

newsletter

Depression

Depression is recognised as a serious illness with many different symptoms. It can afflict anyone. The WHO predicts that within 15 to 20 years clinical depression will grow to be the most prevalent mental illness in industrial nations and become "the single biggest cause for burden out of all health conditions" worldwide. This trend has implications also for certain areas of the insurance industry.

Definition

Depressions are affective disorders characterised by clinically significant mood swings. Often, the condition is masked by physical symptoms, and it tends to be associated with anxiety disorders. A person may suffer from depression only once in their entire lifetime or in recurrent episodes. In its *International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)*, the World Health Organisation (WHO) refers to the condition, in chapter 5, as a "major depressive episode" (MDE) and a "recurrent depressive disorder". It is diagnosed on the basis of defined symptoms and their persistence (for a minimum of two weeks without intermittent relief). The DSM-IV meanwhile is a US classification system and lists additional diagnostic criteria. An MDE is diagnosed under this system if at least five symptoms are present that indicate a depression: despondency, joylessness, low energy, loss of self-confidence, unfounded self-accusations, undue feelings of guilt, a shorter attention span, recurring thoughts of death, lack of appetite, and sleep disorders.

Current issues

In the late 1990s the WHO launched the World Mental Health (WMH) Survey Initiative, the largest-scale coordinated, cross-national series of surveys ever done on the epidemiology of mental illnesses. Data were collected in structured and standardised interviews. Using this method, an international team of researchers in July 2011 published results from the pilot survey which contrasted the prevalence of depression in wealthy (high GDP) countries with that in emerging and developing nations. More than 89 000 individuals in 18 countries were interviewed for the survey and their state of health recorded, along with their history of MDEs, if any (www.biomedcentral.com/content/pdf/1741-7015-9-90.pdf). The ten high-GDP countries surveyed were Germany, Belgium, France, Israel, Italy, Japan, the Netherlands, New Zealand, Spain and the US. The eight low- to middle-income nations were Brazil, Colombia, India, China, Lebanon, Mexico, South Africa and Ukraine. The survey again highlighted that MDEs are a major issue in every region of the world. Nearly 121 million people are affected each year (EU: 21 million; US: 19 million). In high-GDP countries, 15% of the population are at risk of suffering an MDE at some point in their lifetime, versus 11% in low- to medium-income countries. Women are twice as likely to be affected. The survey found that the number of screen-positive respondents with lifetime MDE – that is, interviewees who had experienced at least one episode in the past – was significantly elevated in the high-GDP countries, at 28%, versus 20% in developing and emerging nations. The percentage of respondents with lifetime MDE was particularly high (over 30%) in France, the US and the Netherlands; the ratio for China was only 12%. Further surveys are being planned to investigate

how MDEs are associated with demographic risk factors in the countries most affected. A major factor will likely be stress induced by today's work environment (high workloads, job-security fears and mobbing).

