

PUBLIC HEALTH

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**Problems of regulating the quality
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Due to the increasing prevalence of depression, it is necessary to improve medical care to manage the disease. The problems of regulation of medical care quality are analyzed in the article. It is established that the problems are connected both with the general economic condition of Russia, and with the problems in regulation of activity. The second group of problems includes the absence of approved clinical recommendations, mixing of different nosologies in the Standards and Criteria of quality, incomplete set of examinations necessary for patients with depression. Further economic development and approval of the Clinical Guidelines should improve the quality and availability of care for depressed patients.

Keywords: recurring depression, quality of medical care, legal regulation of health care, optimization of health care, health infrastructure.

Major depressive disorder is a chronic mental illness and is characterised by depressed mood and diminished ability to experience pleasure [1]. In recent years, an increase in the prevalence of the disease has been recorded, accompanied by an increase in years lived with disability (YLD) [2]. According to the World Health Organization, the proportion of the population with depression is estimated to be 5.5 % and account for 7.8 % of YLD [3]. According to some calculations, the economic burden of disease is approximately 1.26 % of Gross Domestic Product [4]. The large burden of disease requires an adequate response from the health system to the mental health problems encountered. However, before solv-

ing problems, it is necessary to understand how medical care is provided for recurrent depression and what bottlenecks exist in its provision. The aim of this work is to analyze the regulation of the quality of medical care in recurrent depression.

Review of the regulation of quality care in recurrent depression

As of today the quality of psychiatric care is regulated by the Law on the Protection of Citizens' Health (Federal Law No. 323) [5]. The access to and the quality of medical care consists of ten characteristics, which are regulated by the Federal Law № 323 [5]. Part 1 of Art. 10 requires the proximity of the organization providing medical care to the place of residence, work or training [5]. This provision is implemented in the territorial principle of the work of neuropsychiatric dispensaries, hospitals, offices [6]. However, there is a general problem of developing medical infrastructure and transport accessibility. According to some authors, 17.5 thousand settlements do not have medical infrastructure, 35 % are not covered by public transport [7]. These problems lead to the automatic failure to implement part 7 of Art. 10 of the Federal Law No. 323 [5], as transport accessibility of medical organizations for the entire population is not provided.

Part 2 of Article 10 requires the necessary number of health care staff with the appropriate level of qualification [5]. This requirement is also problematic. So, for the period 2011–2013, the number of psychiatrists decreased from 14,117 to 13,709 [8]. In 2015, there were 12,949 psychiatrists, while in 2017 there were 12,937 of them [9]. A decrease in the number of psychiatrists with a simultaneous high coefficient of part-time employment (1.54 for psychiatrists, 2.0 for psychotherapists) [10], obviously, reflects the lack of staffing in psychiatric offices [8]. For example, the coefficient of part-time employment in outpatient clinics in the city of Moscow varies from 1.07 to 1.75, in inpatient clinics — from 1.13 to 1.24 [11].

Perhaps the lack of staffing is the reason for the massive reductions in neuropsychiatric offices and psychiatric hospitals. The number of psychotherapists (from 1440 to 1361) and medical psychologists (from 3824 to 3657) also decreased during the 2015–2017 [9]. It should be noted that there are 160 psychotherapists in Moscow, or 11.8 % of their total [11].

Following the decline in the number of psychiatrists, health facilities have been reduced. From 2011 to 2013, the availability of psychiatric beds decreased from 104.8 to 100.2 per 100 thousand population [8]. In 2015–2017 the trend towards a reduction in the number of beds continued. In 2015, the healthcare authorities had 136,726 beds at their disposal; by 2017, this number had decreased to 131,277 beds [9]. The decrease in bed capacity has led to the liquidation of facilities providing inpatient psychiatric care. Nine psychiatric hospitals and seven psycho-neurological dispensaries with inpatient facilities have been reduced [9]. In addition, the number of outpatient services has decreased.

The decrease in hospital beds can be explained by a decrease in the number of hospitalizations and an increase in the proportion of outpatient visits [10], which may indirectly indicate an increase in the availability of outpatient care. However, there are no statistical data to support this hypothesis. In 2015 there were 92 psychoneurological clinics, in 2017 there were 83 of them [9]. There was a decrease in the number of institutions with psychoneurological offices. During the same time period, the number of institutions decreased from 2023 to 1939 [9]. Reduction has touched psychotherapeutic cabinets. In

2015 676 healthcare organizations had psychotherapeutic cabinets, while in 2017 their number decreased to 607 [9]. The reduction in the number of psychotherapeutic offices affected five federal districts, while the reduction in psychotherapeutic offices affected six federal districts [9]. It should be noted that against the background of a reduction in outpatient care, there has been some increase in the number of dispensaries in psychiatric hospitals — from 186 to 214 [9].

Implementation of Part 3 of Article 10 of the Federal Law No. 323 [5] remains in question in the context of the described problems. Indeed, as a patient with depressive disorder, to realize the possibility of choosing a medical organization and a physician when there are significantly fewer of them and their distribution across the territory is heterogeneous. For example, in the Volga Federal District in the Udmurt region, the availability of psychiatrists is 1.0 per 10,000 population, in the Perm region — 0.9, in Penza region — 0.3, in the Republic of Chuvashia — 0.4 per 10,000 population [12]. For comparison, in Moscow the availability of psychiatrists is 1.15 per 10 thousand population, while the average availability in Russia is 0.83 per 10 thousand population [11; 13].

