Chapter 1

Mental health and work challenges in Switzerland

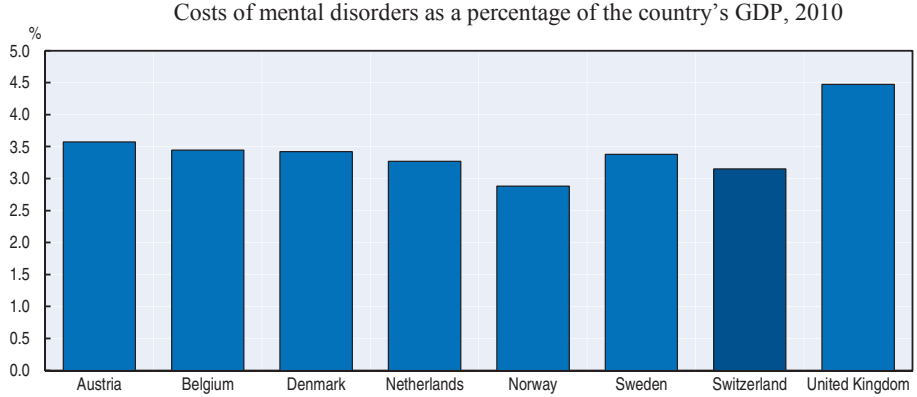
Building on the findings in the recently published OECD report "Sick on the Job?" *this chapter highlights the key challenges facing Switzerland in the area of mental health and work. It provides an overview of the current labour market performance of people with a mental disorder in Switzerland compared to other OECD countries, as well as their financial situation. The chapter also describes the Swiss social protection system which provides the context in which mental health and work policies operate.*

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

Mental ill-health poses important challenges for the well-functioning of labour markets and social policies in OECD countries. These challenges have not been addressed adequately so far, reflecting widespread stigma and taboos as well as a lack of evidence about the extent of the problem and the policy responses that are required. The total (direct and indirect) estimated costs of mental ill-health for society are large, reaching 3-4.5% of GDP across a range of selected OECD countries and 3.2% in Switzerland (Figure 1.1).[1] Most of these costs do not occur within the health sector: indirect costs in the form of lost employment and reduced performance and productivity on-the-job are much higher than the direct health care costs. Based on comprehensive cost estimates in Gustavsson et al. (2011), indirect costs, direct medical costs and direct non-medical costs amount to 53%, 36% and 11%, respectively, of the total costs of mental disorders for society.[2]

Figure 1.1. **Mental disorders are very costly for society**

Costs of mental disorders as a percentage of the country's GDP, 2010



Note: Costs estimates in this study were prepared on a disease-by-disease basis, covering all major mental disorders as well as brain disorders. This chart includes mental disorders only.

Source: OECD compilation based on Gustavsson, A. et al. and CDBE 2010 Study Group (2011), "Cost of Disorders of the Brain in Europe 2010", *European Neuropsychopharmacology*, Vol. 21, pp. 718-779 for cost estimates, and Eurostat for GDP.

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Definitions and objectives

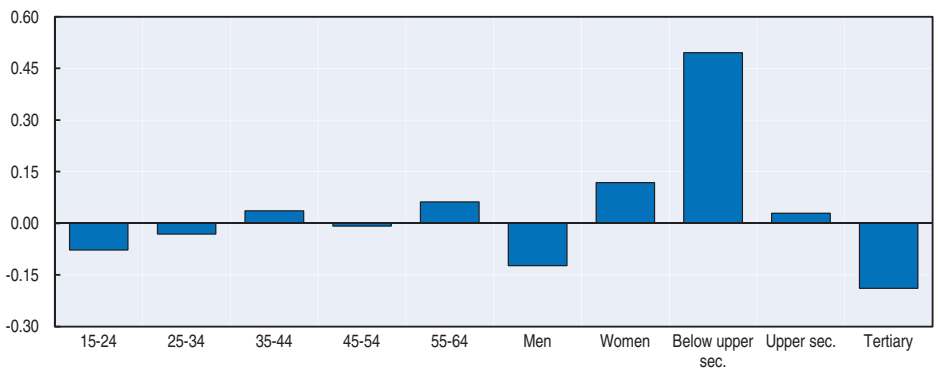
According to the OECD report *Sick on the Job? Myths and Realities about Mental and Work* (OECD, 2012a), the high costs of mental ill-health needs to be tackled by policy that improves the labour market inclusion of people with mental illness. This in turn required that more attention is given to: mild and moderate mental disorders; disorders concerning the employed and the

unemployed; and proactive measures to help them remain in work or find a job. This conclusion is drawn on the basis of a number of findings, which include a high proportion of people with a mental disorder who are working but often suffering productivity losses while at work; and a high prevalence of mental ill-health among people on unemployment, social assistance and disability benefits.

