IBI Research Insights

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Are You Depressed Yet?

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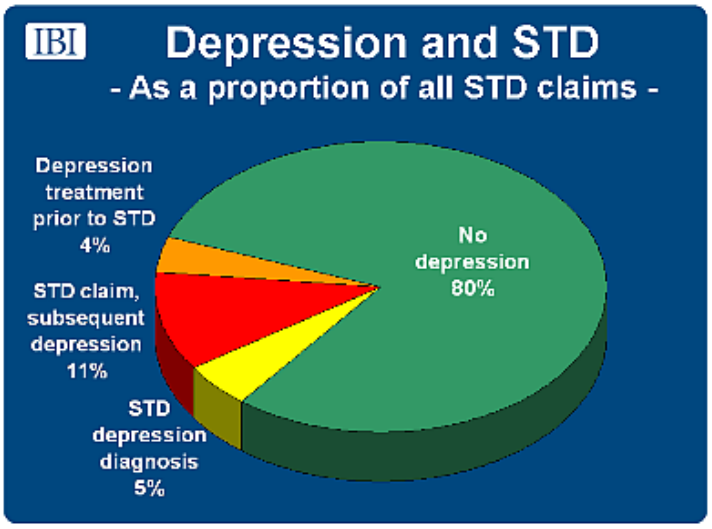
January 2009

It's hard not to be depressed by the news that screams at us every day. The stock market. Retirement plans (or now, lack thereof). Wars. Financial meltdown. Friends losing jobs. Yet, what we experience as anxiety about the future may slip into real depression with all its consequences.

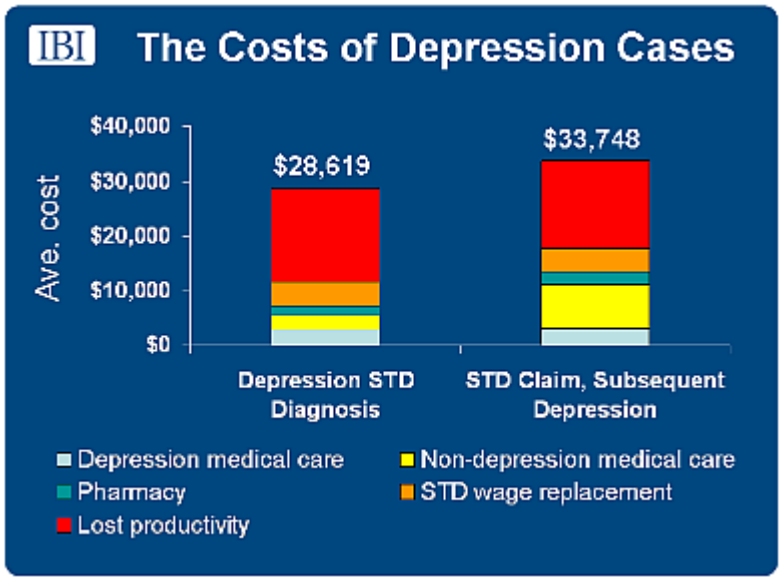
Mental health professionals often refer to depression as the "common cold of mental illness." World wide, depression is the second-leading cause of disability.[1] At the same time, the National Co-Morbidity Survey suggests that timely diagnosis and access to care are problematic: typically, eight years pass between the onset of depression and treatment.[2]

New IBI Research. Because depression is so prevalent, devastating and undertreated, attention now is turning to its broader lost-time and lost-productivity consequences. When considering these broader issues, we often think about depression in terms of short-term disability claims. IBI's newest research extends that view to include cases that develop depression subsequent to the disability event and depression cases that never show up in the medical or disability claims system at all. Some initial insights from this new research are reported here, while expanded preliminary results will be presented at the IBI/NBCH National Forum on Health and Productivity on February 9-11 in Los Angeles,[3] with full publication later this winter.

For the first part of this research, IBI used medical, pharmacy, short-term disability, long-term disability, and workers' compensation claims data for 400,000 employees from six large companies. These data show that, during the 39-month study period, 17% of the employees didn't access health and related benefits. Of those who did, 80% used only group health benefits and 20% had some form of occupational or non-occupational disability claim. Ten percent of all workers received medical treatment for depression.

