Assessment and recommendations

The burden of mental ill-health is too high

The epidemiological, social and economic burden of mental ill-health in OECD countries is enormous.

Mental disorders account for a significant burden of disease worldwide, especially in middle and upper income countries such as OECD countries. The companion study to this book, *Sick on the Job? Myths and Realities about Mental Health and Work* (OECD, 2012), found that at any given moment, on average in the OECD around 20% of the working-age population is suffering from a mental disorder that reaches the clinical threshold for diagnosis.[1] Lifetime prevalence has been shown to reach levels up to 50%: one person in two will have a mental health problem at some point in their lifetime. Even more worryingly, estimates suggest that up to 60% of those who need treatment do not get it.

People with mental disorders often also have physical disorders and this can lead to increased mortality, poorer health outcomes, and higher associated health care costs. Individuals with severe mental illnesses (typically acute cases of depression, bipolar disorder and schizophrenia) experience reduced life expectancy, dying up to 20 years earlier than the general population. In England, people with severe mental illness are three times more likely to die early than the general population, while in Nordic countries, those admitted to hospital for a mental disorder have a mortality rate two to three times higher than the general population, with this gap more pronounced for men than for women. In Australia, men with psychiatric disorders die almost 16 years earlier than the general population, while the gap is 12 years for women.

Not only does mental health represent a significant disease burden, it is also very costly to OECD economies. Globally, the total costs – direct and indirect – of mental ill-health were estimated at USD 2 493 billion in 2010. In the European Union, the cost was estimated to be equivalent to a loss of 3-4% of total GDP in 2004. It has been estimated at 4.4% of GDP in Canada, 4.1% of GDP in England, and 2.3% of GDP in France. Spending on mental health can be one the highest areas of health expenditure, representing between 5% and 18% of total health expenditures for a selection of countries able to break down total spending (Germany, Hungary, Korea, the Netherlands and Slovenia). While these figures can point to high spending for mental health, it may still not be commensurate to the high prevalence and burden of disease represented by mental ill-health. The proportion of total public health expenditure allocated to mental health care is often very small. For example, mental illness is responsible for 23% of England's total burden of disease, but receives 13% of National Health Service health expenditures.

The indirect costs of mental health – the economic consequences attributable to disease, illness, or injury resulting in lost resources, but which do not involve direct payments related to the disease – are particularly high. This includes the value of

lost production due to unemployment, absences from work, presenteeism (the loss in productivity that occurs when employees come to work even when unwell and consequently function at less than full capacity) or premature mortality. *Sick on the Job? Myths and Realities about Mental Health and Work* (OECD, 2012) found that mild-to-moderate mental illnesses such as depression or anxiety disorder[2] have a strong relationship with higher unemployment, higher absenteeism, lower productivity in the workplace, and a rising burden of disability benefits claims. *Drinking Lives Away* (OECD, 2014, forthcoming) provides evidence of the employment and productivity outcomes of alcohol-use disorders, and their broader social impacts.

Indeed, across OECD countries, 88% of workers with a severe mental disorder stated that they accomplished less than they would like as a result of an emotional or physical problem, compared to 69% of those with moderate disorders, and 26% of those with no mental disorder. Unemployment is also a key issue for people with severe mental illness; they are typically six to seven times more likely to be unemployed than people with no such disorder. *Sick on the Job?* (OECD, 2012) and the accompanying reviews of mental health and employment policies in OECD countries clearly highlight the shortcomings in the way that the employment systems of OECD countries address sick leave, disability and joblessness amongst populations with mental health needs.

This report complements *Sick on the Job? to* underline how OECD health systems are not doing enough to improve mental wellbeing. OECD health systems should be doing more to help get people back to work and working productively, and reduce the economic burden of mental ill-health. OECD countries must do more to make mental health count: policy makers must give mental health the importance it demands, in terms of resources and policy prioritisation, while the care delivered for mental health must, simultaneously, add up and make good economic sense. To reduce the burden of mental ill-health, commitment to mental health should remain high, while decision making about where to direct precious resources needs to get better. Making the right prioritisations for mental health, based on good information, will be key.