Understanding the characteristics of mental ill-health is critical for devising the right policies. Mental disorder in this report is defined as mental illness reaching the clinical threshold of a diagnosis according to psychiatric classification systems like the International Classification of Diseases (ICD-10) which is in use since the mid-1990s (ICD-11 is currently in preparation). Thus defined, at any one moment some 20% of the working-age population in the average OECD country is suffering from a mental disorder, with lifetime prevalence reaching up to 40-50%. For the purpose of this report, survey data is used to assess the characteristics and labour market outcomes for this group in Switzerland (see Box 1.1). In Switzerland, people with below upper secondary education are much more likely to have a mental disorder than their better educated counterparts (Figure 1.2). The prevalence of mental disorders is also slightly higher among women than among men and among the age groups 35-44 and 55-64 than among other age groups.

Figure 1.2. **The prevalence of mental disorders in Switzerland varies with age, gender and especially the level of education**

People with a mental disorder (either severe or moderate) by age group, gender and educational attainment, deviation from to the overall prevalence in the Swiss working-age population, 2007



Note: "Below upper secondary" refers to ISCED 0-2, "Upper secondary" to ISCED 3-4 and "Tertiary" to ISCED 5-6 (International Standard Classification of Education).

Source: OECD calculations based on the Swiss Health Survey, 2007.

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Box 1.1. **The measurement of mental disorders**

Administrative clinical data and data on disability benefit recipients generally include a classification code on the diagnosis of a patient or benefit recipient, based on ICD-10 (International Classification of Diseases, version 10), and hence the existence of a mental disorder can be identified. This is also the case in Switzerland. However, administrative data do not include detailed information on an individual's social and economic status and they only cover a fraction of all people with a mental disorder.

On the contrary, survey data can provide a rich source of information on socio-economic variables, but in most cases only include *subjective* information on the mental health status of the surveyed population. Nevertheless, the existence of a mental disorder can be measured in such surveys through a mental health instrument, which consists of a set of questions on aspects such as irritability, nervousness, sleeplessness, hopelessness, happiness, worthlessness, and the like, with higher values indicating poorer mental health. For the purposes of the OECD review on *Mental Health and Work*, drawing on consistent findings from epidemiological research across OECD countries, the 20% of the population with the highest values according to the instrument used in each country's survey is classified as having a mental disorder in a clinical sense, with those 5% with the highest value categorised as "severe" and the remaining 15% as "mild and moderate" or "common" mental disorder.

This methodology allows comparisons across different mental health instruments used in different surveys and countries. See OECD (2012a) and www.oecd.org/els/disability for a more detailed description and justification of this approach and its possible implications. Importantly, the aim here is to measure the social and labour market outcomes of people with a mental disorder, not the prevalence of mental disorders as such.

For Switzerland, predominantly the Swiss Health Surveys are used (2002 and 2007; data for 2012 will become available soon). The mental disorder variable in these surveys is based on a set of ten depression-related items: sadness, interest, fatigue, appetite, sleep, speed of actions, sexual desire, confidence, concentration and suicidality. Each question has three answer categories (1 = most of the days, 2 = sometimes, 3 = never); hence, the total score goes from 10 (very severe mental health problems) to 30 (no mental health problems).

In Switzerland, as in other countries, the key attributes of a mental disorder are: an early age of onset; its severity; its persistence and chronicity; a high rate of recurrence; and a frequent co-existence with physical or other mental illnesses. The more severe, persistent and co-morbid the illness, the greater is the degree of disability and the potential impact on the work capacity of the person. The specific type of mental disorder that is diagnosed also matters, but mental illness of any type can be severe, persistent or co-morbid. The majority of mental disorders fall in the category mild or moderate, including especially depression and anxiety disorders.

One important general challenge for policy makers is the high rate of non-awareness, non-disclosure and non-identification of mental disorders – directly linked with the stigma attached to mental illness but also the very essence of mental cognition because people consider what they experience as normal. However, it is not clear in all cases whether more and earlier identification would always improve outcomes or, instead, may contribute to labelling and the risk of stigmatisation. This implies that reaching out to people with a mental disorder is more important than labelling them and policies that avoid labelling might sometimes work best.

