

The Controversy Of Increased Spending For Antidepressants

These drugs are a highly visible target for drug industry critics and for analysts trying to explain increased overall health spending.

BY THOMAS W. CROGHAN

MOST OF THE PAST DECADE has been characterized by moderating growth in health care spending, enough so that health insurance premiums paid by employers declined between 1997 and 1998.¹ Analysts have traced this moderation in spending growth to the rise of various forms of managed care, a mechanism that mitigates incentives for overuse of health care services through capitation payment, utilization controls, and contracts for discounted services.² In the early 1990s many believed that the “managed care effect” would also apply to pharmaceuticals. Spending on pharmaceuticals has grown faster than that for other health spending components, however, with annual growth of about 24 percent between 1996 and 1999 for persons with generous pharmacy benefits.³ This rise in drug spending has drawn special attention from payers, purchasers, and policymakers.⁴

Antidepressant medications provide an excellent case study of the broader issue of drug spending, for a number of reasons.⁵ Depressive disorders are common, affecting 5–10 percent of Americans each year, and they are costly in terms of both direct expenditures for medical care and social burden.⁶ After thirty years of little innovation, treatment for depressive disorders has changed dramatically over the past twelve years. New treatments, such as the selective serotonin reuptake inhibitors (SSRIs) and brief psychotherapy, offer depressed persons choices for effective treatment. For example, at least eight new antidepressants have been approved for use in the United States since 1987, and more are in the pipeline.

There is now evidence that much of the increase in spending for

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antidepressants is due to rising utilization. Antidepressant prices have not increased considerably more than have other medical prices, and there has not been extensive substitution of new, expensive drugs for older, cheaper ones.⁷ Furthermore, the number of new treatment episodes has increased, as has the length of treatment.⁸ This increase in utilization raises important questions regarding the necessity and appropriateness of that use.

Policy analysts have suggested several reasons why increased use of antidepressants may include considerable amounts of unnecessary use. A decade ago, antidepressant prescribing was largely confined to psychiatrists; in the SSRI era, most are prescribed by generalists with much less training and comfort in the diagnosis of mental disorders.⁹ More Americans have some form of prescription drug coverage, a benefit associated with rising drug utilization.¹⁰ The increase in coverage raises the problem of “moral hazard” in which individuals demand more drugs than necessary when they don’t have to pay their full price. Drug advertising may accentuate the moral hazard problem by further inducing inappropriate demand and pressure on primary care physicians.

Despite these factors, there is also solid evidence that depressive disorders remain undertreated in the United States. The National Depressive and Manic-Depressive Association Consensus Statement on the Undertreatment of Depression concludes that one-third of persons with major depression fail to seek treatment and that only one in ten receive adequate treatment.¹¹ If the U.S. Surgeon General’s conservative estimate that 6.5 percent of Americans ages eighteen to fifty-four experience an episode of major depression each year is correct, then more than 8.5 million persons can expect inadequate care and increased risk for continued symptoms, functional disability, and symptom relapse.¹²

Thus, we are left with the difficult challenge of containing costs while getting treatment to those truly in need. In addressing this challenge, we must recognize that overuse of antidepressants by those who do not need them can coexist with undertreatment. However, the desire for cost containment has resulted in a focus on the issue of overuse, largely ignoring the equally important issue of undertreatment. Putting these two issues into a more balanced perspective, however, should result in policy prescriptions that are less likely to exacerbate the problem of undertreatment than is the case with options now being considered.

Cosmetic Psychotropics For The Worried Well?

Those who believe that antidepressants are used too frequently raise two issues relevant to questions about appropriate use. First, they

contend that many or most antidepressant recipients have minor mood disorders or seek lifestyle enhancements for conditions that are not serious enough to require medication or other treatment. This concern must be addressed by the answers to two interrelated questions. First, what are the appropriate uses of antidepressants? Second, are antidepressants used only for those conditions in which there is sufficient evidence to justify their use?

■ **Appropriate use.** Evidence for the appropriate uses of antidepressants comes from the clinical trial literature, but it is far from complete. Although there are other uses for antidepressants, including treatment of bulimia and obsessive-compulsive disorder, the concern regarding overuse focuses on depressive and anxiety disorders. Most agree that antidepressants are effective treatments for major depressive disorder and double depression, the episodic and chronic variants of depressive disorders characterized by very intense symptoms. The psychiatric literature suggests response rates of about 50–60 percent, with placebo response rates of 20–30 percent.¹³ However, the magnitude of treatment resistance and high placebo response rates have led some to conclude that there is little valid evidence for antidepressants' effectiveness, even in major depressive disorder, a view that remains unsubstantiated in the opinion of the psychiatric community.¹⁴

A major limitation in our knowledge results from the relative paucity of treatment studies of other mood disorders, such as dysthymia, minor depression, and anxiety disorders. Dysthymia and minor depression, forms of depression characterized by less intense symptoms, are associated with significant physical, social, and role disability, often worse than that associated with physical illness and major depressive disorder.¹⁵ However, the impact of antidepressant treatments on these outcomes has not been firmly established.

