College voor Zorgverzekeringen

Depression Package Scan

Discrepancies between requested care, provided care and insured care

Summary & Conclusions

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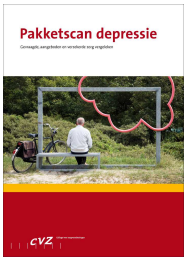


*The original text of the **Depression Package Scan** of CVZ was in Dutch. Although great care was taken in translating the text from Dutch to English, the translation may nevertheless have resulted in discrepancies. Rights may only be derived on the basis of the Dutch version of CVZ's Depression Package Scan.*

Furthermore, CVZ points out that only the summary and conclusions of this report were translated. A proper understanding of all relevant considerations and facts would require familiarity with the Dutch version of this report, including all appendices.

Summary & Conclusions

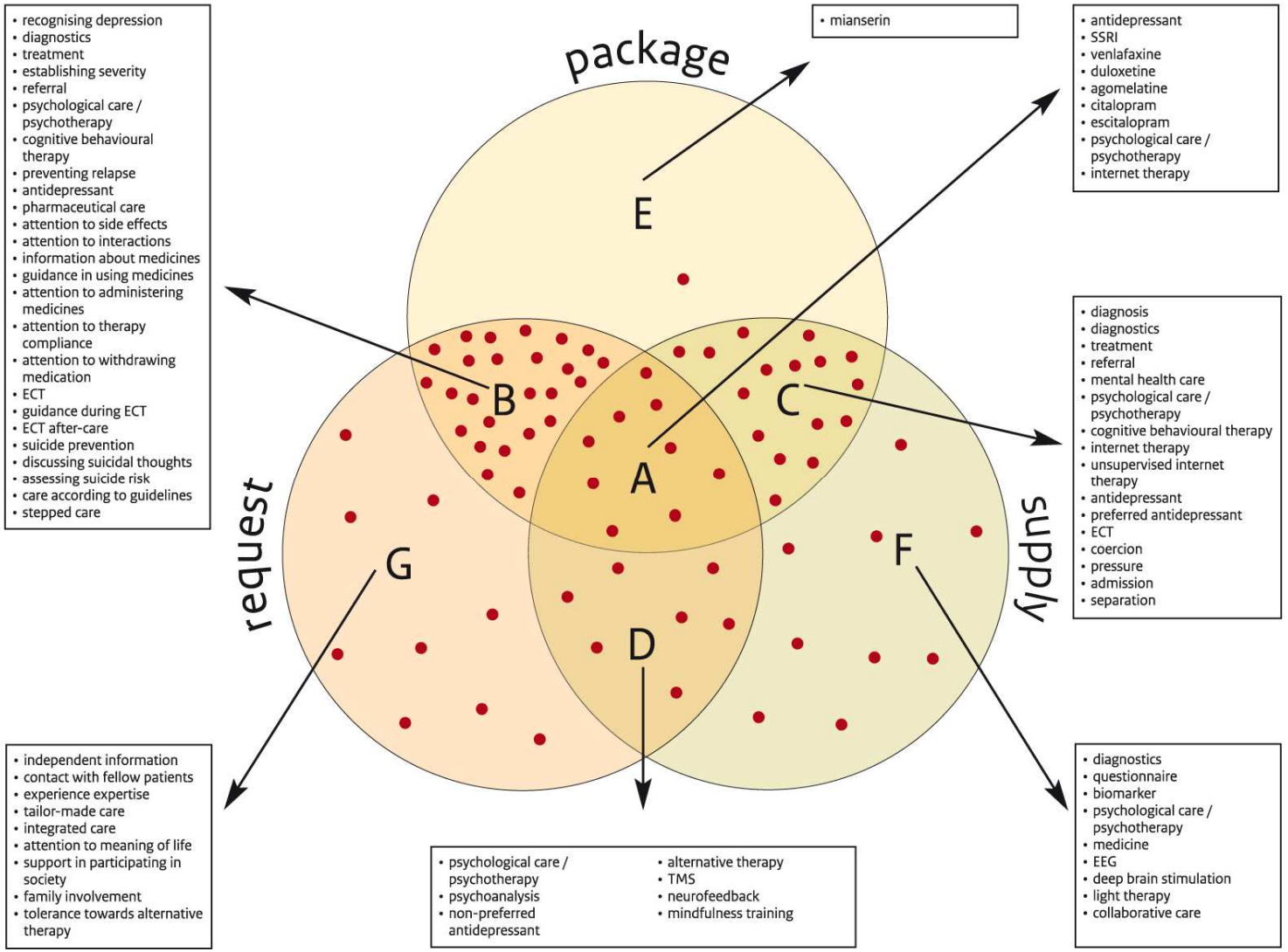
The Health Care Insurance Board in the Netherlands, CVZ, is the organization responsible for advising the Ministry of Health on the composition of the basic insurance package of health care covered by the Health Insurance Act and the Exceptional Medical Expenses Act. To find out whether the package of care is sufficiently adequate and accessible, CVZ developed the so-called package scan method. So far, we have applied this method to four of the top ten disorders with the highest social burden of disease in the Netherlands, namely Diabetes, Coronary Heart Disease, Depression and COPD. Below we summarize the findings of the Depression Package Scan.