The OECD report *Sick on the Job?* (OECD, 2012a) identified two key directions for reform. First, policies should move towards prevention, identifying needs quickly, and intervening at various stages of the lifecycle, including during the transition into work, at the workplace, and when people are about to lose their job or to move into the benefit system. Secondly, steps should be taken towards a coherent approach across different sectors, integrating health, employment and, where necessary, other social services for people with mental ill-health.

Notwithstanding the major costs of poor mental health for both individuals and society, policies and institutions are not addressing mental ill-health sufficiently. Four core priority areas are identified in the report, which need urgent policy attention. These include:

- *The importance of schools* to protect and promote the mental health of children and young people and of transition services to help vulnerable youth access the labour market successfully.
- *The importance of workplaces* to protect and promote mental health of workers in order to prevent illness, reduced productivity at work and, ultimately, labour market exit.
- *The importance of employment services* for beneficiaries of long-term sickness, disability and unemployment benefits who are not working.
- *The importance of psychiatric services* delivered in ways that assist people of working age to either remain in work or return to work.

This report examines how policies and institutions in Switzerland are addressing the challenge of ensuring that mental ill-health does not mean exclusion from employment and that work contributes to better mental health. The structure of this report is as follows. The first chapter sets the scene by looking at some of the key labour market and social outcomes for people with a mental disorder in Switzerland, and describing the main social protection systems catering for people with mental illness. This is followed

by chapters which consecutively analyse the policy challenges Switzerland faces in the workplace, the disability benefit system, the unemployment and social assistance system, the health system, and the education system.

