ECONOMIST IMPACT

Depression in Europe

Building resilience through awareness, improved access, integrated care, and parity of esteem

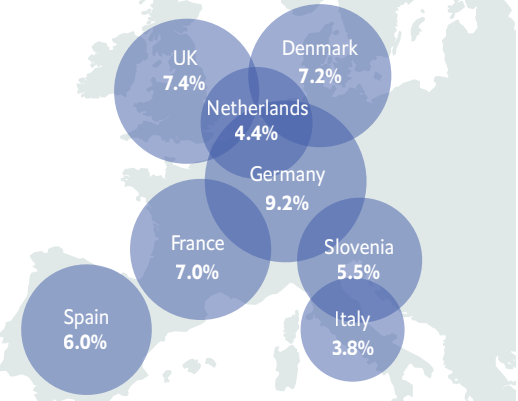


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Depression, the hidden pandemic

Cases of depression are growing in the wake of two years of the covid-19 pandemic and are likely to continue escalating amid growing economic strains and social stress. The burden of depression is also changing shape, as more young people are reporting symptoms of depression.

Europe's health systems are struggling to effectively prevent, diagnose and treat depression. However, Europe is not homogenous: Economist Impact looked at the successes and failures of depression management in eight countries (their prevalence of depression shown here). With health budgets stretched, policymakers face increasing demands from both mental ill health and chronic physical conditions.



Depression is difficult to treat. Only 40–60% of patients achieve remission after initial antidepressant treatment, regardless of the drug chosen. Lack of remission is associated with a worse quality of life, higher comorbidity, increased resource use, and social and occupational disability.



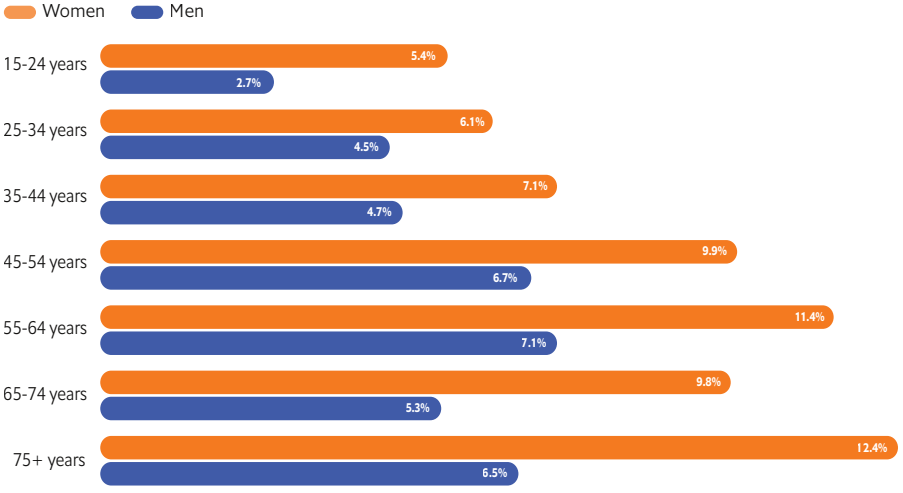
1 in 14

Just over 7% of the European Union's population reports having chronic depression, according to Eurostat figures from 2021.



Chronic depression in men and women across EU countries

Percent with chronic depression.

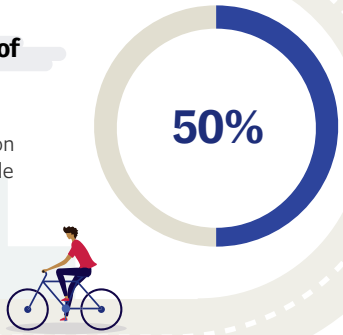


Women are nearly twice as likely as men to suffer from chronic depression.



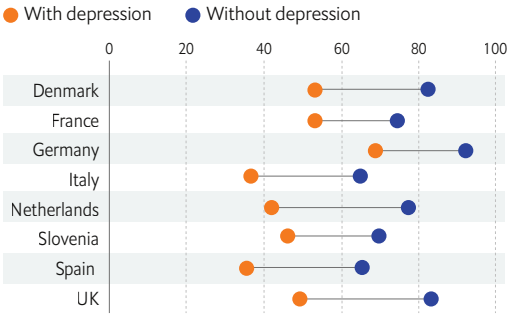
Depression accounts for up to 50% of chronic sick leaves in the EU.

People with depression are less likely to be employed compared to the general population for all EU countries. Even when at work people with depression may not function to their full abilities, and are estimated to be 6% less productive than usual.



People with depression find it much harder to obtain, or remain in, employment

Employment rate of people reporting chronic depression vs without depression (% of working age population ages 24-64), 2018



120,000

Depression is the primary risk factor associated with suicide and suicidal ideation. An estimated 120,000 people take their own lives every year in the WHO European Region, equivalent to 1.3% of all deaths in 2019



Stigma remains a challenge…

Individuals who feel stigmatised are more likely to conceal their condition and, in turn, delay care-seeking behaviour. Even when individuals do seek care, they are often reluctant to report their mental health challenges and instead tend to report more physical complaints. This perceived stigma therefore ultimately leads to delays in starting treatment and lower adherence.

The foundation for progress

Healthcare systems and societies can improve resilience in the face of depression by focussing on awareness, access to treatment and innovation, offering an integrated approach to care, and ensuring parity of esteem between physical and mental health.