There are three things that countries must do to respond better to the growing urgency of poor mental health:

- Measure mental health to better understand the scale of the problem, and what works in tackling it.
- Increase provision of evidence-based services, especially through expanding the role of the primary care sector, with appropriate system-wide support.
- Secure better outcomes for mental disorders through better use of incentives.

Measure mental health to better understand the scale of the problem, and what works in tackling it

The first crucial step that policy makers must take towards tackling the high burden of mental ill-health, while using scarce resources as effectively as possible, is to improve measurement and data availability. There is shockingly little information on almost all aspects of mental health in OECD countries, which means that policy makers cannot fully understand the scale of the challenge of mental ill-health, or what works in tackling it. There is too little evaluation of the prevalence of mental disorders, the costs of mental ill-health, treatment outcomes and service quality. This information is crucial if policy makers are to commit greater resources to mental health care, to prioritise areas of greatest need, and

make sensible decisions about effective and efficient care for mental ill-health. A better information infrastructure will be the foundation of stronger mental health systems. There are three building blocks for making this happen: understanding the prevalence of mental ill-health; measuring the high costs of mental ill-health; and tracking treatment outcomes and care quality.

Understanding the prevalence of mental ill-health

There are strong indications that the burden of mental ill-health is high, but not all countries are doing enough to measure and understand the prevalence of mental disorders across their population. In order to address the large treatment gap for mental illnesses, and the significant individual, social, and economic costs associated with mental ill-health, there is a need to systematically measure the prevalence of mental disorders and estimate unmet need. Detailed and up-to-date information on the prevalence of mental disorders can help countries make better decisions about how to best target scarce resources for tackling mental ill-health, and can serve as a starting point for understanding which mental health policies are working, and which need further attention and reflection.

Household surveys as well as national and international health surveys can be used to inform and improve mental health services, but these instruments, which exist in less than half of OECD countries, are not standardised, and vary in their ability to capture the prevalence of mental health problems in the population. Existing surveys about the prevalence of mental ill-health often cannot be broken down sufficiently so as to help better target resources; for example, it would be helpful to policy makers to know that mild-to-moderate mental disorders are particularly prevalent in urban areas rather than rural areas – or vice versa – so as to further explore the reasons behind such a trend, for example unmet need for treatment. Not all countries are able to understand the burden of mental ill-health in their population in such detail.

In addition to prevalence surveys there are other good sources of information on mental ill-health that countries should be exploiting further. Extensive OECD work on mental health and work has shown the value of looking closely at sickness and disability claims as part of understanding mental ill-health across the population and the trends and attitudes towards mental illness. *Sick on the Job?* (OECD, 2012), and the accompanying reviews of mental health and employment policies in OECD countries, have pointed out that service provider attitudes and the burden of mental disorder interact in complex ways. Sickness absences for mental health reasons may be driven by high levels of mental illness in the population; by a tendency for physicians to sign a person off on sick leave quickly due to a lack of experience in treating mental ill-health; because of a shortage of treatment options which would support recovery for individuals for mental ill-health; due to poor support offered by workplaces to employees with mental health needs; or, most likely, a complex combination of all these factors. Understanding these trends, through good collection and interpretation of information, is a first step to better tackling the problem.

Where good data on the burden of mental ill-health in the population does exist, it can be used to guide mental health policy and service design. For example, in Finland, detailed analysis of suicide rates across population groups showed that the risk of suicide was particularly high among young men aged 15 to 29. This led to the establishment of "Time Out! Aikalisä! Elämä raitelleen" ("Time Out! Back on the track!"), a programme targeting men in this age group. This initiative has shown positive results and is in place in over a hundred municipalities, reaching approximately 60% of the target group.

Measuring the high costs of mental ill-health

There are significant gaps in information on the costs of mental health. This prevents greater reflection on spending levels, and on resource allocation, which are needed to better address the unacceptably high burden of mental ill-health. Better measurement of the costs of mental illness is the second building block for a stronger, and more information-rich foundation for mental health systems.