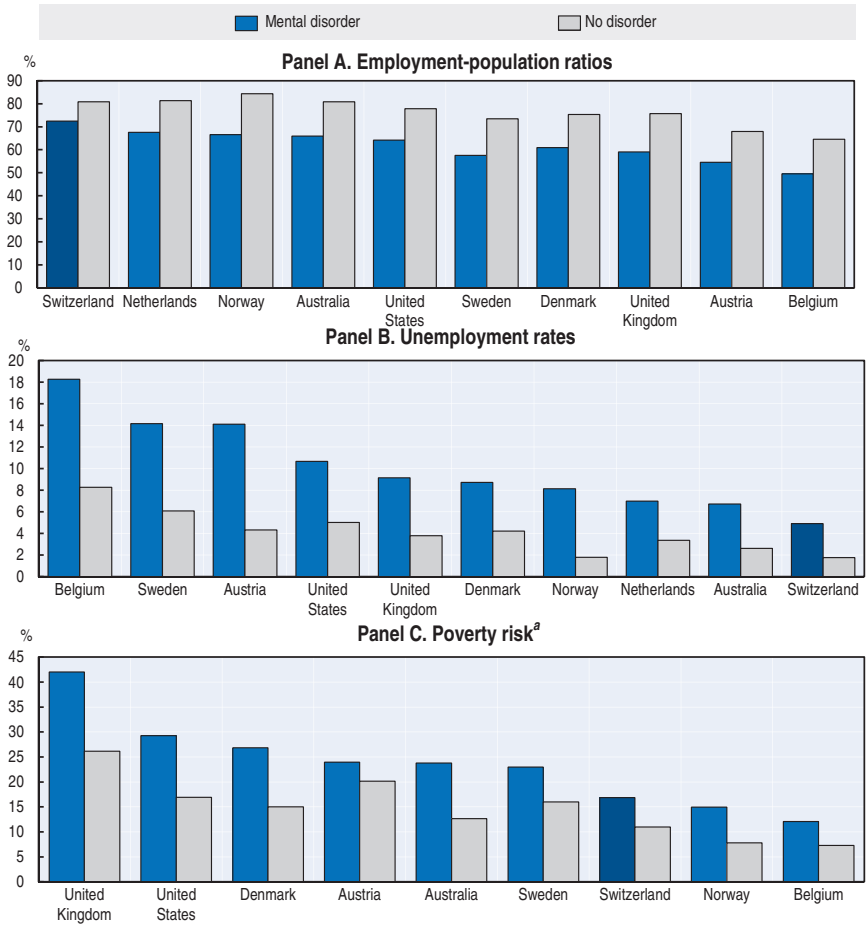
Key trends and outcomes

The employment rate of people with a mental disorder is remarkably high in Switzerland. In 2007, around 70% of the population aged 15-64 with a moderate or severe mental disorder was employed – the highest employment rate among the OECD countries shown in Figure 1.3 (Panel A) – and only ten percentage points below the employment rate of those without mental health problems. No data by mental health status are available for the years after the recent downturn, but, overall, the impact of the economic crisis has been minimal in Switzerland, with unemployment rates remaining around or below 4% in 2008-11 (OECD, 2012b). While the unemployment rate for people with mental disorders is about three times higher than for those without mental health problems, it remains very low in absolute terms at 5% in 2007 (Figure 1.3, Panel B). As a result of these good labour market outcomes, the poverty risk for people with a mental disorder is rather low in Switzerland compared with other OECD countries (Figure 1.3, Panel C). Nevertheless, this group is one and a half times more likely to live in relative income poverty than people without mental illness.

In addition, both the disability benefit recipiency rate and the share of mental disorders among disability beneficiaries have been rising persistently over the past two decades in Switzerland – as was the case in many OECD countries. Since 1995, the disability beneficiary rate increased annually by 1.5% on average and by 2012 4.7% of the population aged 20-64 was receiving disability benefits in Switzerland (Figure 1.4, Panel A). The annual increase in disability beneficiary stock was larger for mental health problems, on average 2.6% during the period 1995-2012. By 2012, mental disorders accounted for about 37% of the total disability beneficiary stock, up from 24% in 1995 (Figure 1.4, Panel B).

While the Swiss disability rate is a percentage point below the OECD average, Switzerland stands at the top of the ranking for expenditure on sickness and disability benefits, both as a percentage of total public spending and as a percentage of unemployment benefit spending (Figure 1.5, Panel A and B). In 2008, Switzerland spent 2.6% of GDP on sickness and disability programmes, which is about five times the budget spent on unemployment programmes.

Figure 1.3. **Labour market outcomes are remarkably good in Switzerland**



Note: The United Kingdom poverty risk is an over-estimate because the underlying data provide gross rather than net incomes (while net incomes are used for all other countries). However, net-income based data from the Health Survey for England for 2006 confirm the high poverty risk, comparable to the level found in the United States.

a. The percentage of people living in households with equivalised incomes below the low-income threshold (defined as 60% of median equivalised household income).

Source: OECD calculations based on national health surveys. Australia: National Health Survey 2007/08; Austria: Health Interview Survey 2006/07; Belgium: Health Interview Survey 2008; Denmark: National Health Interview Survey 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Survey on Living Conditions 2009/10; Switzerland: Health Survey 2007; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

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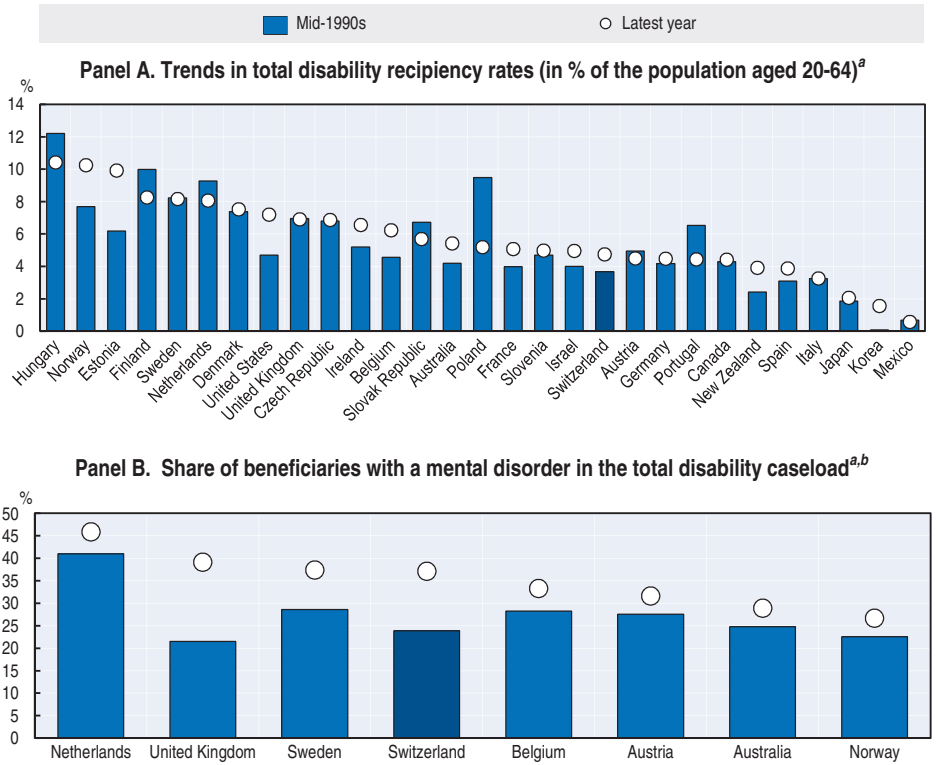
Figure 1.4. **Fast increase in the share of disability benefit recipients with a mental disorder**



