



This research was commissioned and funded by AbbVie

EXECUTIVE SUMMARY

Depression: the “Chronic Pain” of the Modern WorkPlace

In the mid-20th century industrial economy, a majority of workers performed physical labor, and the biggest chronic workplace health issues causing the most functional impairment and productivity loss from absenteeism and presenteeism were musculoskeletal. Low back pain and osteoarthritis were the leading reasons for this as well as the main cause of early exit from the workforce due to disability. The workplace of today reflects the developed world’s dramatic shift away from physical labor to knowledge-based work in a “post-industrial” economy. In this changed workplace, **mental pressures have replaced physical strains as the more common health risk factor, explaining why depression has become the leading cause of productivity loss and disability from functional impairment – worldwide.**

Depression, indeed, is the “new chronic pain” of the modern economy.

Domains of Depression

Clinical depression is not a simple condition to address, however, validated screening tools such as the PHQ-9 help to identify common symptoms such as:

- **depressed mood,**
- **loss of interest** in life and work,
- **sleep issues and fatigue,**
- **functional impairment** that interferes with work performance/productivity,
- thoughts of **self-harm** and **suicide.**

PHQ-9 scores can exceed 20, with a score of 10 considered the “threshold” for **Major Depressive Disorder (MDD)** – incorporating the categories of *Moderate, Moderately Severe, and Severe* depression.

Prevalence and Total Economic Cost Burden

At any given time about **8% of adults** suffer from **MDD (6% of men and 10% of women)** with double that rate in younger adults. The **Total Economic Cost Burden of MDD in 2023 was more than \$380 billion,** including:

- **Workplace costs of absenteeism and presenteeism for MDD itself and – for 60% of sufferers – co-morbid health conditions** such as anxiety, substance use disorders, and chronic cardio-metabolic conditions such as heart disease, diabetes, and obesity.
- **Direct treatment costs** for MDD as well as these same co-morbid conditions.

Only about 40% of the total economic cost burden of MDD was attributable to MDD itself, with the larger share due to the co-morbidities.

- These **co-morbid conditions complicate treatment of MDD** – reducing the efficacy of anti-depressants while increasing the risk of depression relapse.

Workplace costs have risen much more than direct treatment costs since 2010 – from 48% to 61% of the total economic cost burden – meaning that **employers are experiencing greater productivity loss from workers with MDD while spending less on direct treatment, even as the prevalence has risen.**

Depression and Productivity Loss

The significant increase in workplace costs as a share of total economic costs has occurred in a younger working population, as the combined effect of:

- **absenteeism** (constituting **30%** of workplace costs)
- **presenteeism** (constituting **70%**) – as **MDD interferes with performing job demands more than 40% of work time, heavily impacting productivity while at work.**

The average employee with *clinically diagnosed depression* experiences **functional limitations** in performing their work from **20% to almost 50% of the time** in a *two-week period* – **equivalent to missing 1 to 2 workdays** in those two weeks.

In Summary

Major Depressive Disorder (MDD) has become a **leading cause of disruption and economic cost** in the modern knowledge-based workplace – from **productivity loss** as well as **early exit from the workforce due to disability.**

- The **prevalence of MDD has increased among working-age Americans over the past decade or more** – especially among younger workers
- The **total economic cost burden of MDD has increased even more markedly, mostly from workplace-related costs** such as lost productivity due to absenteeism and presenteeism
- The **direct treatment cost of MDD has declined as a share of total cost burden**, as the percentage of those diagnosed and seeking treatment has remained at just 60%, helping explain the significant increase in workplace-related costs as the prevalence of MDD has increased, especially among younger workers
- The **share of total costs from MDD itself has remained the same at just under 40%. The greater share still comes from co-morbid conditions:** 1) other mental health disorders such as anxiety; 2) chronic diseases such as diabetes and obesity.

The Economic Burden of Major Depressive Disorder (MDD)

Key Findings from Published Research

Depression: the “Chronic Pain” of the Post-Industrial Economy

The mid-20th century U.S. economy was dramatically different from today’s – with half or more of workers engaged in the “industrial” economy of physical labor. It was more an economy of “things” – the extraction and processing of raw materials, the production of intermediate goods such as steel and lumber, and the manufacture of finished goods such as machinery, housing, and automobiles.

In that more physical economy, the biggest chronic workplace health issues causing the most functional impairment and productivity loss from absenteeism and presenteeism were musculoskeletal – low back pain and osteoarthritis, in particular. They also were the leading reason for early exit from the workforce because of disability.