In a package scan we analyse the adequacy and accessibility of the package of insured care for a particular disease. Does the insured package cover the care needed? And, in practice, do people receive the care for which they are insured? In a package scan we compare requested care, provided care and insured care with one another. We describe any discrepancies between them in what we refer to as 'package questions'. This results in an up-to-date picture of how the insured package in the Netherlands is functioning in practice. The package questions are described from the patient's perspective.
We have collected information on care not only from written and electronic sources, but also via interviews, visits to congresses and television programmes. The report is based on an analysis of almost 600 sources, collected from 2009 to 2012. At various stages we had the results examined by experts and relevant organisations.

In 2009 there were 555,000 people suffering from depression in the Netherlands. The degree to which people with a depression function socially is often severely limited. Furthermore, depression doubles the chance of premature death. As a result depression takes fourth place in the list of illnesses with the highest social burden of disease in the Netherlands. Social burden of disease is defined as: the number of healthy life-years lost due to disease in the population.

Package questions

The following figure reflects the results of this *Depression Package Scan* in a diagramme. The diagramme shows three circles which represent the requested care, the supply of care and the insured care. The three circles partly overlap one another, resulting in seven different areas: these are the package questions. The figure shows the discrepancies between requested, provided and insured care. Certain forms of care appear in more than one area in the diagramme (for instance, citalopram, cognitive behavioural therapy). This is because these forms of care can involve different types of discrepancies, for example (a certain type of) cognitive behavioural therapy may be unavailable for patients who need it (B) but at the same time may be provided for patients who do not need it (C).



Key:

A Requested, provided and insured, but …

B Requested and insured, not provided

C Provided and insured, not requested

D Requested and provided, not insured

E Insured, not requested and not provided

F Provided, not requested and not insured

G Requested, not provided and not insured

The following are our conclusions on package questions raised in connection with symptoms of depression and full-blown depression.

Package question A
In this area there is no discrepancy between requested, provided and insured care: patients receive the insured care they need. Still, we found some problems which are related to the delivery and use of care, like safety issues and therapy non-compliance. We label these type A problems. We found the following undesirable situations.

- *A number of antidepressants are thought to be unsafe*

There are indications that a number of medicines insured for depression are unsafe. For instance, some possibly new negative side effects of a number of antidepressants have come to light: flushes due to SSRIs and venlafaxine, sensations of an electrical shock due to duloxetine and nightmares due to agomelatine. It has also become apparent that high doses of citalopram and escitalopram can lead to abnormal heart-rhythm disorders that may even prove fatal.

- *People suffering from depression are not always therapy-compliant when taking medicine*

The negative side effects of antidepressants form the main reason why patients stop taking their medicine. Therapy non-compliance is widespread and can have enormous consequences for the effectiveness of medicinal treatment of depression and also, therefore, for the health of the patients involved.

- *Therapy non-compliance also exists with respect to psychological care or psychotherapy*

It seems that patients with a depression do not always complete this type of treatment (whether or not in the form of internet therapy). As a result, treatments for depression are less effective than they would otherwise have been. This form of therapy non-compliance is particularly widespread among certain immigrant groups.

Package question B
Package question B is about care that is requested by patients with depression and which is insured, but which care-providers supply insufficiently, or not at all. This affects the accessibility of the insured package. However, package question B is also about the quality of the care provided. After all, where quality is lacking, good care, by definition, is not being given.

- *Patients themselves, and care-providers, do not always recognise depression or symptoms of depression*

Depression often goes unrecognised, particularly in the elderly, but also in children and young people. Other factors, apart from age, that can play a role in the (non-) recognition of depression are gender, ethnicity, socioeconomic status and pregnancy. The failure of care-providers to recognise depression is related to the way in which patients present their symptoms, and also to the way in which the diagnosis is determined.