■ **Available evidence.** Are antidepressants used primarily in conditions for which there is solid justification? The evidence on this issue is very poor, even in the case of major depression. Most data suggesting extensive use outside major depressive disorder rely on insurance claims and medical record review, but the accuracy of these records has been called into question.¹⁶ Data from confidential logbooks in which prescribing physicians record the reasons for each prescription suggest that almost all persons receiving an antidepressant have a serious mental disorder.¹⁷ Although consistent with limited survey data, because the accuracy of the diagnosis cannot be validated, these data do not provide sufficient evidence to alleviate concerns regarding inappropriate use.¹⁸ In spite of many thousand references to SSRIs in the medical literature, we know very little about the illnesses of those who receive them.

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Quality And Value Of Antidepressant Treatment

The second main concern raised regarding increased spending for antidepressants is about the value of that care. Much of the debate has focused on the value of relatively new antidepressants, such as the SSRIs, compared with that of older medications such as the tricyclic antidepressants (TCAs). This literature has largely ignored other areas of important concern. For example, while it is clear that medications are preferred by some and counseling by others, the literature on value tends to focus on solutions that imply a single treatment is best for all.¹⁹

Any clinical advantage of the SSRIs resides completely in their more favorable side-effect profile and ease of use that mostly avoids the need for adjustments in the first weeks of treatment. Although the number of side effects is about the same as that associated with TCAs, and some side effects are more troublesome, most experts believe that SSRIs are more tolerable and easier to use.²⁰ Many studies suggest that SSRIs’ “user-friendly” profile may be associated with higher quality, reduced costs of care, and better cost-effectiveness of care when compared with the TCAs.²¹ However, the results of these studies are largely dependent on nonclinical measures of effectiveness. Many analysts thus believe that the SSRIs do not provide enough clinical benefit to justify their acquisition prices.²²

Cost and cost-effectiveness studies may be helpful, but they are not the best method for judging the overall value of the changes in antidepressant care that have occurred over the past dozen years. Two new methods—price indices for medical treatments and system cost-effectiveness studies—offer the promise of filling this gap, and pilot studies of each in the treatment of major depressive disorder have suggested that increasing antidepressant use can be justified.²³ Unfortunately, the studies to date are limited by many factors. They fail to account for treatment of depressive disorders other than major depressive disorder, use insurance claims for case finding, lack detailed clinical information on outcomes, and study only the first few months of treatment. Thus, there is still much uncertainty regarding the value of increasing antidepressant use.

Summary, Implications, And Policy Options

Spending for antidepressants has increased by about 600 percent, or more than \$6 billion, during the 1990s, driven in large part by in-

creased use. Although restrictions on this use might seem good fiscal management, we must challenge ourselves to remember the equally important problem that depressive disorders are undertreated. We do not yet know the degree to which unnecessary care contributes to rising expenditures. Until we understand the magnitude of the problem and how to encourage proper matching of treatment and patient, overzealous cost cutting directed at reducing utilization could result in reducing medication treatment for those truly in need.

Managed care has used several methods to reduce unnecessary use of antidepressants, including utilization controls and cost sharing. When cost-sharing arrangements have been studied for general medical problems, they appear to reduce costs and overuse without harming health status.²⁴ However, several important policy questions remain with regard to cost sharing for antidepressant medications. First, several studies of drug cost sharing have suggested that even modest levels may reduce care for vulnerable populations and those with the poorest health status.²⁵ Second, persons with mental disorders appear more likely to reduce utilization at a given level of cost sharing than are those with physical illness, at least with regard to ambulatory mental health care.²⁶ If persons with depressive disorders are highly sensitive to cost sharing, there is a high likelihood that necessary care will be limited.

In the broader context, most pharmacy benefits are designed to cover medications for all illnesses and do not separate coverage for mental health and somatic treatments. This "one-size-fits-all" concept also presents a challenge to benefit planners, who must design a single benefit that provides incentives for appropriate use of all medications. In the case of depressive disorders, it may be that more use would be appropriate. In the case of infectious diseases, there are reasons to believe that less medication use might be appropriate. While a particular benefit design might reduce overuse of antibiotics, it also might deprive depressed persons of needed medications.

Utilization controls represent another mechanism for controlling unnecessary antidepressant use. In a commonly used method, one "preferred" antidepressant is made available without restrictions, while alternatives are available only after prior approval. This has the perceived advantage that treatments can be matched to those who most need them. While theoretically appealing, these mechanisms have not been subjected to rigorous review, and there is preliminary reason for caution. A recent study found that a prior-approval restriction on antidepressant choice had a notable effect on measures of quality of care: Compliance with antidepressant treatment fell 80 percent when SSRI choices were reduced from two to

one.²⁷ Studies suggest that both utilization controls and cost sharing may be too “blunt” to limit unnecessary care while preserving access to and quality of needed treatment, at least with regard to mental disorders.

PERSONS WITH DEPRESSIVE DISORDERS represent a large, vulnerable population whose individual treatment outcomes are impossible to fully value. As outlined here, there is also a considerable degree of uncertainty regarding the degree of unnecessary treatment and the value of antidepressant care from a public health perspective. However, the stakes are high. If we assume that even 15 percent of prescriptions are unnecessary and that available tools could precisely limit this care, then we could save a billion dollars. But if the assumption is wrong and physicians are correctly reporting that very few prescriptions are unnecessary, then limiting care would result in substantial pain, suffering, and disability. The lure of a billion dollars saved is great, but at what cost?

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