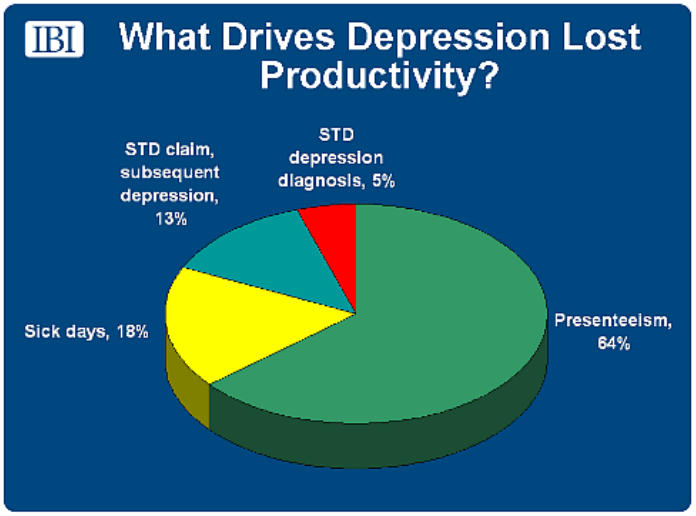


Two in ten of the employees in this data set who filed at least one claim for short-term disability (STD) received medical treatment for depression. What is notable is that only about 5% of the STD cases were filed with a depression disability diagnosis. More than twice that proportion (11%) filed an STD claim for a non-depression diagnosis, yet were treated for depression during the STD episode (and without any previous depression medical care during the study period).



In this exhibit, we examine costs for two types of cases involving depression: those filed as an STD claim with a depression diagnosis and those filed as an STD claim with a non-depression diagnosis but involving medical care for depression during the STD episode. Several things stand out. First, lost productivity[4] associated with STD lost time is the largest component of the "full costs"[5] for both types of cases (59% and 48% of the total, respectively). Second, medical care for multiple health conditions exists in both types of cases, but medical care represents a significantly smaller share of the full costs for depression STD cases (26% vs. 39%, respectively; it is unclear whether better depression management would have an impact on other medical costs for the second type of cases). Third, in both types of cases, pharmacy costs are a relatively small share of the total (only about 6% in both).

Going Beyond Claims Data. However, we also have evidence through our work with employee self-report data from the Health and Work Performance[6] (HPQ) database that depression is a far more frequent condition than medical and disability claims data would suggest. These data tell us that, while 28% of employees report being depressed (compared to the 10% we see in this research database), 70% of those individuals are not currently under the care of a medical professional, and 97 out of 100 report co-morbid chronic conditions. Furthermore, these individuals reporting being depressed average about 10 days of absence and presenteeism lost time each year.



We develop estimates of lost productivity associated with depressed employees by bringing together prevalence and lost-time statistics from the claims and HPQ data sets. Analysis of these joint data suggest that lost productivity for employees with depression is heavily influenced by presenteeism--nearly two-thirds of depression lost productivity occurs while people are at work. Absence sick days are the second largest source at 18%, while 13% is associated with cases where depression develops after a non-depression STD claim is filed. Only 5% of depression lost productivity is generated by people filing STD claims for depression.

Commentary. The preliminary findings from this research suggest three things. First, managing the full consequences of depression means that we have to step well outside of the short-term disability system. Second, because of the prevalence of co-morbidities, we also must take a "whole person" approach and not just a "disease-specific" approach. Third, the research emphasizes that the prevalence and impact of depression are far more significant than we would expect from simply examining medical, pharmacy and disability claims data. To measure the full effect, it will be critical for employers and their supplier partners to expand sources of health-related data into the self-reporting arena.

Research by RAND shows that there is a great deal of room for improvement: there continues to be low rates of detection of the condition, depression treatment is effective in 70 to 80% of the cases, yet only about 60% of those treated for depression are getting recommended care[7].

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1. *The Societal Promise of Improving Care for Depression*. RAND, 2008 and *The First National Report Card on Quality of Health Care in America*. RAND. 2006.

2. Kessler, R; et. al.; "The National Comorbidity Survey Replication (NCS-R): Cornerstone in Improving Mental Health and Mental Health Care in the United States;" in The WHO World Mental Health Surveys. World Health Organization, 2008.

3. Click here for more information about the Forum.

4. Lost productivity is quantified using "opportunity cost" multipliers developed by Nicholson and Pauly (see Sean Nicholson, Mark Pauly, et al., "Measuring the Effects of Work Loss on Productivity with Team Production," Health Economics 15: 111-123 (2006).

5. Full costs include medical care for depression; medical care for co-morbid conditions; pharmacy; STD wage replacement; and lost productivity)

6. The Health and Work Performance Questionnaire was developed by Dr. Ronald Kessler, Harvard Medical School, and the World Health Organization.

7. *The Societal Promise of Improving Care for Depression*. RAND, 2008 and The First National Report Card on Quality of Health Care in America. RAND. 2006.

Thomas Parry, Ph.D. is President of the Integrated Benefits Institute and serves as IBI's Chief Executive Officer. Tom is heavily involved in IBI's research program. Most recently, he directed a study analyzing the impact of linking medical care and disability data and directed research on how Chief Financial Officers link workforce health to business outcomes.

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