The changed workplace world of today depends far more on the brain than the body, as the developed world has moved increasingly away from physical labor – now engaging less than a fifth of workers – to knowledge-based work in the “post-industrial” economy. This transformative shift to a more “mentally-based” workplace has been accompanied by a shift in the preponderance of chronic health risks and conditions, from musculoskeletal to mental health disorders, making **depression a leading cause of disability worldwide**.¹

It’s not an exaggeration to call depression the “new chronic pain” of this modern economy of mental and interpersonal work, having seized that mantle from musculoskeletal pain. Among all medical conditions, depression may have the greatest negative impact on time management and productivity.^{2,3} Presenteeism – or productivity loss while at work – is 5 to 10 times greater than absenteeism in its impact on productivity.^{4,5}

The Domain of Depression

Although clinical depression is not a simple condition to address, validated screening tools such as the PHQ-9 help to identify common symptoms such as:

- depressed mood

- loss of interest in life and work
- sleep issues and fatigue
- functional impairment (which interferes with work performance/productivity)
- thoughts of self-harm and even suicide (which call for an immediate, thorough clinical assessment regardless of the PHQ-9 score).

PHQ-9 scores measure the presence or absence of major depression, and its severity, which along with a diagnosis from a medical professional, can guide treatment. A score of less than 5 means minimal or no depression, while a score of 10 is considered the “threshold” for **Major Depressive Disorder (MDD)**, which incorporates the *moderate*, *moderately severe*, and *severe* (a score of 20 or more) categories of depression.

Prevalence and Economic Cost Burden

Major Depressive Disorder (MDD) is prevalent at a given time in about 8% of adults (6% of men and 10% of women), with much higher rates for younger adults.⁶

This White Paper presents findings from the published research on the **Total Economic Cost Burden of MDD**, which includes:

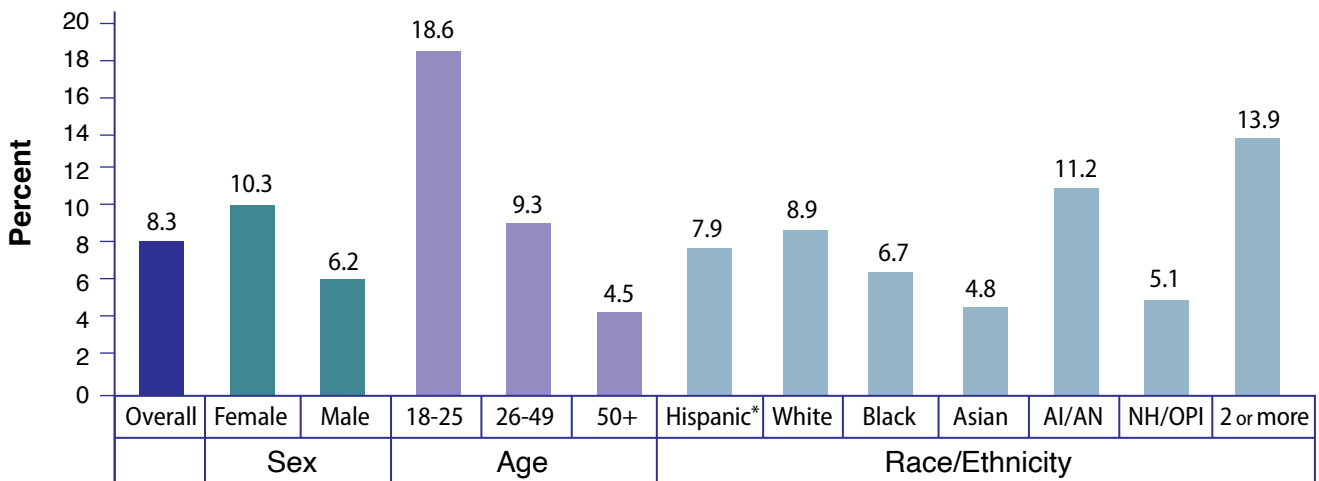
- Workplace costs (absenteeism and presenteeism for MDD and co-morbid health conditions)
- Direct costs
 - depression diagnosis and treatment (underdiagnosis and undertreatment of MDD will increase workplace costs from absenteeism and presenteeism)
 - additional costs of diagnosis and treatment of co-morbid health conditions
- Other Indirect Costs:
 - Suicide-related costs (mortality)
 - Workplace costs for informal caregivers (absence/lost work time, presenteeism and lost productivity)