Socio-economic aspects and costs

A depression (www.psychosoziale-gesundheit.net, in German) is a significant burden on those affected, causing them much suffering and impairing their quality of life and, notably, affecting their social and professional relationships. The costs to the economy associated with diagnoses of depression are becoming an ever-growing challenge. This is because despite high success rates and good prognoses for patients receiving early and adequate treatment (through antidepressants and psychotherapy), only a third of those affected in the EU receive professional attention, or undergo therapy, in any form. To make matters worse, treatment often only starts years after the onset of depression and rarely meets the minimum standards of adequate therapies (European Neuropsychopharmacology 2011; 21: 655-679). If left untreated, depressions can become chronic or may aggravate various physical symptoms and require more extensive treatment as a result. Some 30% of patients need to be readmitted within two years for inpatient treatment of mental disorders. One in ten returns within a month of being discharged, one in five does so within three months (Krankenhausreport Barmer, in German). Between 10%-15% of patients attempt suicide. Surveys among patients found that between 8%-17% received no recommendations from their hospital for follow-up treatment on an outpatient basis. This may be due to poor coordination between inpatient and outpatient care, a shortage of places available on treatment programmes, a lack of prompt follow-up treatment, or demand-requirements planning that fails to meet actual treatment demand. Depression in all its forms is a major contributor to the global health burden (in terms of disability-adjusted life years, or DALY, it ranks first in 17 EU member states and fourth worldwide), the more so for being associated with many serious physical ailments (Bundesgesundheitsblatt 2011 54:15-21, in German). In Germany in 2010, 8.5 in 1 000 insureds were in hospital care for mental disorders, up from 3.7 in 1990. Averaging 31 days per stay and accounting for 17% of total hospital days, mental disorders surpassed cardiovascular diseases for the first time last year. In the EU, direct medical costs per patient and treatment range between EUR 200 and EUR 14 000 (Eur J Neurol 12, Suppl. 1, Andlin-Sobocki et al (2005)). These make up only some 35% of total costs, however. The bulk of the cost burden is due to temporary and long-term disability, early retirement and lower productivity, and is absorbed by the social insurance systems and by employers. In the EU close to 1% of GDP (EUR 255 per capita) is spent on treating depression overall (http://ec.europa.eu/health/mental_health). A person with MDE is unfit to work roughly 25% of the time any given year; the rate for a diabetic is only 12%. Depressions are the main cause underlying productivity losses in the EU. About 13% of the population will suffer an MDE at some point in their lives. Another 32% have a temporary or a long-term disability due to mental illnesses. Extensive research done over the past ten years on the psychological impact of catastrophes has shown that depressions, anxiety disorders and post-traumatic stress disorders (PTSD) are the primary health consequences for a majority of survivors, frequently in association with somatic symptoms. It is reasonable then to assume that the same applies to countries recently hit by environmental or social catastrophes or wars, in combination with long-term social, cultural and economic fallout. No EU data are available, in particular, on the prevalence and epidemiology of mental health issues among the 65-and-over age demographic. To address this gap, the EU Commission launched its MentDis 65+ project in 2008 (www.mentdiselderly.eu). Corresponding data on children and youth are in similarly short supply.

Information for the underwriter

Depression is a serious condition with an impact on a range of insurance lines. Applicants for life, accident or pension insurance who report a known history of mental illness undergo a personalised risk assessment procedure to help guide the decision on their insurability, premium loads, rejection or deferral. Accident and disability income insurers are seeing a marked rise in the frequency of mental illness-related claims. This reflects the growing recognition of accidents as a cause of mental-health issues.

Other sectors so far have been less responsive to the issue of mental health-related disability and to the rapid changes it is introducing to the health and occupational disability risk landscape.

Insurers therefore are encouraged to develop new insurance and service solutions for the mental-health market and to roll out disease- and case-management programmes. The objective should be to increase the direct health costs (through education, early detection, information, comprehensive offerings, and access to the full spectrum and range of therapy options) with a view to lowering the enormous indirect costs in the long term. This might be achieved through tailored insurance plans and tariffs.

At the same time, it is important for companies to remember to take actions in-house for the mental health of their own employees, as partial or full productivity losses directly hit the bottom line. Accordingly, risk assessments on companies applying for insurance should verify what mental-health programmes these have in place, if any, as well as programmes for early detection and intervention in the workplace. It may not be long before prevention programmes to ensure financing for preventive mental-health insurance become law.

Product liability is directly affected. In the pharma business, for example, growing demand drives the development of new pharmaceutical solutions and the approval of new products (including such for self-medication). Capping expenditure earmarked for therapy may lead to a shortage of antidepressants and to more affordable substances being prescribed that may not be state of the art.

In the context of the debate on genetic testing, it should be noted that a person's predisposition to depression appears to be hereditary and to depend on the length of the 5-HTT, or 5-HT (serotonin) transporter, gene.

Moreover, depression may have an impact on insurance covers under which a diagnosis can trigger a payment. Examples of these include disability income insurance, occupational and private retirement provision, travel cancellation insurance, supplementary health insurance, credit life insurance, loss-of-licence insurance for air pilots, and other products.

Contact

AssTech GmbH
Postfach 1211
85766 Unterföhring bei München
Telephone + 49 89 3844-1585
Telefax + 49 89 3844-1586
info@asstech.com
www.asstech.com