a. Norway includes the temporary benefit in Panel A, but not in Panel B.

b. Data for Belgium, the Netherlands and Sweden include mental retardation, organic and unspecified disorders (categories which are not otherwise covered in this report).

Source: OECD calculations based on the OECD questionnaire on disability and OECD questionnaire on mental health.

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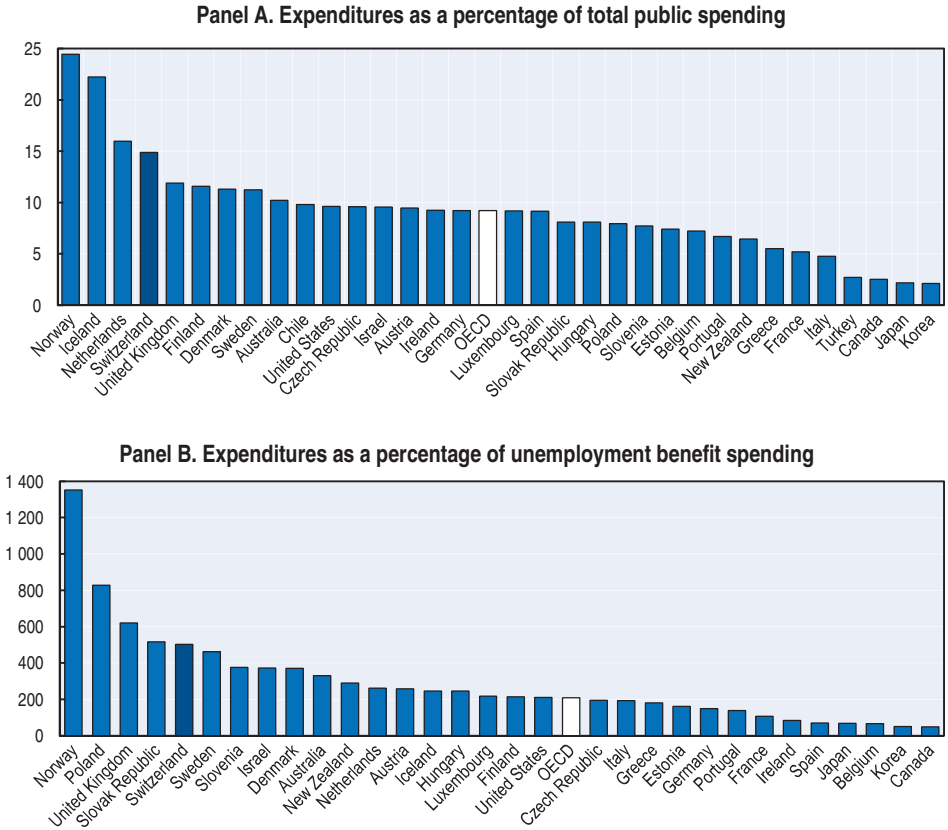
The high public costs of the sickness and disability programmes led to significant reforms, initially targeted at reducing the number of new claims for disability benefits (and with considerable success recently) and currently being broadened to also reach current disability benefit recipients (see Chapter 3 for more details). New claims into disability benefits started declining in 2004 (Figure 1.6, Panel A) and translated into a gradual decline in the caseload of disability beneficiaries since 2006 (Figure 1.6, Panel B). Yet, the continuing increase in the number of disability benefit recipients on the basis of mental illnesses remains a challenge.

Figure 1.5. **Sickness and disability benefit spending is high in Switzerland**



Note: Sickness benefits include all public and mandatory private paid sick-leave programmes (occupational injury and other sickness daily allowances); disability benefits include all public and mandatory private disability benefit programmes, such as in the case of Switzerland public disability insurance and mandatory occupational pension plans, as well as allowances covering extra costs arising from a disability. Data for Switzerland refer to 2008 while data for most other countries refer to 2009.