1 Awareness

Awareness incorporates recognition, attitudes and knowledge. Recognition is the extent to which the public is aware of depression as a concept and the terminology used to describe it. Attitudes refer to the way in which people relate to depression as a condition. Knowledge conveys a broader understanding of depression as a condition and the kinds of support that providers can offer.

Evidence snapshot



- Positive impact
- Potential for positive impact
- No change
- Potential for negative impact
- Negative impact
- Not addressed

Key Takeaways

Stigma remains a factor
Although the stigma associated with poor mental health is decreasing in some cases, progress is uneven across countries and demographic groups.

People are scared of revealing their depression to work colleagues and others
There remains a concern that bosses will not understand and that jobs will be at risk. On the plus side, more people anticipate discrimination at work than report experiencing it.

Health literacy needs to include depression literacy
People tend to be better at recognising moderate depression than either its mild or more severe varieties. This can mean lost opportunities to identify those who need help.

Everyone agrees in principle with improved awareness but…
Awareness is not the end-point. After awareness comes knowledge and changes in behaviour. And behaviour change is difficult to sustain.

2 Access to treatment and innovation

Treatment for depression is often divided between pharmacological interventions and non-pharmacological, or "talk-based" interventions. Interventions can be classified into four broad groups: interventions for underserved groups and technology-based, community-based and "talk-based" interventions.

Evidence snapshot



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- Potential for positive impact
- No change
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- Not addressed

Key Takeaways

Rising and changing demand is being placed on a system that was already struggling
The number of psychologists, psychiatrists and psychiatric nurses regularly fails to meet the demand.

Digital health is opening up access
eHealth, mHealth and other innovations are offering expanded access to care. However, they need to be supported via payment systems and incorporated into patient pathways.

Community interventions can help people who won't or can't talk to their GP
Many hard to reach groups feel uncomfortable talking to healthcare providers. Community interventions offer a non-judgemental setting for vulnerable people, supported by their peers.

Innovative therapies are not easily available
Non-traditional interventions remain difficult to access. Allowing temporary access to such treatments would support development of an evidence base.

Everyone agrees in principle with improved access but…
One of the chief barriers to better access is the lack of staff. Mentors and peer support can supplement formal care by offering an understanding and non-judgemental ear.

3 Integrated approach to care

Integrated care can be broken down into three key components: collaborative care, patient-centred care, and family engagement. There is some overlap between these concepts, as they all focus to some degree on communication between health professionals, and between health professionals and the patient, family and carers.

Evidence snapshot



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Key Takeaways

Being "on the radar" means the most vulnerable are supported
An important benefit of integrated care is that joined-up institutions can together identify and make contact with hard to reach populations.

From episodic care to pathways: prevention, treatment and follow-up
Improved collaboration promises not only better identification and chances for prevention, but also at the other end of the pathway it supports improved follow-up.

Primary care is the original "integrated care"
Better understanding of the whole patient and their background makes it easier to address unhealthy lifestyles and long-term conditions. 60% of depression cases are accompanied by one or more comorbidities.

Extending benefits beyond the patient
Supporting family and carer engagement will help the patient to recovery, while also preventing harm to those around them.

Everyone agrees in principle with better integrated care but…
The chief barrier to better integrated care is the siloed nature of health and care needs. Patient pathways need to reach across institutions, settings and teams.

4 Parity of esteem with physical health

Parity of esteem implies care in which there is equivalent consideration of physical and mental health. Components that support parity include access and utilisation, quality assurance, resource allocation, education, and treatment goals and outcomes.

Evidence snapshot



- Positive impact
- Potential for positive impact
- No change
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- Not addressed

Key Takeaways

Parity of training would improve outcomes
Better training of the primary care workforce would allow these providers to take on mild to moderate cases, freeing up specialists to take care of those with more severe mental illness.

Parity of research needs real world data
Better data makes it easier to continuously evaluate outcomes and determine where care delivery needs to be improved.

Political will trumps all
Parity of esteem is not a zero sum game: it is not seeking for mental health budgets to prosper as a result of physical health budgets being cut. Rather, the focus is on ensuring mental health considerations are always "at the table" throughout pathway development, service planning and other key decision points.

Everyone agrees in principle with parity of esteem but…
Funding remains a barrier. Even in the UK, the best example of long-term focus on parity between physical and mental healthcare, commitments to mental health funding have not always been maintained.

What next?

Continuing as we are is not an option. Progress has stalled. No reduction in the global prevalence or burden of depression has been detected since 1990.

Depression is both hard to prevent and difficult to treat. There is no simple answer, so how can healthcare systems and society do things differently in order to reduce the impacts of depression?



1. **Healthcare systems need to remain adaptable as rates of depression are rising in most European countries, particularly among the young**
2. **Awareness campaigns need to be targeted to remove stigma; broad educational campaigns are not sufficient**
3. **More support is needed to get treatments to people, whether it's digital health, talking therapies or other innovations**
4. **Healthcare systems should be integrated on all levels, leading to both more efficient and resilient care delivery**
5. **Family and carers should be included in treatment plans to improve support for everyone affected**

The way forward

The principles above offer starting points around which policymakers can build effective and resilient services. Achieving mental health gains will require not just sufficient investment, but committed and sustained efforts to address a range of other barriers, such as a paucity of suitably trained staff, weak governance, and stigma.

Find out more in Economist Impact's latest report on depression in Europe at impact.economist.com/projects/depression-in-europe