A lack of data on the costs of mental ill-health, including direct costs, indirect costs and intangible costs, also limits the scope for meaningful cross-country analysis. The majority of data is available only at a national level, and even here data availability is uneven across countries and across cost domains. Where internationally comparable data exist, they are restricted to expenditures in hospitals. Under the OECD's System of Health Accounts, just 11 countries could break down hospital expenditures by main diagnostic group (e.g. circulatory diseases, mental and behavioural disorders), and only 6 countries could then break down spending on mental and behavioural disorders by disorder subcategory (e.g. schizophrenia, mood disorders). These shortcomings show that it is not possible to capture the full picture of the cost of mental illness in health systems that now commonly use community care, which means that policy makers are taking decisions on resource allocation based on incomplete information. These information gaps ultimately also limit the potential for countries to assess which services represent value for money and where direct spending is bringing down indirect costs – within the mental health sector, health more generally, and across the economy.

However, there are some encouraging steps in the establishment of internationally comparable data on the cost of mental illness, some of which could become still richer sources of information – and a valuable resource for prioritising mental health spending and policy setting – if a larger number of countries were to participate:

- The OECD's work on expenditure by disease as part of the System of Health Accounts gives a framework for internationally comparable reporting of mental health expenditures. Whilst some limitations remain, for example an inability to capture the costs of co-morbidities, an expansion in the number of countries able to submit expenditure by disease data for mental health would already widen the potential for meaningful analysis.
- OECD work on the impact of mental illness on employment, productivity and social benefits costs indicates the importance of indirect costs as a result of mental ill-health.
- The WHO's Global Burden of Disease created the DALYs measure to quantify the burden of disease, including mental health. DALYs combine the impact of premature death and of disability and other non-fatal health gaps, giving a good picture of the intangible costs of mental health internationally and between regions.
- OECD uses the DALY approach in estimating the health and economic impacts of prevention policies, for instance, in the area of alcohol-use disorders.

Tracking treatment outcomes and care quality

While there are some promising areas of improvement in the collection of quality and outcome indicators for mental health, overall data weaknesses continue to significantly limit understanding of the state of mental health and mental health care systems, and limit the capacity of policy makers to drive effective and efficient change.

There is an urgent need for better mental health care quality and outcome indicators. The development of mental health quality and outcome indicators is not widespread across OECD countries. While over two thirds of OECD countries (20) report using "outcome" indicators,

these may be restricted to discharge rate or suicide rate. Administrative hospital data with elements of mental health information is almost universally present in OECD countries, allowing the collection of data such as bed days and average length of stay. National registries or data collection covering severe mental disorders and suicide are also quite widely available, though not in all OECD countries, and not at all levels of care (e.g. in primary care settings).

A number of factors are responsible for the weak data infrastructure for mental health care, including the complex nature of mental health problems, high rates of co-morbidity, lack of agreement on suitable measures and weak measurement infrastructures. The absence of a unique patient identifier in many countries poses problems to building richer indicators assessing continuity of care and quality of prescription or treatment, as data sets cannot be linked across care settings. These shortcomings limit the capacity of policy makers, care commissioners, and providers to secure good care for mental health. Care commissioners, for example, cannot assess the quality of services that are in place, and care providers cannot compare outcomes for mental disorders that they are treating with those of other care providers, without improved information infrastructures tracking treatment outcomes and care quality.

The mental health subgroup of the OECD's Health Care Indicator Project recommends collection of a number of indicators of mental health care quality – for example assessing continuity of care or patient outcomes. However, many countries are still unable to report on such data.

Limited reporting of mental health data

Indicators	Number of countries able to report
Continuity of visits after mental health-related hospitalisation	6
Timely ambulatory follow-up after medical health hospitalisation	5
Visits during acute phase treatment of depression	3
Re-admission rates to the same hospital for schizophrenia and bipolar disorder	20
Excess mortality from schizophrenia or bipolar disorder	6

Source: Information compiled by the OECD based on the OECD HCQI Sub-group for Mental Health (18 countries participating).

The quality and outcomes of mental health care will continue to lag behind other disease areas until adequate information systems are put in place to track pertinent indicators and collect appropriate data. Advancing the measurement and comparison of the quality of inpatient care, primary and secondary community-based care and social outcomes first and foremost necessitates increased development and utilisation of mental health quality measurement infrastructure.

