EE628

Quantifying the Fiscal Value of Prevention Programmes for Depression in England

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Background and objectives

- Depression is among the most prevalent mental health conditions in the UK and can lead to economic inactivity and a need for welfare, with significant implications for public spending.
- Preventative programmes may significantly reduce the risk and symptom severity of depression.[1]
- Preventing incident cases of depression may have considerable fiscal value in reduced exits from the workforce and need for associated welfare. This analysis had the following objectives:

To calculate the number of adults in England with depression who are receiving PIP (Personal Independence Payment), UC (Universal Credit) and ESA (Employment Support Allowance), and projecting these to 2030.

To quantify the associated cost of depression in terms of welfare payments between 2025-2030

To estimate potential cost savings of reducing the number of new welfare claimants for depression through prevention programmes for depression over this time period.

Methods

1 We estimated the total fiscal impact of depression using StatXplore.[2] Claimant populations were projected from 2025-2030, in line with published Department of Work and Pensions projections.[3]

2 Annual unit costs were calculated for depression-related PIP, UC and ESA claims, and applied to current and projected populations. Table 1 illustrates the process of estimating current and projected populations and costs.

A granular breakdown of claimant populations by diagnosis is not available for ESA or UC – only by ICD-10 chapter. To estimate the number of claimants for depression, we applied the prevalence ratio between depression and all mental health conditions (Figure 1) to the ICD-10 chapter-level estimates.

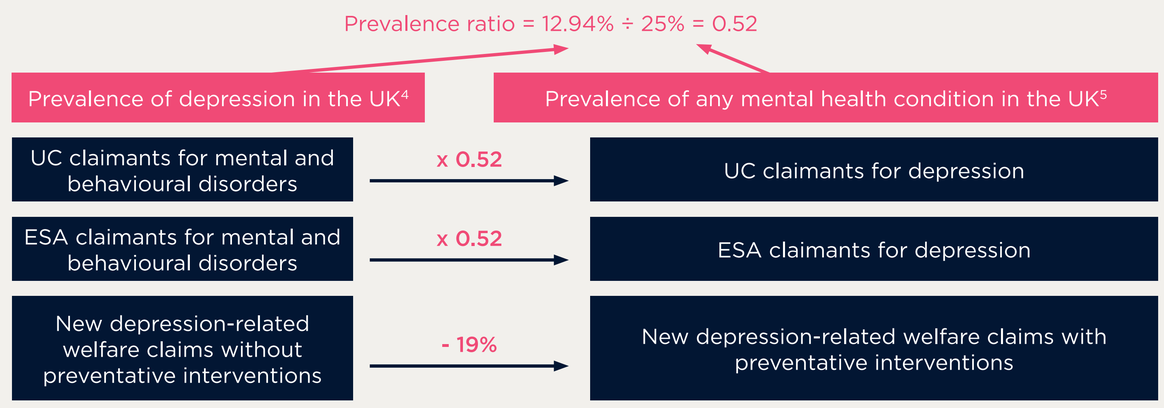
3 Double counting of ESA and UC population is accounted for by reducing the ESA population by the proportion of overlap

4 We estimated potential fiscal savings through preventing depression. A meta-analysis of clinical trials[6] found that psychological interventions for preventing depression reduced risk of onset by 19%. We applied this to annual incident depression-related welfare claims (Figure 1)

Table 1. Overall model structure for fiscal analysis

Baseline	Populations		Cost	
	ESA and PIP	UC and PIP	ESA and PIP	UC and PIP
Historical	Annual ESA claims	Annual UC claims	Annual ESA/PIP claims x Average ESA/PIP cost	Annual UC/PIP x Average UC/PIP cost
Projected	Annual claims change by ESA growth rate	Annual claims change by UC growth rate	Annual ESA/PIP claims x Average ESA/PIP cost	Annual UC/PIP claims x Average UC/PIP cost

Figure 1. Calculating and applying prevalence ratios and intervention effects to depression-related welfare claims



Results

Figure 2. Projected claimant population sizes for depression, across 2025-2030, with and without preventative interventions

The depression-related welfare population for UC/PIP and ESA at baseline (2025) and projected populations by 2030 respectively are illustrated in Figure 2