Paul Greenberg’s landmark study⁷ published in *Pharmacoeconomics*, showed significant increases in both the prevalence and total economic cost burden of MDD since 2010 (the last year of his previous study published in the *Journal of Clinical Psychiatry*). Over this **pre-pandemic period 2010 to 2018**, the **prevalence** of MDD among working-age adults increased from 7.1% to 8.7%, while

FIGURE 1

Past Year Prevalence of Major Depressive Episode Among U.S. Adults (2021)

Data Courtesy of SAMHSA



* Persons of Hispanic origin may be of any race; all other racial/ethnic groups are non-Hispanic
AI/AN = American Indian/Alaskan Native
NH/OPI = Native Hawaiian/Other Pacific Islander

the **economic cost burden** rose by twice as much to \$326 billion. Based on population surveys, the prevalence of depression symptoms (some of which may have been clinical depression) jumped during the pandemic (especially for adolescents), eventually returning to 8.3% for all adults in 2021, with higher rates for younger adults (Figure 1).

Shift in the Makeup of the Economic Cost Burden

Based on Greenberg's studies⁷, the rise in the total economic cost burden of MDD slowed compared with the earlier period of 2010 to 2018 but still reached \$382 billion in 2023. The composition of the cost increase in MDD shifted markedly over the period 2010 to 2018 after remaining stable during the previous period of 2005 to 2010 studied by Greenberg.

- **Workplace costs** (absence/time loss and presenteeism) **rose**, from 48% to 61% of total economic cost – or **from half to three-fifths**
- At the same time, **direct costs of treatment fell** from 47% to 35% of total costs – or **from half to one-third**

The average direct cost of treating an MDD case fell 9.3% – driven significantly by a big decline in pharmacy expenditures from 13% to 6% of direct costs, due in part to a reduction in the cost of prescription drugs as generic antidepressants became increasingly available.

- Overall, however, the **total economic cost burden rose 38%**, though the treatment rate increased only 2.8%, and the proportion of those severely impaired by MDD did not change.
- **Suicide-related costs declined** from 5% to 4% of total costs even though they rose 22.8% in absolute terms – in parallel with a 25% increase in actual suicides.

The overall increase in the total economic cost of depression incorporates a dramatic shift in the composition of that total, from the direct costs of treatment to workplace costs. This 2010 to 2018 change was partly due to population demographics; the number of adults with MDD rose by 12.9%, or 2 million, while the proportion of those adults aged 18 to 34 jumped from a third to half of the total.

During this period, the proportion of all adults receiving treatment remained the same – at about 60% for those with a major depressive episode in the past year. Treatment rates for those with severe functional impairment were higher (75%), but a ***persistent overall treatment gap remains***, with 2 in 5 not getting care – especially those with less severe but still debilitating symptoms.

In the ***post-pandemic years***, direct treatment costs have risen ***slightly*** as a share of economic cost burden, while workplace/indirect costs (including suicide-related) have remained about the same, reaching a total of \$382.4 billion in 2023, compared with direct treatment costs of \$127.3 billion. In brief, the makeup of MDD-related total economic costs did not change notably as it had in the period prior to the pandemic, leaving ***workplace/indirect costs, including lost productivity, as the largest economic burden on employers from MDD.***⁸

Cost of Co-Morbidities of MDD

Strikingly, ***less than half the total economic cost burden of MDD is due to its diagnosis and treatment. In fact, most of the direct costs of care reflect the costs of treatment for co-morbid conditions.*** At least 60% of MDD sufferers have one or more comorbidities and more than half also suffer from anxiety disorders, while many also have substance use disorder and chronic cardio-metabolic conditions such as heart disease, diabetes, and obesity. These comorbidities generate additional costs attributable to both their care as well as the added costs of treating the MDD.

These co-morbid conditions complicate treatment of MDD itself – reducing the efficacy of anti-depressants and increasing the risk of depression relapse. ***The proportion of total economic costs attributable just to MDD remained stable from 2010 to 2018 at 37% to 38%***, so that for every dollar spent directly for treatment of MDD and \$2.30 incurred in related workplace costs, another \$5.61 was spent or incurred for the treatment of comorbidities or their impact on productivity due to absenteeism or presenteeism.

Caregiving Costs

The costs of informal caregiving for those with MDD are also significant. A 2020 study of employed informal caregivers for patients with Treatment-Resistant Depression (TRD)⁹ determined the average annual indirect costs were \$3,300 higher for these caregivers than for caregivers of non-TRD patients. Most of this cost was due to lost productivity at work due to presenteeism.