There are encouraging developments, though. A few OECD countries are already using quality and outcome indicators to drive improvements in mental health care:

- Australia, England, the Netherlands, Sweden, New Zealand and the United States have put in place more comprehensive systems to collect indicators which can encourage better treatment outcomes.
- In Sweden, the National Board of Health and Welfare developed a multi-dimensional quality framework, "Good Care", to monitor health care performance. The framework covers several dimensions of care including effectiveness, safety, patient-centeredness, timeliness, equity and efficiency, with more than 30 process and outcome indicators used to compare quality across regions or patient groups.

- In England, outcome indicators have been developed for both mild-to-moderate and severe mental illness. These outcome measures reflect patient experience, quality of life and social outcomes as well as quality of care and symptoms. The outcome measures have now been used to derive indicators for a framework to support the commissioning of mental health services. This framework, the new Clinical Commissioning Group Outcomes Indicator Set, will be used to support and enable commissioning groups to measure and benchmark outcomes of services that they commission for their patients. The framework will also provide clear, comparative information for patients and the public about the quality of health services commissioned and the associated health outcomes.
- Several international collaborations – for example, the Nordic Indicator Project and the REFINEMENT project, involving nine European research institutions – are seeking to encourage good indicator development for mental health and to support countries in gathering better data.

Increase provision of evidence-based services, especially through expanding the role of the primary care sector, with appropriate system-wide support

The high epidemiological burden, and the high economic and societal costs of mental ill-health, demand that policy makers scale-up evidence-based treatment, prioritising approaches that deliver good outcomes and which represent good value for money.

The "treatment gap" represents the gap between the true prevalence of a disorder and the proportion of affected individuals who are receiving treatment, and can also be expressed as a percentage of individuals who require care, but do not get it. Evidence shows that shortages in mental health services mean that some individuals in contact with mental health services, or receiving some treatment, are not receiving the most appropriate treatment for their disorder, or they are receiving insufficient treatment. Treatment gaps for mental disorders vary across OECD countries, but mental ill-health is undertreated, to varying extents, in all OECD countries:

- Between one-third and one-half (or more) of those with mental health disorders do not receive treatment. The "treatment gap" ranges from 32.2% for schizophrenia, to 57.5% for anxiety disorder. The gap was estimated at 56.3% for depression, 50.2% for bipolar disorder, and 57.3% for obsessive compulsive disorder.
- The ESEMeD survey of Belgium, France, Germany, Italy, the Netherlands and Spain estimated that 3% of the population have an unmet need for mental health care. Nearly one in two people with a diagnosable mental disorder reported no formal health care use for their mental disorder; in comparison, this is the case for less than one in ten of people with diabetes.

Action is needed to address this treatment gap, which contributes significantly to the high social and economic costs of mental ill-health in OECD countries. To do this, evidence-based services for mental disorders should be scaled-up. Care for mild-to-moderate disorders should be improved through better provision from primary care, and primary care providers should play a greater co-ordinating role to help deliver more integrated care for severe mental illness.

Improve provision for mild-to-moderate disorders through stronger primary care

The treatment gap for mild-to-moderate mental disorders is particularly large and as shown in *Sick on the Job?* (OECD, 2012), the impact of these disorders – which are strong drivers of presenteeism, abstenteeism, disability and unemployment – is significant.

To strengthen provision for mild-to-moderate disorders, improving and expanding the care provided at the primary care-level is a first step. In most OECD countries, primary care providers are already playing a significant role in providing care for mild-to-moderate disorders and, with a relatively small amount of additional support and resource allocation, could do more still.

Building on the good foundations in place in many OECD countries, efforts to improve primary care provision and close the treatment gap for mild-to-moderate disorders should include:

- Comprehensive training and Continuing Professional Development for diagnosing, treating and managing mild-to-moderate disorders for all primary care providers.
- Putting in place primary care-appropriate clinical guidelines for mild-to-moderate mental disorders, which are easily accessible, and up-to-date.
- Exploring the potential for primary care practitioners to deliver evidence-based treatments such as Cognitive Behavioural Therapy, with appropriate training.
- Putting in place specialist mental health services to which primary care providers can refer patients for more intensive treatment.
- Securing good support networks between primary care and specialist mental health services, in order to support primary carers with more complex cases and to help build competency and expertise at the primary care level.