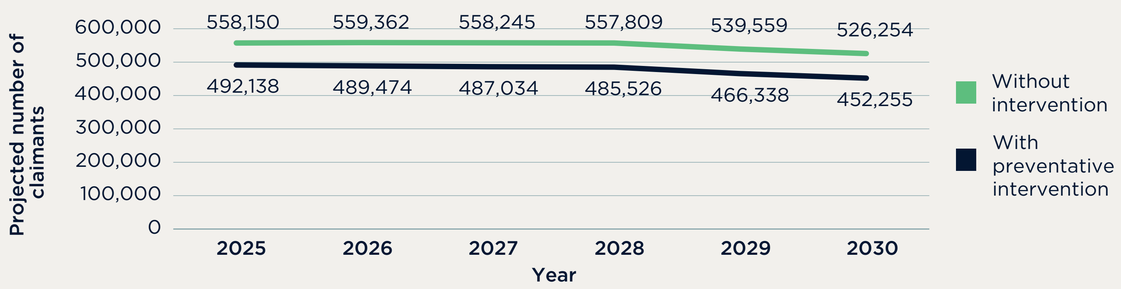


Figure 3. Projected total fiscal costs of depression, across 2025-2030, with and without preventative interventions

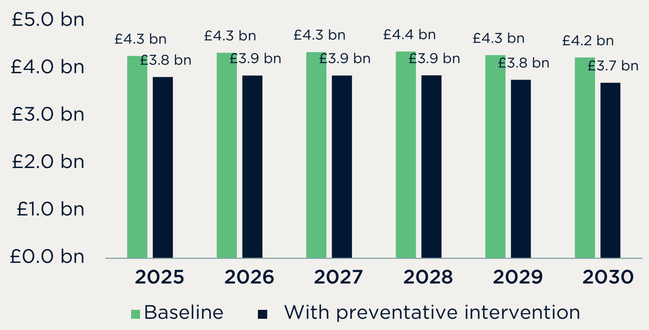


Table 2. Projected cost savings associated with a 19% reduction in incident depression-related welfare claims in 2025 and 2030

Year	Five-year claim costs (£)		
	Baseline	19% incidence reduction	Savings (£)
2025	£21.34 bn	£19.12 bn	£2.21 bn
2030	£21.19 bn	£18.52 bn	**£2.67 bn**

- Whilst the depression-related welfare population for UC/PIP is estimated to increase from 226,379 to 332,458 by 2030, the ESA population is expected to decrease from 313,939 to 193,795 as it becomes a legacy benefit.
- Total current fiscal cost is estimated at £4.1 billion annually, reaching £4.2 billion in 2030 (Figure 3); five-year claim costs are expected to be £21.2 billion by 2030 (Table 2).
- If new cases of depression requiring welfare can be reduced by 19%, the overall population dependent on welfare could be reduced by 14% by 2030, translating to fiscal savings of £2.7 billion over five years (Figure 2, Table 2).

Discussion

- There may be significant fiscal savings associated with the prevention of depression – per person prevented from requiring welfare payments for depression, the fiscal savings are equivalent to over 68 full courses of a cognitive behavioural therapy-based prevention programme.[6]
- While this analysis focused on depression, future research should cover other common conditions such as anxiety, as well as rarer psychiatric conditions such as bipolar disorder and schizophrenia which have considerable negative impacts on patient productivity and quality of life.

This analysis has the following limitations which should be addressed in future research:

- We assumed that a reduction in risk of depression would translate directly into a reduction in welfare claims; more research is required to assess what impact, if any, such interventions have on the number of welfare claims specifically.
- Due to a lack of clinical granularity in StatXplore by condition for UC and ESA, we assumed that the prevalence ratio between all mental health conditions and those for depression also apply to UC and ESA claims; however, the number of welfare claims for individual mental disorders requires further investigation.
- Despite poor length of claim data, there are indications that roughly 10% of people flow off PIP every year. This suggests that after 5 years, 50% (i.e., the median) will have flowed off claiming – length of claims for mental health conditions specifically should be investigated in future research as these may have implications for fiscal savings from prevention or treatment interventions.

Conclusion

This analysis shows that preventive interventions may offer significant fiscal value. Despite having value beyond the healthcare system, implementation of such interventions on a large scale is lacking.

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