Source: *OECD Social Expenditure Database*, www.oecd.org/els/social/expenditure.

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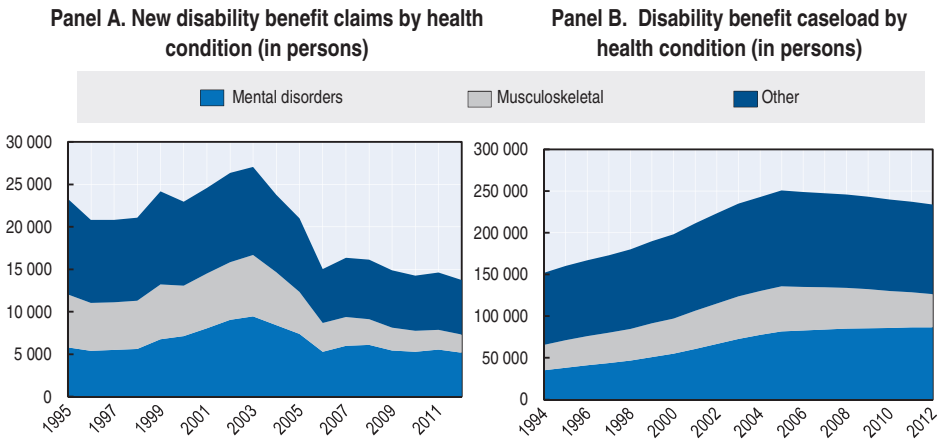
Figure 1.6. **New disability claims have fallen but the caseload of beneficiaries with a mental disorder continues to increase**



Source: OECD calculations based on data from the Federal Social Insurance Office.

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Description of the Swiss social protection system

The Swiss social security system consists of the following schemes: 1) old-age, survivors' and invalidity insurance (three-pillar system); 2) sickness and accidents insurance; 3) maternity benefits; 4) income compensation allowances for military service; 5) unemployment insurance; and 6) family allowances. The Federal Office of Public Health oversees issues related to sickness, accidents, occupational diseases, and maternity, while the Federal Social Insurance Office has responsibility over pensions and administers family allowances together with the cantonal authorities, and the State Secretariat for Economic Affairs has overall responsibility for unemployment benefits. Eligibility conditions and benefit rates for selected Swiss benefit schemes are discussed in Box 1.2.

Social protection is in the first place financed through contributions levied on income, with the exception of health insurance, for which each person pays a premium to a private health insurance fund – health insurance is mandatory, but each person can choose the insurance provider. In addition, the Confederation and the cantons contribute different amounts to several of the social security funds, provide supplementary benefits and subsidise premiums for persons with very low incomes (see FSIO, 2012, for a detailed overview of the organisation and financing of the Swiss social security system).

Box 1.2. **Eligibility conditions and benefit rates for selected Swiss benefits**

Unemployment benefits

To be entitled to unemployment benefits, a job seeker must have contributed for at least twelve months in the two previous years. Exceptions to this rule are provided in certain circumstances, such as if the person has not been working because of training, illness, accident or maternity leave, or was re-entering the workforce after a divorce, a withdrawal of a disability benefit or after working abroad. If the unemployed person left a suitable job without being sure of having a new job, he or she is subject to a benefit suspension of 6-12 weeks. Eligibility requires beneficiaries to be actively searching for work, including if they participate in labour market measures. Unemployment benefit recipients must generally accept any job that they are capable of doing, even if it is outside their previous profession. However, they have the right in the initial period of unemployment to focus their job search on jobs similar to their previous job, subject to there being enough vacancies, and can refuse a job that pays less than 70% of their previous salary. People under 30 must accept any job deemed suitable by the employment agency counsellor. The duration of unemployment benefits depends on the contribution period and ranges from maximum 200 to 520 days, with the benefit amounting to 80% (70% in a number of exceptions) of the insured salary which is capped at CHF 10 500 (EUR 8 740) per month (FSIO, 2012).

Sickness benefits

Social sickness insurance includes a compulsory health care insurance and an optional insurance for sickness benefits. Even so, employees are protected by law with continued wage payments during sick leave with the duration depending on their tenure. Individual contracts and collective agreements may provide better conditions in many cases through collective insurance for daily sickness allowances (see Chapter 2). Social sickness insurance is provided by recognised sickness funds and private insurance institutions under the supervision of the Federal Office of Public Health.