Depression and Productivity Loss

The significant increase between 2010 and 2018 in workplace costs of MDD as a share of total economic costs for a younger employed working population of sufferers was the combined effect of:

- more absence from work
 - **Absenteeism** increased by 129% to make up 30% of total workplace costs
- greater presenteeism while at work
 - **Presenteeism** rose 57% to account for 70% of total workplace costs

In a seminal peer-reviewed study¹⁰ (republished by IHPM in ***Health & Productivity Management*** magazine; **Academy Brief: The Clinical and Occupational Correlates of Work Productivity Loss Among Employed Patients With Depression**, pg. 28), Dr. Debra Lerner (*Director of the Program on Health, Work and Productivity at Tufts Medical Center*) found that MDD interfered with performing job demands 40% or more of the workday – resulting in presenteeism that heavily impacted productivity at work. The study was conducted using the Work Limitations Questionnaire (WLQ), a survey instrument developed by Dr. Lerner and Ben Amick using the science of psychometrics to measure the degree to which health conditions interfere with specific components of work performance and the productivity impact of these work limitations.

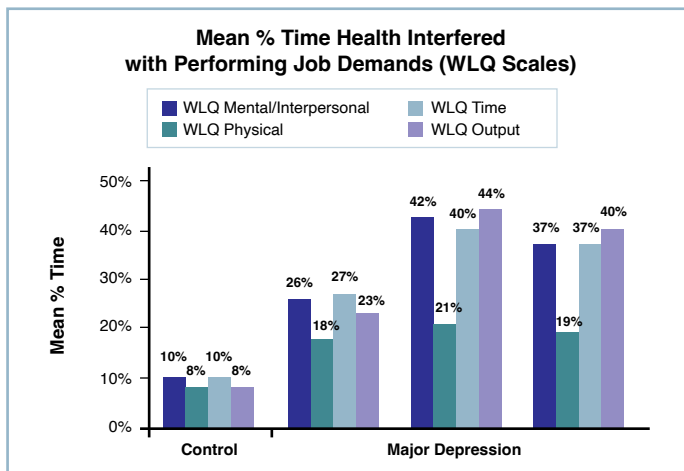
Not surprisingly, these losses were greater for employees whose work required proficiency in decision-making, communication, or frequent customer contact, rather than physical tasks.

Productivity loss was influenced markedly by depression severity with MDD having the greatest impact, much greater than Persistent Depressive Disorder (formerly called Dysthymia – a chronic low-level form of depression lasting at least two years).

FIGURE 2

ACADEMY BRIEFS

The Clinical and Occupational Correlates of Work Productivity Loss Among Employed Patients With Depression



Occupational requirements are associated with productivity loss among employees with depression

- Productivity loss was influenced by depression severity
- Losses increased when employees had occupations requiring proficiency in decision-making and communication and/or frequent customer contact
- By identifying employees with most productivity losses, the WLQ tool can help to identify productivity improvement priorities

Regression Models: Relationship of Productivity Loss to Specific Occupational Requirements and Specific Depression Symptoms

	Mental/ Interpersonal	Physical	Time	Output
Variables	β	β	β	β
Occupational Requirements				
Judgment/communication (0-1)	10.0	-3.9	16.9*	22.9*
External customers (0-1)	8.5*	8.8*	6.2	4.4
Depression Symptoms				
Concentration loss (0-1)	29.7*	9.0*	27.1*	36.0*
Fatigue/sleep problems (0-1)	15.6*	5.4	12.7*	18.8*
Physical health (0-1)	-28.4*	-49.6*	-37.6*	-23.4*

* $p < .05$

The study sample consisted of 246 employees with diagnosed depression (dysthymia, major depression or double depression²⁰) and 143 healthy controls. All depression and control subjects were recruited from primary care physicians' offices between February 2001 and February 2003. Enrollees were asked to complete mail surveys every six months for eighteen months. A \$20 cash incentive was paid for the baseline survey and \$10 for each follow-up.

Surveys included 25-item Work Limitations Questionnaire (WLQ), PHQ-9 depression questionnaire and SF-12 physical health assessment. Enrollees were primarily female (88%) and white (90%) with a mean age of 40 years.

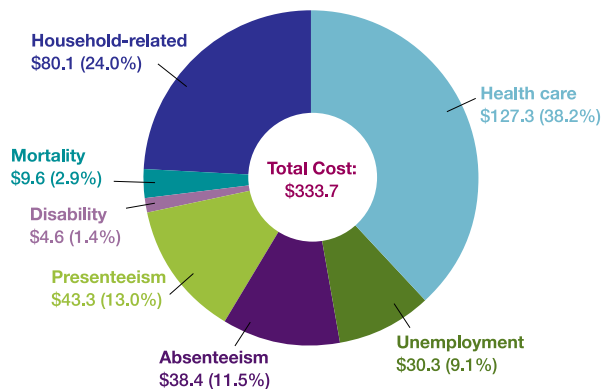
Results indicated that depression severity and specific symptoms influenced productivity losses. Losses increased when employees had occupations requiring proficiency in decision-making and communication and/or frequent customer contact.