- *A considerable proportion of patients with depression receive no treatment, though they do need it*

This is partly related to underdiagnosing. However, even when depression is recognised, care-providers do not always establish its severity, resulting in

undertreatment: some patients are not referred further, others have to wait (too long) for treatment. Undertreatment occurs particularly with respect to the elderly and immigrants with depression.

- *Patients with depression receive insufficient psychological care and psychotherapy*

GPs do not offer enough psychological treatment and they often fail to refer patients. Patients with depression who are referred, frequently end up on the waiting lists of primary care psychologists and mental health care institutes. Even after this, it is not a matter of course that they receive psychotherapeutic treatment (mostly in the form of cognitive behavioural therapy). When it is provided, there is the risk that it will be given too infrequently, for too short a period of time or its quality may be insufficient. In addition, patients who have recovered receive insufficient assistance in preventing a relapse. Patients may also fail to receive a given form of psychotherapy because it was not purchased by their health insurer.

- *Some patients with depression are prescribed insufficient medication*

Although discussions about the use of medicines for depression are mainly about excessive treatment with antidepressants, the opposite may also occur, i.e., undertreatment: some patients with depression receive no antidepressants, too few, too late or for too short a period of time. Undertreatment with antidepressants seems to occur mainly with respect to the elderly, children with depression and pregnant women.

- *Patients with depression receive insufficient pharmaceutical care*

For instance, they feel that insufficient attention is paid to the negative side effects and interactions of antidepressants. Information about the mechanism of action and the unintended effects of antidepressants, and about using antidepressants during pregnancy is lacking or inadequate. Furthermore, insufficient guidance is given to patients taking antidepressants: care-providers pay insufficient attention to the method of administration, therapy-compliance, possible interactions with other medicines and withdrawing antidepressants gradually.

- *Patients with severe depression are not offered electroconvulsive therapy (ECT) sufficiently*

What's more, patients who did receive ECT are not satisfied about the information, guidance and after-care.

- *Care focusing on preventing suicide is sometimes inadequate*

There seems to be insufficient room for discussing suicidal thoughts. Nor do care-providers always assess the risk of suicide among patients with depression. Furthermore, people who already attempted to commit suicide in the past receive inadequate after-care and continuity of care.

- *Guidelines on depression are applied insufficiently*

For instance, the severity of a depression is not always established and the principle of stepped care is not always applied during treatment.

Package question C

Package question C is about care that is offered and is insured but which patients do not want or need. This refers to both overtreatment (patients receive care they do not want) and inappropriate or inefficient use of the package (patients receive unnecessarily expensive care). In this case the package is in fact too accessible and possibly even too adequate.

- *People are wrongly diagnosed*

People who are not depressed are sometimes wrongly diagnosed as having depression. Or people who are depressed are wrongly diagnosed as having another disease. Patients are sometimes diagnosed with a depression, but they do not regard themselves as such. Overdiagnosing depression seems to result mainly from the available diagnostic instruments and how they are used. Doubts also exist about the quality of GPs' diagnoses.

- *Cases of overtreatment*

Some patients with symptoms of depression or who are suffering from depression are overtreated; for instance, they receive treatment that is not necessary, they are referred to mental health care specialists or they receive treatment that is too taxing or too expensive in relation to the severity of the symptoms of depression.

- *The efficacy of psychological care and psychotherapy are subjects of debate*

Some patients feel that the psychological care or psychotherapy they receive for their depression is ineffective. Furthermore, care-providers and scientists are still debating the efficacy of psychotherapy (particularly cognitive behavioural therapy) partly because its efficacy was overestimated in the past. In addition, people suffering from depression sometimes receive forms of psychological care or psychotherapy that are not in line with the nature and severity of their symptoms. Others receive psychological care or psychotherapy they do not want.

- *Patients do not seem particularly interested in internet therapy*

The supply of (preventative) internet therapy is increasing, but it does not seem to have attracted much interest from patients. On an annual basis, only about one and a half per cent of those with symptoms of depression use it. Cognitive behavioural therapy, on which many internet treatments are based, seems too complicated for immigrants and people with a low socioeconomic status. Various forms of internet therapy are offered without any guidance. There are indications, however, that unsupervised internet therapy has little effect.

- *Cases of overtreatment with antidepressants*

Patients with symptoms of depression are overtreated with antidepressants, particularly by GPs. In particular, people with a mild form of depression are often overtreated with antidepressants. During recent years various attempts have been made to reduce overtreatment with antidepressants. To this end, the conditions for reimbursement were tightened up in 2011: an antidepressant is only reimbursed if prescribed according to the guidelines. However, health insurers have decided not to monitor prescriptions for antidepressants. The question remains as to whether the stricter conditions for reimbursement will reduce overtreatment with antidepressants. The use of antidepressants in 2011 is actually expected to have risen by 5 per cent.

