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Social inequalities in the treatment of depression

PERSPECTIVES

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Treatment for depression in general practice varies according to patients' age and level of education. This perpetuates health inequalities in the population.

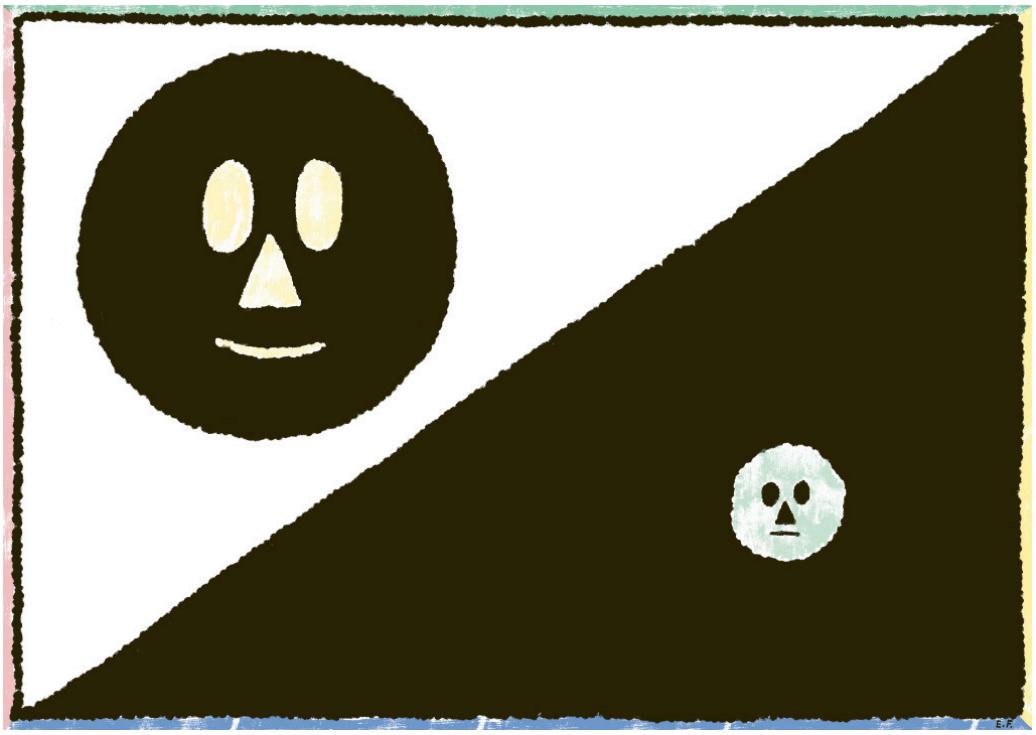

Illustration: Espen Friberg

Approximately one in ten people in Norway will develop a depressive disorder within the course of a year. Women, older adults and people with a low socioeconomic status are at increased risk (1). Depression is the most common mental health problem seen in general practice, and general practitioners (GPs) play a key role in its management (2).

More expertise, more help

National policy requires the health service to provide equal access to treatment for all, thereby helping to reduce health inequalities in the population (3). Paradoxically, it has proven challenging to ensure that those with the greatest need receive the most care, a phenomenon first described over 50 years ago as the inverse care law (4). A study using linked national population and health registry data on adults (2008–16) examined whether the Norwegian GP scheme has succeeded in prioritising patients with the greatest need (5).

> ***«Findings suggest systematic differences in treatment based on education level and age. If the Norwegian GP scheme is not exempt from the inverse care law, it is likely that patients with the most resources benefit at the expense of those with the least»***

Approximately half of all adult patients presenting with a new episode of depression receive talking therapy, and one in three are prescribed antidepressants (6–8). However, highly educated women are less likely to be given antidepressants than women with lower levels of education (6), and patients of both sexes with a low level of education are less likely to receive talking therapy than those with a higher level of education (8). There are also

age-related differences in treatment: older patients are more likely to be prescribed antidepressants and less likely to receive talking therapy compared with middle-aged patients (6–8). These findings suggest systematic differences in treatment based on education level and age. If the Norwegian GP scheme is not exempt from the inverse care law, it is likely that patients with the most resources benefit at the expense of those with the least.

Interestingly, no educational differences in antidepressant use have been observed among men (8).

Sociodemographic inequality

There are several possible explanations for the social inequalities in the treatment of depression in general practice. Patients' health literacy and preferences may be associated with education level and age, and this may influence GPs' treatment decisions. Health literacy refers to the ability to access, understand, evaluate and apply health information, and levels of health literacy tend to be higher among younger and more highly educated patients than older and less educated groups (9). GPs' assumptions about a patient's health literacy, based on implicit biases and stereotypes, can also influence their treatment decisions (10, 11). Highly educated women may be more aware of the limited effects and potential adverse effects of antidepressants and may therefore prefer talking therapy over pharmacological treatment. They may also feel more confident in advocating for their own health and expressing their treatment preferences. As there is no evidence that the severity of depression varies by education level, it is possible that highly educated women are under-treated with antidepressants when these are indicated, while women with a lower level of education may be over-treated.

Regardless of age and sex, patients with depression prefer psychological treatment over antidepressants (12). Engagement and a sense of ownership of treatment increase the likelihood of a positive outcome (13) and should therefore be important considerations when GPs assess treatment options.

> ***«Age and education-related differences in the treatment of depression suggest systematic inequality, which can exacerbate health disparities and affect vulnerable groups, particularly older adults and those with a low level of education»***

If doctors assume that older or less educated patients have a reduced capacity to engage in or benefit from talking therapy, they may favour pharmacological treatment without investigating whether this assumption is justified. Indeed, talking therapy is discussed less often with older patients than with younger ones (14). However, the use of antidepressants in older adults is associated with a higher risk of adverse effects and drug interactions than in younger patients, particularly in cases of multimorbidity and polypharmacy (15). This evidence suggests that antidepressants should be used *less* for older patients than

middle-aged and younger ones. International literature refers to age discrimination, or ageism, as a potential explanation for negative attitudes and differential treatment of older people (16).

Unwarranted social variation

The Norwegian GP scheme is widely regarded as a successful public service, in which equal access to health care is a core value. However, age and education-related differences in the treatment of depression suggest systematic inequality, which can exacerbate health disparities and affect vulnerable groups, particularly older adults and those with a low level of education. These differences are relevant at the population level and show that the GP scheme does not operate in line with the core value of equal access to health care. At the system level, health authorities could strengthen national guidelines by explicitly addressing social differences in recommendations for the treatment of depression. In clinical practice, greater awareness of the inverse care law among GPs could help ensure equal access to treatment.

The Norwegian GP-DEP Study on the treatment of depression in general practice is largely based on diagnostic codes and GPs' reimbursement claims. The relatively crude nature of the diagnostic system means that it lacks information on the severity of depression. More precise recording of diagnoses could improve the usefulness and clinical relevance of health registries and help reduce inequalities.

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