

Inequities in Medical Follow-up for Depression : A population-based study in Montreal.

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Référence complète de l'étude

Houle, J., Beaulieu, M.-D., Lespérance, F., Frasure-Smith, N, Lambert, J. 2010. Inequities in Medical Follow-up for Depression : A population-based study in Montreal. *Psychiatric Services*, 61(3), 258-263.

Préblématique et cadre théorique

Each year, approximately 8% of Canadians experience an episode of major depression. Without treatment, depression can lead to severe disabilities and an increased risk of death. A rapid, sustained, and appropriate medical response is required to properly treat depression, particularly in the acute phase of treatment, which is the first three months after diagnosis. We lack data on the quality of medical treatment provided to Canadians suffering from depression. The data that exist are based on cross-sectional selfreport surveys and subject to self-reporting bias, diagnostic uncertainties, and the inability to establish a time sequence in health service utilization. There is a critical need for better assessment of the quality of medical follow-up provided to people with depression in order to determine where changes are most needed.

Previous studies examined the care provided for depression in various organizational models in the United States, where medical coverage depends on sociodemographic characteristics such as employment status or income. Such models include Medicaid, health maintenance organizations, the Veterans Health Administration, and the private sector. This study was based on data from a Canadian population, which benefits from a universal health care system that provides access to all medical and hospital services without copayments. All citizens receive the same health coverage. In the United States, the quality of depression management varies from one organizational model to the next; for example, the private sector usually provides better management than the Medicaid system. Because the Canadian system provides universal coverage, such socioeconomic disparities should not occur. To our knowledge this is the first study to have used administrative databases to examine this issue.

Four recognized indicators were used to assess the quality of medical follow-up: occurrence of follow-up, promptness of follow-up, continuity of follow-up by usual provider, and optimal frequency of practitioner contacts. In contrast to previous U.S. studies that used pharmaceutical databases to produce quality indicators of effective acute-phase treatment based on an adequate duration of antidepressant prescriptions, our administrative database for drug prescriptions was incomplete; the public drug insurance program does not cover the entire population. It covers only individuals aged 65 and older, recipients of social assistance (welfare recipients), and workers and their families (participants) who do not have access to private insurance. For this reason we focused on medical follow-up, which is a crucial dimension of quality in the care provided for depression.

Méthodologie de l'étude

Description de la ou des méthodes utilisées

This retrospective cohort study of adult patients who received diagnoses of depression between April 2003 and March 2005 in Montreal used administrative data to measure the quality of medical follow-up within the first three months of diagnosis. Indicators of adequate follow-up care included having at least one outpatient visit to a family physician or a psychiatrist, the first follow-up visit within 30 days of diagnosis, more than half of follow-up visits with the same physician, and at least three follow-up visits.

We obtained denormalized person-level variables from two sources: the database of physician claims for payment made to the Régie de l'Assurance maladie du Québec (RAMQ) and the Med-Echo database of hospital discharge information. These two databases have complete medical records of all Montreal residents who are aged 18 and older. The study sample came from the population of all residents in the Montreal administrative region who were 18 or older and who had consulted a physician at least once between April 2003 and March 2005. This population consisted of 1,972,529 individuals. The following inclusion criteria were used to identify patients who had experienced a new episode of depression: one inpatient or two outpatient visits with a primary diagnosis of depression according to the *ICD-9* (codes 296.2–296.6, 300.4, 308, 309, and 311.9) and a six-month period free of any diagnosis of depression before the first visit with a depression

diagnosis (the index visit). To prevent false positives, a confirmation visit was required in which depression was diagnosed in an outpatient visit (10). This requirement was essential because we lacked information on the use of antidepressants. We did not use the prescription drug database of the RAMQ because it does not cover the entire population of the Montreal region. Individuals whose consultations with a physician led to a diagnosis of schizophrenia (*ICD-9* codes 295.00–295.95) during the study period were excluded.

Échantillon(s) et période(s) de collecte des données

41 375 Hommes et femmes adultes ayant reçu un diagnostic de dépression entre avril 2003 et mars 2005 dans la région de Montréal.

Principaux résultats

Results suggest that universal access to health care provides better optimal practitioner contacts during the acute treatment phase of depression. However, despite universal access, our study has revealed that some inequities persist based on age and sex, with elderly persons and men being less likely to receive adequate follow-up.

These findings reinforce the results of previous studies that have found poor depression treatment among elderly patients and men. The elderly population and men tend to be more fearful of being stigmatized because of their depression and are less likely to consult a physician for a mental health problem. This fear of social stigma may lead them to reject a diagnosis of depression and the recommended medical follow up. Given that the suicide rate for men is three times that for women and that the rate of suicide in the elderly population has risen alarmingly, the poorer quality of follow-up for depression in these groups is cause for considerable concern.

Besoins identifiés

More proactive strategies, such as telephone follow-ups and house calls, should be pursued when a patient does not appear at a followup visit after having received a diagnosis of depression.

Population cible

41 375 Hommes et femmes adultes ayant reçu un diagnostic de dépression entre avril 2003 et mars 2005 dans la région de Montréal.

Objectifs et hypothèses

The aim of this study was to measure the quality of medical follow-up of depression in a universal-access health care system and identify its main correlates.

We had two objectives: to determine the quality of medical follow-up for depression in a universal access health care system and to identify the main correlates of quality of medical follow-up, including patient characteristics (sex, age, socioeconomic status, and comorbidity profile) and the type of physician involved (provider specialty).

Hypothèse: However, despite universal access, our study has revealed that some inequities persist based on age and sex, with elderly persons and men being less likely to receive adequate follow-up.

Mots-clés Inégalité, suivi médical, dépression, Montréal, service psychiatriques, Hommes

Juillet, 2014