Overtreatment with antidepressants also occurs because doctors increase the doses of SSRIs when they are insufficiently effective. However, increasing the dose of SSRIs will only result in disadvantages: the side effects increase while there is no effect on patients' symptoms of depression.

Lastly, overtreatment with antidepressants occurs because doctors sometimes continue to prescribe them year after year (more than ten years). Patients do want to stop earlier and regularly attempt to do so. However, such attempts are rarely successful because patients usually suffer from withdrawal symptoms. Doctors seem to interpret these failed attempts to stop the use of antidepressants as a motive for continuing prescription, instead of guiding patients through the withdrawal.

- *Preferred medicines are not always welcome*

The preferential policy of health care insurers may result in patients with depression receiving care they do not want, i.e., (generic) antidepressants designated by their health care insurer.

- *Therapy non-compliance is inefficient*

Therapy non-compliance can result in medicines remaining unused in people's medicine chests, and it can lead to overtreatment or unnecessarily expensive care. In other words, therapy non-compliance is a form of inappropriate or inefficient deployment of insured care.

- *ECT is not always welcome*

ECT is often the last possible treatment option for severely depressed patients. However, patients do not always want to undergo this treatment, they cannot face continuing it or they are left suffering long-term memory disorders. Patients sometimes feel they are coerced into undergoing ECT.

- *Coercion and pressure are sometimes exerted during treatment*

Patients with depression sometimes feel they are being coerced and that pressure is put on them during treatment. For instance, they feel pressure is put on them to take medicines or to make behavioural adjustments. People with severe depression are sometimes forcibly admitted or separated, e.g., if they have suicidal tendencies.

Package question D

Package question D relates to requested care which is provided, but which the package does not reimburse or not in full. As a result patients ask for this care to be included in the package. In other words: patients experience these aspects of the package as inadequate.

- *Patients ask for more reimbursement for psychological care and psychotherapy*

Patients suffering from depression (or another mental disorder) worry about the reimbursement of psychological care and psychotherapy. The personal contribution for first-line psychological care was recently increased and the total number of reimbursable sessions reduced. Furthermore, a personal contribution was introduced for secondary mental health care and for residence in a mental health care institute. Patients (organisations) claim that people can no longer afford the psychological care and psychotherapy they need, and that this will lead to avoiding or delaying necessary care or to prematurely terminating treatments.

- *CVZ has terminated the reimbursement of psychoanalysis*

In March 2010 CVZ ruled that psychoanalysis was no longer included in the insured package. Some patients who had undergone psychoanalysis, or who were still receiving treatment, did not agree with CVZ. However, the LPGGz, the umbrella organisation for mental health care patient organisations, has not yet responded to CVZ's standpoint.

- *Almost all medicines for depression are reimbursed*

There is no demand from people suffering from depression for the reimbursement of medicines that are not included in the package. This is probably because almost all medicines for depression that are currently used in practice can be (fully) reimbursed via the basic insurance. Since 2011 antidepressants are only reimbursed subject to certain conditions. However, health insurers have decided not to monitor prescriptions for antidepressants. As a result we found no indications of patients

experiencing any consequences of the stricter reimbursement conditions for antidepressants.

- *Preferential policy means that patients do not always receive reimbursement of the antidepressant of their choice*

As a result of the preferential policy of health care insurers, patients with depression do not always receive reimbursement for their preferred medicine, even though the product is included in the basic insurance. Patients feel that this limits their freedom of choice.

- *Demand for reimbursement of alternative treatments and medicines*

Patients suffering from depression sometimes want reimbursement for alternative therapies, Transcranial Magnetic Stimulation, neurofeedback and mindfulness training.

- *Lack of clarity about the reimbursement of mindfulness*

Mindfulness training is increasingly available and very popular, also among patients suffering from depression. However, people are extremely confused about the reimbursement of mindfulness training. It seems to be the case that mindfulness training provided by mental health care institutes is reimbursed under the basic insurance. As yet however, it has not been established whether mindfulness training fulfils the necessary requirements.

Package question E

Package question E relates to superfluous insured care. This is care for which there is no request, nor is it available, but it is still insured.

- *The package does not include any superfluous insured care for depression*

There is no care for depression that is in principle reimbursed, but which in practice is not (or no longer) provided nor wanted. The question that remains is whether the reimbursement of the antidepressant mianserin (Tolvon®) should be discontinued.

