

staff might be forgiven for thinking that the government would want to take stock and consolidate its achievements before embarking on the next stage of change.

The prime minister's decision not to go down that route but to maintain the course that has been set reflects the constraints under which the government is working, especially in relation to the future funding of the NHS, and the stage that has been reached in the election cycle. It also signifies a perception that change is likely to be too slow and limited unless the process of reform moves up a gear.

Taking the constraints first, the NHS in England has just entered the last two years of annual increases in funding of around 7% in real terms. With discussions on the next spending review gathering pace in the government, most observers expect that the NHS will receive around half that level of growth from April 2008. The changes needed to complete the reform of the NHS are likely to become more difficult as the rate of increases in funding slows, and this helps to explain the impatience at the highest level of the government to accelerate the pace of change.

Overlaid on this issue is a political calculation that dealing with the inevitable costs of reform is best done as far ahead of the next general election as possible. Some of these costs arise from the need to tackle the financial deficits in the NHS in England, estimated at around £700m (€1010m; \$1250m) in 2005-6, and already leading to job losses and cutbacks in the organisations that are most affected. Other costs will be incurred from radical reductions in hospital capacity where surplus beds and services become unsustainable as policies on patient choice and payment by results destabilise the system.<sup>2</sup>

In this context the perception in the government that there are bigger risks in change being too slow and limited than too fast and extensive becomes particularly important. This view reflects a process of learning in the government and the difficulty of bringing about change from Whitehall in an organisation as large and complex as the NHS. Put simply, ministers have become increasingly frustrated at the time it takes to achieve service improvement in the NHS and at the barriers to spreading innovation and best practice. This is why the prime minister emphasised his desire to make reform self sustaining and to drive change

through financial incentives and patient choice instead of targets and performance management.

Viewed from the outside, these policies bear all the hallmarks of the "creative destruction" that generates growth and change in competitive industries. This phrase was coined by the Austrian economist Joseph Schumpeter in the 1940s to describe the incessant process of innovation in capitalist economies, enabling development from within as established companies are threatened and destroyed by new entrants.<sup>3</sup> Independent sector treatment centres, NHS foundation trusts, patient choice, and the incentives offered through payment by results and practice based commissioning are designed to introduce the forces of creative destruction to the NHS. The aim is to produce a system that will adapt itself to changing circumstances instead of constantly being driven by the government to reform.

This implies that the changes to the NHS so far will look like minor skirmishes compared with the bigger battles that lie ahead. And although the prime minister is clear that he and his government are prepared to bear the costs of reform, it remains to be seen how they will handle hospital closures and cutbacks as and when these become necessary. At the heart of this transition is the tension between a system based increasingly on markets and decisions that remain centred on politics.

With most NHS services still under the ultimate control of government, painful and unpopular decisions about the future of local hospitals—as occurred at Kidderminster in 2000<sup>4</sup>—will end up in Whitehall. Will ministers then have the courage of their convictions? Or will the forces of creative destruction they have unleashed come back to destroy them, rather than the "old monolithic NHS" that the prime minister took to task in his speech?

Chris Ham *professor of health policy and management*

(cj.ham@bham.ac.uk)

University of Birmingham, Birmingham B15 2RT

Competing interests: CH was director of the strategy unit in the Department of Health from 2000 until June 2004.

- 1 Prime Minister speaks to NHN Clinician Forum. [www.newhealthnetwork.co.uk/Content.aspx?id=224](http://www.newhealthnetwork.co.uk/Content.aspx?id=224) (last accessed 23 April)
- 2 Ham C. Does the district general hospital have a future? *BMJ* 2005;331:1331-33.
- 3 Schumpeter J A. *Capitalism, socialism and democracy*. New York: Harper, 1975. Originally published 1942.
- 4 Lock D. Stuck in the middle? *BMJ* 2001;323:1195.

## Depression should be managed like a chronic disease

*Clinicians need to move beyond ad hoc approaches to isolated acute episodes*

Analysis and comment  
pp 1027, 1030

Depression is often referred to as the common cold of psychiatry. But this analogy is wrong: although common, most depressive disorders are not mild and self limiting. It is time that we treated depression as the chronic disease that it is.

The World Bank ranks unipolar depression as the number one contributor to the global burden of disease in adults aged 19-45 in the developed world.<sup>1</sup> Up to 15% of adults may experience clinical

depression, 20% will not recover fully from the index episode, and 70-80% of those achieving remission succumb to at least one recurrence. Eighty per cent of individuals with milder persistent symptoms or dysthymia will develop a major depressive episode, and 15% of all patients with depression will eventually commit suicide.

Ninety per cent of cases of depression are treated in primary care, where depression is the third most

*BMJ* 2006;332:985-6

common reason for consultation. Two articles in this issue hypothesise that screening for depression cases would not improve patient outcomes (p 1027),<sup>2</sup> whereas increased access to therapy would (p 1030).<sup>3</sup> The truth probably lies somewhere in between. So what should primary care offer to individuals with depression?

The two most important barriers to effective depression management are under-recognition (30% remain undetected) and undertreatment (>50% are untreated).<sup>4</sup> Gilbody et al's paper<sup>2</sup> and their previous Cochrane review<sup>5</sup> suggest that screening is unlikely to improve short term outcomes (6-12 months) or be cost effective so it does not meet enough of the National Screening Committee's criteria to warrant introduction. However, universal screening as an isolated intervention, divorced from a coherent plan of how to manage detected cases, is neither supported by the National Screening Committee nor likely to be advocated by healthcare providers for any disorder. Screening for depression, as for diabetes, is of value only when the rationale for enhancing case recognition is clear, the programme targeted at high risk populations, and the strategy linked to a systematic approach not only to acute treatment but also to tertiary prevention.<sup>6</sup>

The value of "chronic disease management" has been shown in other disorders such as asthma and hypertension, so templates exist to develop a similar shared care approach to depressive disorders with appropriate, achievable primary care targets. Short term health economic benefits may not materialise, as cost effectiveness will not only depend on detecting and treating individual depressive episodes but also on reducing recurrences and persistent subsyndromal symptoms.

