* 2005;3:7–14.

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