In addition, it is not clear how patients can get the guaranteed amount of assistance under Part 5 of Article 10 of the Federal Law No. 323 [5], if there is a lack of psychotherapists and medical psychologists. Despite the development of telemedicine and proposals for the introduction of consultation communication [14], this cannot compensate the lack of specialists on the site. These circumstances are compounded by the reduced availability of psychiatric care due to poverty and social vulnerability of people with mental disorders [15]. In terms of psychological and psychotherapeutic care, this is particularly pronounced. The lack of psychotherapeutic assistance in the framework of obligatory health insurance and most voluntary health insurance programs leads to an increase in the patient's financial costs or to the complete rejection of these medical services [16]. This is especially important when considering that some depressed patients may turn to other specialists for help because of masked depression.

As a consequence of the lack of specialists in the psychiatric field, it should be noted the low detectability of recurrent depressive disorder. In 2009, the prevalence of psychiatric disorders was 4,215,043; by 2018, the number of patients fell to 3,933,156 [17]. According to epidemiological data from the World Health Organization, 7,815,714 people in the Russian Federation suffer from depressive disorders (major depressive disorder, depressive episode or dysthymia) [3]. Obviously, not all depressed patients are covered by psychiatric care. For example, in the course of a continuous clinical and epidemiological survey, it was found that 21.5% of those who applied to a local therapist had depressive disorders [18]. The problem is exacerbated by the limited competence of general practitioners in diagnosing depression and the traditional problem of stigmatization [19]. Typical risk factors for recurrent depression are cited as a demonstration of the likelihood of general practitioners providing care to depressed patients. Factors considered include: female sex, 45 years of age or older, urban population, divorce, unemployment, pension status, agricultural employment, negative family relations and poor relations with other people [20].

Another problem is the practicability of Part 4 of Article 10 of the Federal Law No. 323 [5], which prescribes to be guided by the Procedures and Standards in the provision of medical care. Standards for Treatment of Patients with Recurring Care depression [21–24], as well as the Mental Health Care Procedure [6], approved in 2012. In this case,

there is a problem with the approved Standards. According to part 14 of Article 37 of the Federal Law № 323 [5] Standards are developed on the basis of approved properly clinical guidelines. Clinical guidelines for patients with recurrent depression were first developed in 2014 [25], that is two years after the Standards came into force. As of early March 2020, we had no approved Clinical Guidelines. Therefore, the question arises not only about the legality of the current Standards, but also about their conformity with actual scientific evidence. The Standards are common for both recurrent depression and bipolar affective disorder, although it is known that these are different diseases that require different treatment [1]. Compliance with such Standards can only be formally assessed as quality care, since the possibility of incorrect treatment is inherent in them initially.

In 2017, criteria for assessing the quality of medical care, which relate to the direct assessment of medical activity (PM RF No. 203n), were adopted [26]. This Order has criteria that relate directly to patients with recurrent depression, but only at the hospital level. The requirements are that patients should be examined for depressive and manic symptoms, suicidal risk, psychological evaluation, antidepressant treatment, and symptom reduction of more than 50 % by discharge [26]. In our opinion, there are three problems associated with the implementation of this Order. The first problem is that the criteria formulated are the same for patients with recurrent depression and for bipolar affective disorder, that is, the situation with the Standards of medical care is repeated. This is manifested by the need to evaluate manic symptoms in recurrent depression. A significant diagnostic difference between bipolar affective disorder and recurrent depression is the absence of manic symptoms in the second case [27]. Of course, the diagnosis can change and individual manic symptoms in recurrent depression can be admitted. However, this cannot be considered as a rule. Therefore, a mandatory assessment of manic symptoms seems unnecessary.

The second problem is that the criteria relate only to the inpatient level, although for the outpatient level dynamic assessment of depressive symptomatology is necessary [28]. Outpatients should be examined for depressive severity and suicidal risk in the same way as inpatients. Patients also need to be treated with antidepressants. Of course, there may be options to refuse maintenance antidepressant therapy, but this requires the autonomy of the physician in making decisions. A wide discussion is needed to decide which quality criteria are needed for outpatient care. But there is no doubt that they are necessary.

The third problem was mentioned by A. N. Gvozdetckii et al., namely the absence of cognitive function assessment [28]. Within the framework of the Order only a deployed clinical and psychopathological examination is required. This formulation contains a different spectrum of psychodiagnostic methods. However, according to the latest data, cognitive functions, as well as depression symptoms, have a significant impact on social functioning and quality of life of patients [29; 30], and therefore, their disorders have been singled out as a separate group of symptoms [1]. The absence of objective measurements in the field of mental health does not allow for appropriate monitoring of both the condition and expert issues. The implementation of cognitive function assessment will require the establishment of monitoring mechanisms. Without detracting from the importance of other psychological methods of examination, emphasis should be placed on cognitive assessment of patients.

Conclusion

The problems considered can be divided into two groups as a whole. The first group includes the problems of Russian public health. Underfunding and inefficient spending, as well as poor infrastructure in some regions, make it impossible to fully implement the requirements of Federal Law No. 323 concerning the quality and accessibility of medical care [7]. The second group of problems is specific to psychiatry. Lack of relevant clinical recommendations, individual standards, dynamic assessments at the outpatient phase makes it impossible to adjust the treatment process properly. The solution of the first group of problems lies on the economic plane. To solve the second group of problems, it is necessary to obtain approval of the Clinical Recommendations and revise the Standards based on them, which may become the basis for further improvement of the care of depressed patients.

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