Society for Women's Health Research

January 25, 2022

Jennifer Bright, MPA
Executive Director
Innovation and Value Initiative
917 Prince Street
Alexandria, VA 22314

Rick Chapman, PhD
Chief Scientific Officer
Innovation and Value Initiative
917 Prince Street
Alexandria, VA 22314

Re: Innovation and Value Initiative Comment Period on the Major Depressive Disorder Draft Model Protocol

Dear Ms. Bright and Dr. Chapman,

On behalf of the Society for Women's Health Research (SWHR), I am writing to provide comments on the Innovation and Value Initaitive (IVI) draft protocol of IVI's economic model for major depressive disorder (MDD). SWHR appreciated the opportunity to provide comments in May on the value model's scope and is glad to now share thoughts on the draft protocol.

For more than 30 years SWHR has been dedicated to promoting research on biological sex differences in disease and improving women's health through science, policy, and education. SWHR has brought attention to diseases and conditions that disproportionately or differently impact women—like MDD. MDD is nearly twice as likely to occur in women than men, with lifetime prevalence rates of 21% and 12%, respectively.[1] This increased prevalence for women emerges around puberty and continues throughout the lifespan.[2] While it is unclear exactly why the gender gap in MDD exists, hormonal changes, inherited traits, and stressful personal life circumstances and experiences have all been associated with a higher risk of depression in women.

Given MDD's prevalence in women, SWHR is pleased to provide the following comments on IVI's economic model for MDD for consideration:

[1] Sloan, DM, & Sandt, AR (2006). Gender differences in depression. *Women's Health, 2*(3), 425-434.
[2] Albert, PR (2015). Why is depression more prevalent in women? *Journal of Psychiatry & Neuroscience, 40*(4), 219-221. doi: 10.1503/jpn.150205

1025 Connecticut Ave NW, Suite 1104
Washington, DC 20036
T 202.223.8224
F 202.833.3472
W swhr.org

Target Population

SWHR appreciates IVI's work to ensure that the model design reflects real-world treatment sequences and key value elements from a societal perspective, and we are glad to see that the model design will allow users to specify subgroups, including gender, and/or use subgroup-specific inputs to make comparisons across them. However, we would strongly encourage IVI to ensure that its protocol includes both sex and gender to reveal the biological and environmental and social impacts across pouplations. It is well-known that symptom presentation varies by gender, and the differences in prevalence, presentation, and coping are important to consider in determining the value of treatments. There also exists some evidence that certain treatments may be more effective depending on an individual's biological sex—for example, selective serotonin reuptake inhibitors (SSRIs) may be more effective in the presence of estrogen.[3] Having the ability to disaggregate data based on factors such as sex and gender will be important for answering IVI's prioritized research questions regarding the societal burden of untreated or under-treated MDD, differences in model outcomes across subgroups compared with the overall population, and "low-value" care in real-world treatment sequences.

Of note, SWHR encourages IVI to revisit MDD with respect to preconception, as well as prenatal and postpartum, women. "Pregnancy" is not mentioned once within the draft economic model, and "postpartum" is mentioned just once. SWHR recognizes that separate recommendations are available for postpartum depression, but we suggest IVI explicitly and operationally define postpartum depression within the list of exclusion criteria. There remains a great deal of debate as to whether a depressive episode occuring during the postpartum period is sufficiently different than MDD episodes that occur outside of this life stage. Evidence as to the clarity and certainty of this distinction is mixed and largely depends on how the postpartum period is classified (e.g., depression occuring early in the postpartum period—up to eight weeks postpartum—may be distinct from depression with onset during the later postpartum period, with the latter more similar to typical MDD episodes).[4]

Patient Experience

Women are frequently primary caregivers for their family members; between 53 and 68 percent of caregivers are estimated to be women.[5] These roles can be either informal or formal: hands-on caregiver, case manager, companion, decision-maker, and advocate.

SWHR was pleased to see that IVI's model incorporated caregiving, noting that it "is a concern in the MDD community." Yet, while SWHR was glad to see that factors related to informal caregiving were included in the model, the focus was on individuals with MDD who have a caregiver. SWHR would encourage IVI to revisit its decision that

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[3] Gorman, JM. (2006). Gender differences in depression and response to psychotropic medication. *Gender Medicine, 3*(2), 93-109. doi: 10.1016/s1550-8579(06)80199-3.

[4] Batt, MM, et al. (2020). Is postpartum depression different from depression occurring outside of the perinatal period? A review of the evidence. *Focus.* doi: 10.1176/appi.focus.20190045

[5] Family Caregiver Alliance. Who Are Family Caregivers? https://www.apa.org/pi/about/publications/caregivers/faq/statistics. Accessed 25 January 2022.

"other concerns about caregiving, including that some caregivers have lost work, have changed jobs, or have suffered mentally and/or physically…are not planned to be incorporated in the model." Reports suggest that up to 20% of family caregivers suffer depression—a rate approximately twice that of the general population. In general, women who provide care for family members experience higher rates of depression than men.[6] SWHR strongly recommends the needs and input of individuals who have MDD and who are also caregivers for others be considered when evaluating patient needs and experiences.

Also related to patient experience is the economic burden of MDD, and specifically, the economic burden of MDD on women. A draft economic model such as IVI's could help determine whether insurance coverage and out-of-pocket costs are imbalanced for women and how that economic burden impacts their care. According to findings from the 2020 Kaiser Family Foundation's Women's Health Survey, among women who have been to the doctor in the past two years (93%), uninsured women (55%) are significantly less likely to have discussed mental health issues with their health care provider than women with health insurance (70%)—and further, Black (61%) and Asian (60%) women are less likely to have had this discussion with their provider than white women (72%).[7] SWHR appreciates IVI's comment that studies of the national economic burden tend not to be granular enough to differentiate between treatments, and therefore sees the value of utilizing a bottom-up approach for identifying health costs to capture this information, as it is critical to one's experience.

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SWHR appreciates the opportunity to comment on this important economic model. If you have questions, please do not hesitate to reach out to me at kathryn@swhr.org.

Kathryn G. Schubert, MPP
President and Chief Executive Officer
Society for Women's Health Research

[6] Family Caregiver Alliance. Caregiver depression: A silent health crisis. https://www.caregiver.org/resource/caregiver-depression-silent-health-crisis/

[7] Long, M, Frederiksen, B, Ranji, U and Salganicoff, A. Women's Health Care Utilization and Costs: Findings from the 2020 KFF Women's Health Survey. Published April 2021, https://www.kff.org/womens-health-policy/issue-brief/womens-health-care-utilization-and-costs-findings-from-the-2020-kff-womens-health-survey/view/footnotes/ Accessed 19 Jan 2022.