Many of these elements are in place, to varying degrees, in most OECD countries. For example, training and Continuing Professional Development (CPD) for mental health in primary care is in place in two thirds of OECD countries, and appropriate – often primary care specific – clinical guidelines for mild and moderate mental disorders are used in six OECD countries. Nonetheless, there is some evidence of shortcomings in care provided in primary care. Primary carers are often being asked to perform a greater number of functions related to mental health, with few if any additional resources. Studies from Canada, Germany, the United Kingdom and the United States suggest that primary care clinicians often have considerable difficulty accurately identifying emotional distress and mild depression in primary care, with other studies suggesting that primary care physicians may not have the best and most up-to-date information available to them regarding treatment for common mental disorders. The efforts and investments needed to address these shortcomings are worthwhile for countries: not only can better primary care provision help close the treatment gap and reduce the epidemiological and economic burden of mild-to-moderate disorders, but provision in primary care has also been shown to represent good value for money.

Strengthening provision at the primary care level has also been shown to be a cost-effective way of providing care for some mental disorders. Stepped care approaches, for instance, have been supported as a cost-effective approach with good outcomes and can be delivered in part from primary care, with support from specialist services when needed. In stepped care approaches treatment starts with low intensity interventions, for example bibliographic self-help and multimedia self-help, and then rises in intensity in line with responsiveness to treatment and symptom severity, including for example one-to-one psychological therapy delivered by a specialist. The stepped care approach means that treatment intensity is scaled to need. This can reduce pressure on more specialised services by improving availability of low-intensity interventions that can be prescribed by a primary care practitioner. General practitioners (GPs) are overwhelmingly more likely

to be consulted for mental health problems than psychiatrists or psychologists and good diagnostic and referral processes for mild-to-moderate disorders from primary care can also help direct patients towards interventions that have been shown to be effective, including computerised Cognitive Behavioural Therapy (CBT) and eMental health programmes, self-help group and peer support activities.

Some OECD countries have been scaling-up treatment options through the expansion of common behavioural therapies in primary care: in 2012, 12 OECD countries reported that CBT was available in primary care. In Norway, CBT training is available for practitioners and general practitioners can deliver CBT and be reimbursed for providing it. The advantage of such a model is that it equips primary care practitioners with an additional tool with which to effectively treat patients that they are already expected to treat. This is a good way of improving the efficacy and quality of the service already being provided. It also promises to be cost-saving relative to introducing stand-alone programmes, increasing reimbursements for therapies provided by specialists or alternative medicine practitioners (especially where practitioners are in private practice), or delivering psychological therapy.

A stronger co-ordinating role for primary care in delivering more integrated care for severe mental illness

With the process of deinstitutionalisation, care for severe mental illness increasingly takes place in a large range of care settings, making care co-ordination a particular challenge. To improve mental health care for people with severe disorders, such as schizophrenia, bipolar, and severe depression, better co-ordination is needed. Poor outcomes have been associated with poor co-ordination of care, and poor co-ordination of care makes it easier for patients to fall through the gaps between inpatient and community care and for the full spectrum of a patient's care needs not to be met. Co-ordination is important not just between mental health services, but also across the care spectrum. The high level of co-morbidity of somatic disorders and severe mental disorders should be addressed through better co-ordination between the health sector and the mental health system.

A stronger co-ordinating role for primary care is a key way that OECD countries can deliver more integrated care for severe mental illness. Primary care providers have been increasingly taking on this co-ordinating role in OECD countries and this should become even more widespread and robust. Additionally, good engagement by primary care practitioners is crucial to addressing the poor physical health of individuals with severe mental illnesses, as they are more likely to consider the patient's entire physical and mental wellbeing, rather than taking a more narrow symptom-specific focus as might be expected in specialist mental health services. Primary care providers can also play a significant role in the ongoing management of stable cases of severe mental illness. While primary care practitioners rely on effective support from specialist care, and appropriate training and competence, primary care practitioners are, in many OECD countries, allowed to diagnose or adjust common medication for severe mental disorders (for example, SSRIs and antipsychotics) and as such can in some cases lead the management of stable cases of severe mental illness from the community.