We need a paradigm shift to recognise that depression is a life course disorder. The piecemeal approach to treatment, which has too often focused on the ad hoc management of isolated acute episodes, could then be replaced with a systematic sequence of acute, continuation, and maintenance phase interventions.<sup>7</sup> The difficulties of implementing this strategy are the continuing problem of undertreatment and the potential resource implications for primary care teams already stretched by other pressures.

Undertreatment results mainly from doctors failing to prescribe effectively and from patients failing to take their drugs. Failure of prescribing is disappointing as the diagnostic criteria for depressive episodes requiring clinical intervention are more transparent than for many physical conditions.<sup>7,8</sup> When treatment is provided in an adequate dose for an adequate period improvement rates are at least 60% by 12-16 weeks; when medication is continued beyond the acute phase relapse rates are reduced by 50% compared with those in patients who stop taking antidepressants.<sup>7</sup> These outcomes exceed the treatment gains achieved for many common physical disorders.<sup>8</sup>

A barrier to effective treatment seems to be clinicians' perceptions of depression: the onset of an episode is often understandable in the context of life stressors or known personality vulnerabilities, but "normalising" the experience should not exempt it from treatment. Many clinicians and patient advocates argue that patients are often ambivalent about or opposed to antidepressants and often don't take them.<sup>9</sup> Increased

access to treatment would be beneficial if it focused on the provision of evidence based interventions with a durable effect on an individual's pattern of coping, so reducing their risk of relapse after treatment has stopped. There is no evidence that this can be achieved by the recent increase in access to non-specific counselling.<sup>10</sup> Layard's proposal for increased availability of cognitive behaviour therapy may help, but cognitive behaviour therapy is not a panacea: dropout rates (30%) are similar to those for medication and there is no clinical characteristic that allows us to predict which patients will respond best to cognitive behaviour therapy and which to antidepressants.<sup>11</sup>

Would greater case finding and evidence based treatment divert resources away from those with "greater need and ability to benefit"? This argument seems unsustainable. Depression is top of the list of the global burden of disease, and the statistics on recurrence, chronicity, and lost human capital speak for themselves. Depressive disorders are also associated with an increased risk of many highly morbid physical disorders including metabolic syndromes.<sup>12</sup> Studies from the United States and Europe indicate that those with untreated depression attend primary care significantly more often than other patients.<sup>13</sup> Modifying perceptions of the disorder and changing the interventions made during consultations may be more critical than assuming that extra consultations are the only alternative.

Should additional funding be made available? If resources were allocated on the basis of the burden caused by a disease, the prospects would be improved for financial backing to implement better treatment options for depression. But funding issues should not be an excuse for inactivity: the lack of joined up thinking about this much misunderstood disorder seems to be the rate limiting step.

Jan Scott *professor of psychological treatments research*

(j.scott@iop.kcl.ac.uk)

Institute of Psychiatry, London SE5 8AF

Competing interests: None declared.

- Murray C, Lopez A. *The global burden of disease*. Cambridge, MA: Harvard University Press, 1996.
- Gilbody S, Sheldon T, Wessely S. Should we screen for depression? *BMJ* 2006;332:1027-30.
- Layard R. The case for psychology treatment centres. *BMJ* 2006;332:1030-2.
- Hays R, Wells K, Sherbourne C. Functioning and well-being of patients with depression compared with chronic general medical illness. *Arch Gen Psych* 1995;52:11-9.
- Gilbody S, House A, Sheldon T. Screening and case finding for depression. *Cochrane Database Syst Rev* 2005;(4):CD002792.
- Renders C, Valk G, Griffin S, Wagner E, van Eijk J, Assendelft W. Interventions to improve the management of diabetes mellitus in primary care, outpatient and community settings. *Cochrane Database Syst Rev* 2001;(1):CD001481.
- National Institute of Clinical Excellence. *Depression: core interventions in the management of depression in primary and secondary care*. London: HMSO, 2004.
- Wells K, Sturm R, Sherbourne C. *Caring for depression. A RAND study*. Cambridge, MA: Harvard University Press, 1996.
- Lingam R, Scott J. Treatment non-adherence in affective disorders. *Acta Psych Scand* 2002;105:164-72.
- Churchill R, Hunot V, Corney R, Knapp M, McGuire H, Tylee A, et al. Brief psychological therapies versus treatment as usual for depression. *Cochrane Database Syst Rev* 2003;(1): CD001763.
- Scott J, Watkins E. Brief psychotherapies for depression: current status. *Curr Opin Psych* 2004;17:3-7.
- Von Korff M, Ormel J, Katon W, Lin EH. Disability and depression among high utilizers of health care. A longitudinal analysis. *Arch Gen Psych* 1992;49:91-100.
- Herman H, Patrick D, Diehr P, Martin ML, Fleck M, Simon GE, et al. Longitudinal investigation of depression outcomes in primary care in six countries: the LIDO study—functional status, health service use and treatment of people with depressive symptoms. *Psych Med* 2002;32: 899-902.