Package question F

Package question F is about care that is offered but which patients do not (as yet) request and which is not (yet) insured. This relates in particular to new forms of care.

- *Various new forms of care are being developed for depression*

In the field of diagnostics, research is being done into questionnaires and biomarkers. Various other developments relate to psychological care and psychotherapy, e.g., Cognitive Behavioral Analysis System or Psychotherapy (CBASP) for chronic depression, mentalization-based treatment, life-review and preventing relapse. The search is on for medicines with mechanisms of action that differ from those of current antidepressants, drugs that affect cortisol, dopamine or the MIF protein. Furthermore, research is being done into electro-encephalogram (EEG) as a method for determining the effect of medicines on individual patients more rapidly, and into Deep Brain Stimulation and light therapy as new treatments for depression. Another new form of care being offered for depression is 'Collaborative care', an intensified form of the usual care for symptoms of depression in primary care. There is a lack of clarity about the extent to which all these new forms of care meet the needs of those who suffer from depression and whether such care should eventually be included in the insured package.

Package question G
The unfulfilled care needs of patients are central to package question G. These forms of care are not (yet) available nor are they insured.

- *Patients suffering from depression have a number of unfulfilled care requirements*

Patients suffering from depression have a number of unfulfilled care needs, including a need for independent information, contact with fellow patients and the involvement of former patients (experience experts) in treatment. In addition, less-educated people and immigrants who suffer from depression would like more tailor-made care. This is mainly because the current supply of care does not fit in well with their requirements and capacities. Lastly, patients suffering from depression would like more integrated care for patients with attention being paid to meaning of life, support in participating in society, involving families in care and greater tolerance towards alternative therapies. Such care is currently insufficiently provided and is not included in the insured package.

Adequacy and accessibility of the package

Our conclusion on the basis of this package scan is that the insured package for depression is only partly adequate. GP care that is necessary is reimbursed in full, and all medicines that are available for depression in current practice can be (fully) reimbursed via the basic insurance. However, the package seems inadequate with respect to psychological care and psychotherapy. The personal contribution for first-line psychological care was recently increased and the total number of reimbursable sessions reduced. Furthermore, a personal contribution was introduced for secondary mental health care and for residence in a mental health care institute. Patients (organisations) claim that people can no longer afford the psychological care and psychotherapy they need, and that this will lead to avoiding or delaying necessary care or to prematurely terminating treatments. The package for depression is not excessively adequate: it does not include any superfluous insured care. Moreover, not only patients but also care-providers and health care insurers lack clarity about the insured package for depression. This is apparent from discussions about the reimbursement of mindfulness. Both the demand and the supply of mindfulness are increasing. As yet, however, it has not been established whether mindfulness fulfils the requirements of the basic insurance.

We also conclude that the accessibility of insured care for depression leaves a lot to be desired. On the one hand because the package is not accessible enough. In practice, patients suffering from depression do not always receive the care they need although it is insured via the package. Certain aspects seem to involve undertreatment or an inadequate quality of care. Furthermore, the accessibility of the insured package of care differs between various groups of patients suffering from depression. Underdiagnosing and undertreatment occurs particularly with respect to the elderly and immigrants.
On the other hand it seems that some aspects of the insured package of care for depression are actually too accessible. In fact, one can speak of both overdiagnosing and overtreatment. Some patients receive insured care that is unnecessary, or treatment that is too taxing or too expensive in relation to the severity of their symptoms of depression. In particular there is a lot of overtreatment with antidepressants; too many are prescribed too often and for too long. Overdiagnosing and overtreatment with insured care implies an inappropriate or inefficient use of the package.

Another problem is the fact that patients suffering from depression are not always conscientious when consuming their insured care, and care-providers pay insufficient attention to this. Side effects of antidepressants are the main reason why patients stop taking their medicine prematurely. Therapy non-compliance is widespread and can have considerable consequences for the efficacy of medicinal treatment of depression and, therefore, for the health of the patients involved. Furthermore, therapy non-compliance can result in medicines remaining unused in people's medicine cabinets, or in unnecessarily expensive care. In other words, therapy non-compliance is a form of inappropriate or inefficient use of insured care.

Lastly: apart from the package, the care itself is not entirely adequate for patients suffering from depression. This is because they have a number of unfulfilled care needs. Care-providers will first have to develop such care before it can be incorporated into the insured package.
At the same time, care-providers are developing various new forms of care for depression. As yet it is not clear to what extent this new care will meet the needs of those suffering from depression and whether this care should eventually be included in the insured package.