Disability benefits

Disability benefits are provided through a three-pillar system (as are old-age and survivor benefits). The first pillar intends to cover the basic needs of the recipients and is mandatory for everybody, including self-employed people and those who are not in gainful employment. The second pillar is mandatory for employers and employees only, while the third pillar is a voluntary benefit scheme. Disability insurance is organised and implemented by the 26 cantonal disability insurance offices under the administrative and financial supervision of the Federal Social Insurance Office.

1st pillar disability insurance

All persons who are domiciled or engaged in paid employment in Switzerland are subject to compulsory disability insurance. A person whose earning capacity or capacity to carry out usual activities cannot be re-established, maintained or improved by rehabilitation measures and who has work incapacity of at least 40% is eligible for disability benefits. The beneficiary receives a full disability benefit if the degree of disability is at least 70%; three-quarter disability benefit if the disability degree is at least 60%; half disability benefit if the disability degree is at least 50%; and quarter disability benefit if the disability degree is at least 40%.

Box 1.2. **Eligibility conditions and benefit rates for selected Swiss benefits** *(cont.)*

Disability benefit payments begin at the earliest at six months after the insured person has applied for a disability benefit. In the meanwhile, the person is eligible for early intervention measures to keep insured persons in their current job or for rehabilitation. These early intervention measures do not include daily allowances, but consist of workplace adjustment, training courses, job placement service, socio-professional rehabilitation, etc. If during the early intervention period it is determined that a person's earning capacity may be re-established, he or she will not be entitled to disability benefits, but may instead receive rehabilitation measures and daily cash benefits for a maximum of one year. See Chapter 3 for a more detailed discussion of the eligibility process and intervention measures.

2nd pillar disability insurance

Every employed person over the age of 17 who receives from one employer an annual salary of more than CHF 20 880 (EUR 17 378) is subject to a compulsory second-pillar insurance for disability and death risks. Unemployed people are also covered but under more restrictive conditions, and an optional insurance exists for self-employed persons. Disability is defined in the same way as under the first-pillar disability insurance, although insurance companies have the right to use a wider definition. Again, the degree of disability determines the type of benefit a claimant will receive: claimants with a disability degree of at least 40% are eligible for a one-quarter benefit. If their disability degree is at least 50%, they are eligible for a half benefit and a 60% disability entitles them to a three-quarter benefit. Only claimants with over 70% disability are eligible for a full disability benefit. Second-pillar disability benefits may be reduced if, in accumulation with other income and benefits, they exceed 90% of the annual income that the insured person has been deprived of due to the disability.

Conclusion

The following key facts emerge from the evidence available:

- Switzerland has a flexible labour market with high employment and low unemployment rates, and the impact of the recent economic downturn has been minimal. Labour market outcomes for people with mental disorders are also remarkably good and poverty rates are lower than in most other OECD countries.
- Despite excellent labour market outcomes, disability beneficiary rates had been rising steadily until 2006, resulting in high public spending on sickness and disability benefits. Mental disorders have become the single most important reason for the filing of disability benefit claims, accounting for 38% of the total number of new claims in 2012.
- Significant disability reforms strengthening the principle of rehabilitation before benefits and the focus on early intervention successfully curbed the number of new disability benefit claims, but the continuing increase in claims on the grounds of a mental illness remains a challenge.

Notes

1. Mental disorders, as defined in this report, exclude intellectual disabilities which encompass various intellectual deficits, including mental retardation, various specific conditions such as specific learning disability, and problems acquired later in life through brain injuries or neurodegenerative diseases like dementia. Organic mental illnesses are also outside the scope of this report.
2. Indirect costs in this study include productivity losses and the costs of benefits; direct medical costs include goods and services related to the prevention, diagnosis and treatment of a disorder; and direct non-medical costs are all other goods and services related to the disorder, e.g. social services.

References

FSIO (2012), *Overview of Swiss Social Security*, Federal Social Insurance Office, Bern.

Gustavsson, A. et al. and CDBE 2010 Study Group (2011), « Cost of Disorders of the Brain in Europe 2010 », *European Neuropsychopharmacology*, vol. 21, pp. 718-779.

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

OECD (2012b), *OECD Employment Outlook 2012*, OECD Publishing, Paris, http://dx.doi.org/10.1787/empl_outlook-2012-en.