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Introduction

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There have been two relatively recent developments which, when linked together, have brought into focus the cost–benefit and risk–benefit analysis of antidepressant drugs. The first is the development of the new selective serotonin reuptake inhibitors (SSRIs) and the second is the formation within the National Health Service of mental health trusts, based on the principle of providing costed medical care. The SSRIs have a lower risk profile than the older antidepressants, but by contrast are expensive.

In Britain, the exquisite sensitivity to the price of various drugs which has been prevalent in hospital practice, resulting in the production of hospital formularies, has now been followed by similar considerations in general practice, particularly those practices which are fund-holding. Indeed, some of the better ones are now computerised to indicate not only the total costs of prescribing antidepressants, for instance, but also which particular one is chosen and for what reason. One particular practice in the north-east of England was able to give figures on the prescription of SSRIs for depressive illness, eating disorder, and obsessive–compulsive neurosis by each practitioner. That such closer inspection is being given is not surprising, considering the wide range in costs of the various antidepressants. Table 1 indicates the relative costs over 28 days for these drugs: there is almost an 100-fold difference, for example, between generic amitriptyline and paroxetine. Dothiepin is somewhat more expensive than amitriptyline, and lofepramine is a third of the cost of paroxetine. If the comparison is extended to commonly used drugs in general practice over the same period, paroxetine is found to be twice the cost of a month's supply of cimetidine and five times the average cost of a Becotide inhaler.

Mental health units also have to treat patients with costs in mind, and hence there may be a conflict of interest concerning optimal treatment. Since no evidence exists so far that any one of the drugs mentioned has a better efficacy profile than any other, then other considerations such as side-effects and safety become extremely important.

It is not my intention to suggest that pharmacotherapy is the only way to treat depressive illness. Indeed, we must all be hopeful that the research organisations will look at other treatments, such as the psychotherapies and their combination

Table 1
Cost of 28 days' treatment (*British National Formulary*, 23 March 1992)

Antidepressant	Daily dose	Type	Form	Cost
Amitriptyline	75 mg	Generic	84 × 25 mg	= £0.34
		Tryptizol	84 × 25 mg	= £1.93
		Tryptizol s/r	28 × 75 mg	= £2.49
Dothiepin	75 mg	Generic	84 × 25 mg	= £3.99
			28 × 75 mg	= £3.80
		Prothiaden	84 × 25 mg	= £4.20
			28 × 75 mg	= £4.00
Lofepramine	140 mg	Gamanil	56 × 70 mg	= £9.97
Paroxetine	20 mg	Seroxat	28 × 20 mg	= £31.64
Cimetidine	800 mg	Generic	28 × 800 mg	= £16.54
		Tagamet	28 × 800 mg	= £19.19
Atenolol	50 mg[1]	Generic	28 × 50 mg	= £4.81
		Tenormin	28 × 50 mg	= £5.49
Becotide	100 mg q.d.s.	Becotide	112 × 100 mg	= £5.91

1. Usual dose nowadays.

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with drugs, to assess not only how successful is the outcome of treatment, but also to what extent prophylaxis against relapse is engendered. It is unlikely that the perfect drug will be manufactured within the foreseeable future, and it would also be surprising if the perfect psychotherapy could be delivered within the same time. However, a striving towards a union of the two approaches would represent progress along the way to answering the ubiquitous problem of depressive disorder.

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