Scaling-up evidence-based services

While strengthening care delivered in primary care is a good first step, OECD countries also need to scale-up services that are understood to be effective at treating both mild-to-moderate and severe mental ill-health. Given the high indirect costs associated with mild-to-moderate illness in most, if not all, OECD countries, and the large treatment gap

for these disorders, further investment in appropriate services for these disorders is likely a cost-effective approach for most countries. What is key is that resources be allocated to mental health in a way that can deliver good value-for money. Public budgets in many OECD countries are stretched and it will be a challenge to mobilise the time, resources, and expertise needed to tackle the high burden of mental health. Resources for mental health care should be directed towards evidence-based treatments which are understood to be effective.

Some existing evidence suggests that investing in care for common disorders, the majority of which have symptoms that are mild or moderate, could be cost-neutral for OECD economies. This is because when the most effective treatments are prioritised, the indirect costs of mental ill-health and sickness absences tend to drop, productivity improves, disability claims to fall, and employment and tax revenues increase as individuals return to work. Addressing the high burden of mild-to-moderate mental ill-health will demand that countries assure that the right services are in place for disorders such as anxiety and depression, and evidence suggests that innovative new interventions for mild-to-moderate disorders can also represent good value for money.

Some OECD countries have taken steps to build specialised services targeted at mild-to-moderate mental disorders through new and innovative forms of services. These include programmes that fit within the existing health system organisation as well "stand-alone" vertical programmes. Each programme has demanded significant high-level commitment and investment of resources, although there are strong arguments to suggest that such investments can be cost-effective in the medium- to long-term. Noteworthy examples include "Increasing Access to Psychological Therapies" (IAPT) in England and "Access to Allied Psychological Services" in Australia. New models of care delivery are also taking advantage of technological developments: a wide number of computer- and internet-based programmes are being used to treat and manage some forms of mental illness, for example MoodGYM, for anxiety and depression, developed in Australia but now also in use in China, Finland, the Netherlands and Norway. When based on good evidence, carefully put in place, and closely monitored, such interventions can be effective and low-cost ways of treating some mental disorders.

Evidence-based services for severe mental illness are still required of course. Assertive Community Treatment (ACT) – intensive support delivered by multidisciplinary teams available 24 hours a day, with teams often having low caseloads, and usually delivering community-based treatment and services – is a cornerstone in community-based care for people with severe mental illness, and has been associated with better engagement with services and improved quality of life and satisfaction with care. ACT is "assertive" in the sense that it is expected that mental health professionals would be assertive in seeking out and delivering treatment to patients and ensure care co-ordination. Additionally, evidence suggests that ACT is cost-effective as it is associated with improved patient outcomes, even if ACT is associated with a positive or non-negative change in costs. While ACT is far from the only treatment modality shown to be effective for severe mental illness, and while ACT has a number of shortcomings, the important point is that countries ensure that the efficacy of treatment is the primary guide for decisions about which services to put in place, rather than historical or social trends in the mental health care sector.

Further efforts to address the high disease burden of mild-to-moderate disorders should also include attention to evidence-based preventative interventions. International evidence suggests that prevention programmes targeting depression, for example in schools

and workplaces, can be effective at alleviating some of the disease burden that cannot be or is not being addressed by psychological or pharmaceutical treatments, and can represent good value for money. Extensive research carried out by the OECD suggests, similarly, that certain preventive interventions can be very worthwhile investments for reducing harmful alcohol consumption and the associated disease burden and economic costs.

Secure better outcomes for mental disorders through greater use of incentives

Policy makers should use incentives to encourage good outcomes for mental health. In mental health care, where the large treatment gap and high burden suggest that current treatment is insufficient or inadequate, there is a need to catch up with other disease areas: treatment outcomes, as well as system design and input, now need to be a primary focus. Better understanding of what good outcomes are for mental health, the need to put outcomes at the centre of care decisions, and the more effective exploitation of incentives for good outcomes, will in turn influence policy making in other areas. For example, it will help in choosing services based on which interventions deliver good outcomes, and it will render resource allocation more efficient. Furthermore, using incentive structures to drive good outcomes and to meet policy objectives is a core part of effective resource use in other areas of health care. Mental health care need be no exception.