In the workplace, depression and anxiety are associated with presenteeism, absenteeism, work disengagement, job turnover, job loss, and career stagnation, resulting in erosion of economic security and quality of life for employees and their families. Employers also pay a steep price.¹¹ ***In 2023 alone, productivity loss due to depression cost an estimated \$133 billion of its total cost of \$382 billion.***¹²

The pie chart below provides a more detailed breakdown of the total cost in 2019, which was \$333.7 billion, and the lost productivity cost that year of \$117 billion from presenteeism, absenteeism, disability, and unemployment.

FIGURE 3

Main Causes of Depression's Productivity Cost are Absenteeism, Presenteeism, Disability and Unemployment: \$117 Billion Annually



Ref: Greenberg P, et al

"The Economic Burden of Adults with Major Depressive Disorder in the United States (2019)" *Adv Ther* (2023) 40:4460–4479;

<https://doi.org/10.1007/s12325-023-02622-x>

Even before the pandemic, major depression and anxiety disorders already were among the most prevalent of all adult health problems, occurring in approximately 9% and 19% of Americans each year, respectively.¹³ During the pandemic (August 2020 and February 2021), self-reported depression and anxiety symptoms rose from 36% to almost 40% of U.S. adults, with substantially higher rates occurring among front-line workers and young adults.¹⁴ Employee surveys found similarly high rates of self-reported depression, anxiety, stress, and burnout.¹⁵

While many observers interpreted these statistics as evidence of an isolated mental health crisis, this is not

the case as the rates were not so much an anomaly as they were an acute exacerbation of a pre-existing, unrelenting problem. Depression and anxiety were common among employees long before 2020,¹⁶ and their **extensive and expensive workplace consequences were already established.**¹⁷ Importantly, studies had repeatedly found that depression and anxiety rates started to climb years before the 2020 onset of the pandemic.¹⁸

Frequently, ***employees with common mental disorders also develop functional limitations in carrying out work and work-related activities, and a portion will develop a work disability.*** The average employee with clinically-diagnosed depression experiences functional limitations affecting their work from 20% of the time to almost 50% of the time in a two-week period.¹⁹ These are limitations in time management, performing physical, cognitive, and interpersonal job tasks, and maintaining work output (e.g., quantity, quality, and timeliness). ***The average depressed employee misses the equivalent of 1 to 2 workdays in two weeks.***

In Summary

In the modern knowledge-based workplace **Major Depressive Disorder (MDD)** has become a leading cause of disruption, economic cost burden, productivity loss and early exit from the labor force due to disability.

- The **prevalence** of MDD has **increased among working-age Americans over the past decade or more** – especially among the younger workers who entered the labor force after 2010
- The **total economic cost burden** of MDD has **increased more markedly**, mostly from indirect **workplace-related costs such as lost productivity from absenteeism and presenteeism**
- The **direct treatment cost** of MDD has **declined as a share of total cost burden** even after a “bump up” during the pandemic, as the **percentage of those diagnosed seeking treatment has remained at just 60%**, helping to explain the substantial increase in workplace-related costs as the prevalence of MDD has increased especially among younger workers
- The **share of total cost burden from MDD per se has remained the same at just under 40%**, with the **greater share still coming from co-morbid conditions** – other mental health disorders such as anxiety, and chronic diseases such as diabetes and obesity
- Additional and substantial **workplace costs of informal caregiving for MDD sufferers are not yet incorporated into these total economic cost burden calculations**

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20. Defining Double Depression (*Academy Brief, page 6 of this whitepaper*): Double depression is a clinical term for when someone with long-term, low-grade depression (Persistent Depressive Disorder, or PDD) experiences a superimposed episode of severe major depression. “About 75% of people with dysthymia will experience a major depressive episode. This is referred to as “double depression.” After the major episode ends, most people will return to their usual dysthymia symptoms and feelings, rather than feel symptom-free.” Understanding Dysthymia – NAMI: National Alliance on Mental Illness (<https://www.nami.org/blog/understanding-dysthymia/>) and WebMD (<https://www.webmd.com/depression/double-depression>).

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