Focusing on better outcomes for mental health

A more complete understanding is needed of what constitutes "good mental health care". Good information on the quality of mental health care, a strong desire to secure better outcomes for mental health, and a capacity to monitor mental health care in line with expected standards, are fundamental starting points. Part of the problem is due to a significant information gap in what constitutes good outcomes. The importance of measuring the quality of mental health care, which includes measuring treatment outcomes, cannot be understated. Mental health care outcomes are too rarely measured and monitored, often due to a lack of good outcomes indicators, or a framework establishing desirable and undesirable outcomes.

In other areas of health care, understanding what good care and good outcomes look like has been easier: it is possible to measure and aim for better survival rates, reduced symptom severity, more stable management of symptoms, for example. The same is true for mental health, but given the often high complexity of treating mental disorders, the very heterogeneous nature of mental disorders, and the often chronic nature of mental disorders, a definition of what a good treatment outcome is, and a push for providers to move towards it, has been difficult to achieve.

A lack of agreement over which salient measures can capture good treatment outcomes for mental health has slowed progress in the area, as to drive towards better outcomes an agreed conceptual framework is first needed. However, despite the challenge of coming up with such a framework a number of countries do focus on outcomes, using an agreed matrix, and other OECD countries should follow their lead. One noteworthy example is the Australian National Outcomes and Casemix Collection (NOCC), a set of routine outcome measures collected by all Australian states and territories. NOCC includes measures of function and consumer-rated measures of symptoms or wellbeing. NOCC also includes the Health of the Nation Outcome Scale (HoNOS), developed in England in the 1990s, which has 12 items measuring four domains of behaviour, impairment,

symptoms and social functioning, for which providers give patients a score, which can then be compared over time. Such outcome-focused measurement tools should be used widely in OECD countries.

A sufficiently broad conceptualisation of a "good outcome" is also important. For instance, OECD work on mental health and employment highlights the need to include employment and meaningful engagement with the job market as a desirable outcome. Many, if not most individuals with mental illness, can be in work, but care providers have been quick to overlook employment as an important outcome. This shortcoming is especially concerning given not only the high economic costs of unemployment and absence from work due to mental health-related disability, but also given that the right kind of employment can be highly positive for individuals with mental ill-health. A well-conceptualised focus on outcomes can turn provider attention towards such aspects, to the benefit of the individual patient and of society more widely.

Monitoring, outcome frameworks, and availability of comparative data can also help drive better outcomes. In other areas of health care, improvement has been observed as a result of providers better understanding their own outcomes, and benchmarking their outcomes and practice against that of other providers. Indeed, in Scotland the establishment of comparative indicators measuring mental health care outcomes, combined with improvement support for providers, were found to be effective in changing local practice.

Using financial incentives to secure better outcomes

The incentivisation of outcomes has an important role in closing the treatment gap for mental disorders. The introduction of outcomes frameworks, and financial incentives, are being used in different OECD countries to secure better outcomes. Such incentives could be more widespread.

At a primary care level financial incentives can encourage the provision of appropriate services for mental disorders. For instance, additional reimbursements for GPs providing psychological therapies are available in Australia and Norway. A more sophisticated outcomes-focused financial incentive scheme is the QOF, a pay-for-performance programme for GPs in the United Kingdom. The mental health component of the QOF primarily rewards the ongoing management of a serious mental illness through the primary care provider and also puts a strong emphasis on the physical health of patients with a serious mental illness. It is thus a concrete example of how to give primary care practitioners a strong incentive to manage both the physical and mental health needs of people. Under the QOF, GPs can earn points, which translate to financial rewards through establishment of a comprehensive care plan, or by regularly recording required somatic and mental health checks. In Australia, the Mental Health Nurse Incentive Programme provides payments to a range of primary care providers to engage mental health nurses to assist in the provision of co-ordinated clinical care for people with severe mental health disorders, which would include monitoring a patient's mental state, medication management and improving links to other health professionals and clinical service providers. Encouragingly, this programme had a positive effect on patient outcomes due to greater continuity of care, greater follow-up, timely access to support, and increased compliance with treatment plans. Utilisation of inpatient care was reduced and patients experienced increased levels of employment and improved community functioning.

Provider payment mechanisms for specialist care should in theory incentivise integrated care delivered in both hospital and community-based settings, yet, in practice, payment systems remain fragmented and differ according to care setting. Provider payment for mental health is predominantly either through global budgets, which give few incentives to improve quality and efficiency, and fee for service or per diem rates, which can provide incentives for the overprovision of undesirable additional "products", such as inpatient bed days driving up average length of stay.

Policy makers need to design and implement payment systems that are not tied to a particular setting and which reward the delivery of high-quality, efficient and integrated care. Many OECD countries have failed to implement such innovative payment methods due to a lack of good-quality data on costs and outcomes that span the entire care pathway and to governance challenges, among other factors. However, some promising examples do exist, notably the "Diagnostic Treatment Combination" in the Netherlands, which is an episode-based payment system that can include several hospital admissions or outpatient contacts, with the tariff paid determined by client profile, functionality, and assessed service needs.

On the whole, good cost data currently exist at a national level for hospital care in nearly all OECD countries, but high-quality data are not widely available for outpatient and community-based care, with a few notable exceptions (such as Australia, England and the Netherlands). This will likely further hinder the complicated task of developing classifications and payment methods that span care settings. The impetus is on countries to improve their collection of cost and outcome data, particularly for community-based care.

At present data limitations limit the capacity of most countries to undertake such comparative benchmarking activities. However, the understanding that availability of appropriate indicators can in and of themselves drive improvements in care, as well as guiding policy setting and resource, should be added motivation to develop better data infrastructures for mental health care.

Conclusion

Mental disorders represent a considerable disease burden and have a significant impact on the societies and economies of OECD countries, yet are still consistently under-treated or ineffectively treated. Spending on mental health care represents a significant percentage of OECD health budgets, yet the burden of mental ill-health is costing OECD economies millions every year in sickness benefits, through unemployment, and as a result of lost productivity. Policy makers cannot step away from this challenge – they must make mental health count. Governments must measure mental health, in order to better understand the scale of the problem and how to tackle it. They should increase the provision of evidence-based services, particularly through the primary care sector. And they should align financial incentives to help achieve better outcomes for those suffering from mental ill-health.

Notes

1. Psychological distress or the absence of mental well-being can affect all individuals from time to time, and would not meet the clinical threshold of a diagnosis within psychiatric classification systems. This report focuses on mental disorders which do reach the clinical threshold of a diagnosis according to international classification systems – commonly disorders such as depression, anxiety, bipolar and schizophrenia – but clearly acknowledges that "sub-threshold disorders" can account for significant suffering and hardship, and can be enduring and disabling. This report does not directly cover alcohol or substance abuse disorders, although does acknowledge the common co-morbidities of mental disorders and alcohol and substance abuse disorders.

2. *Making Mental Health Count* distinguishes between "mild-to-moderate" mental disorders and "severe" mental disorders. This distinction is based both on a clinical separation commonly made, and related to the different service needs and intensities demanded by different severities of disorder. Severity of the disorder is determined by the number of and severity of symptoms, the degree of functional impairment, and the duration of symptoms. "Mild-to-moderate" disorders usually have less severe and debilitating symptoms than other (for example, psychotic) mental disorders, and would typically include frequently occurring disorders such as depression and anxiety as well as disorders such as obsessive compulsive disorder (OCD) or somatoform disorders. There is little consistency in how severe mental illnesses (SMI) is defined in practice and no operational definitions exist, but in general, severe mental illnesses tend to refer to non-organic psychotic disorders – such as schizophrenia, schizoaffective disorder, bipolar disorder – as well as history of mental illness and treatment, and degree of disability. While the prevalence of SMI is much lower than that of mild-to-moderate mental illness, the primary focus of mental health systems has tended to be on the former. All mental disorders can significantly impede the health, daily functioning, and quality of life of affected individuals, and require appropriate diagnosis, treatment and care. While this report makes a distinction between the severities of mental disorders, it is important to note that for patients and practitioners the reality of disorders is frequently more fluid. The mental state of a patient experiencing a moderate depressive episode can worsen and become "severe", just as a severe episode can be stabilised with symptoms lessened or alleviated.

Reference

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OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, Paris, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264124523-en*.