Chapter 1

Mental health and work: The case for a stronger policy response

Mental health is costly for individuals concerned, for employers, for the labour market, for the social protection system and for the economy as a whole. This is explained by the high prevalence of mental ill-health, the early onset of mental illness that affects education and the labour market transition, high levels of under-treatment and unmet health care needs, and significant stigma associated with mental ill-health especially in the workplace.

The resulting main mental health and work outcomes include:

- *A large employment gap and high rates of unemployment for people with mental ill-health.*
- *High rates of underperformance among workers with mental health problems.*
- *A high prevalence of mental ill-health in all working-age benefit systems.*
- *Much higher income poverty risks for people with mental ill-health.*

Mental health is a key variable both in people's lives and in economic growth and development. It is closely bound up with well-being and quality of life and – when it is poor – affects education, employability, and performance at work. Mental ill-health, especially of the mild-to-moderate kind, affects as much as 20% of the working-age population at any given moment – further evidence of its economic relevance. The widespread costs and gains associated with mental health make it a key issue not only in OECD countries' health policies, but in their labour market and social policies, too.

Defining and measuring mental ill-health

Definition of mental ill-health

This report defines "mental ill-health" as any condition that meets clinically diagnosed threshold criteria. It is a definition that draws on the tenth edition of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) and the *Diagnostic and Statistical Manual of Mental Disorders*, *5th Edition* (DSM-5).

The report chiefly considers the mild-to-moderate end of the mental ill-health spectrum, where most disorders are mood or anxiety-related. It refers to them interchangeably as "common mental illnesses", "mental ill-health", "mental illness", "mental disorders", "mental health complaints", and "mental health problems".

Measuring the social and labour market outcomes of mental ill-health

Identifying and measuring mental ill-health is anything but straightforward. Administrative data often include the ICD or DSM codes that a medical assessment assigns to, say, a patient or a recipient of disability benefit. But they are not very helpful when it comes to measuring the social and labour market outcomes of people suffering from mental ill-health. To measure those outcomes, this report takes data from national health surveys. They combine labour market information with respondents' self-assessments of their mental health measured by validated mental health instruments (e.g. the Kessler Psychological Distress Scale – K10). Such instruments have shown they are good proxies for in-depth clinical interviews.

Comparing the social and labour outcomes of mental ill-health

This report seeks to measure and compare not the incidence of poor mental health in countries' working-age populations, but their social and labour market outcomes. To that end, the prevalence of mental ill-health across the OECD is assumed to be 20% – the stable, long-term rate that consistently emerges in countries' epidemiological studies. It allows comparison of outcomes between culturally different countries and also over time between different mental health instruments. A more detailed examination of this approach and its possible implications and the sensitivity of the assumptions for the resulting outcomes are found in the OECD report *Sick on the Job?* (OECD, 2012).

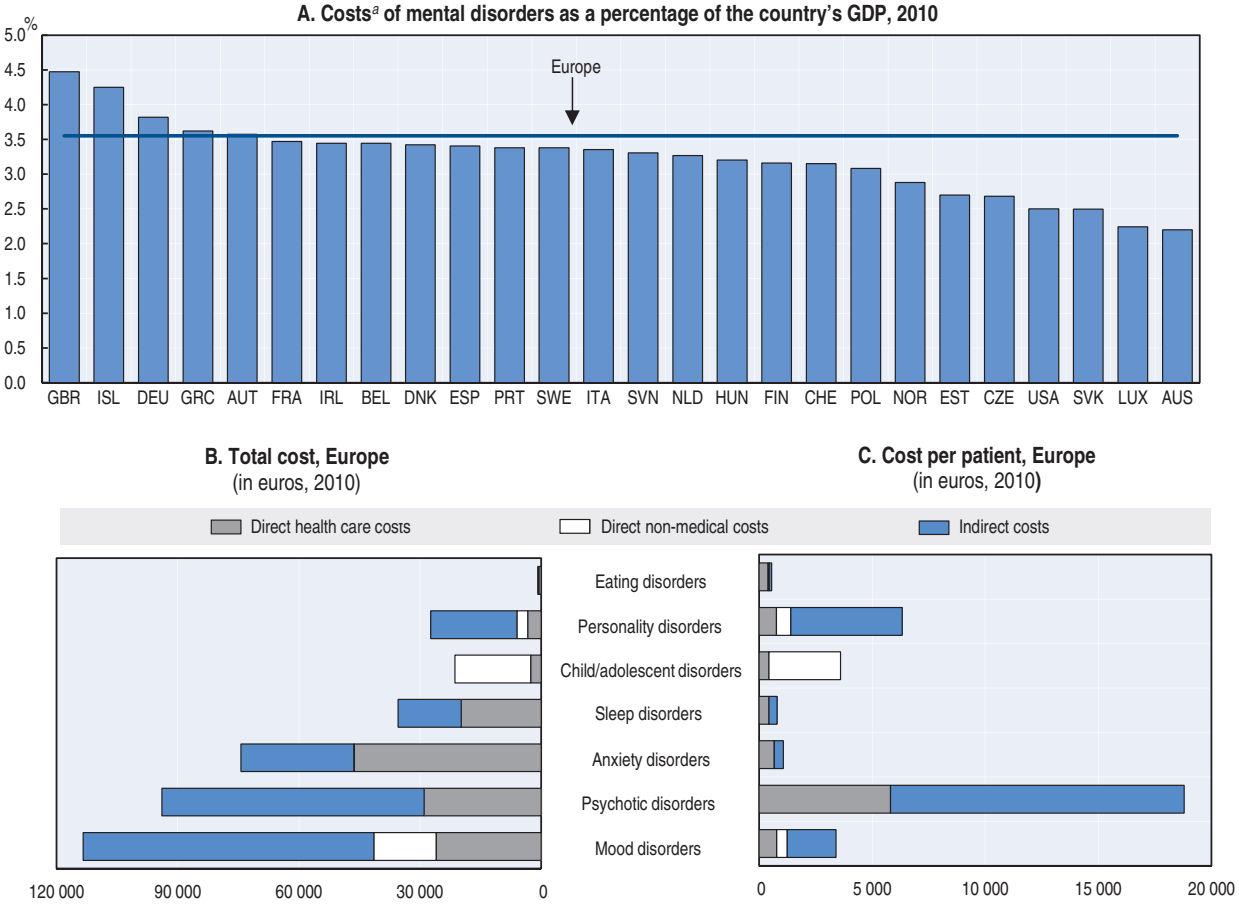
Key outcomes and challenges

A growing body of literature demonstrates the immense epidemiological burden of mental ill-health. According to the Global Burden of Diseases Study 2010, for example, mental disorders and substance abuse were the chief causes of years lived with disability (YLD) – 175 million years worldwide in 2010 (Whiteford et al., 2013). The resulting economic burden is also heavy, with mental ill-health costing individuals and the economy very dear.

Mental ill-health exacts a high price on OECD economies

There are significant gaps in information on the total costs of mental illness. Such costs are of different kinds: direct (especially for health care systems), indirect (especially for benefit systems) and intangible (especially losses in labour productivity). In the European Union, a large-scale project run on a country-by-country and disease-by-disease basis estimated the total costs of mental illness at around 3.5% of GDP in 2010, (Figure 1.1, Panel A). Estimates for non-European countries such as Australia and the United States yield similar results. The European study found that indirect and intangible costs – higher benefit expenditure and falls in productivity – accounted for more than 50% of the estimated total (Gustavsson et al., 2011).

Figure 1.1. **The costs of mental ill-health for the economy as a whole are high**



Note: "Costs" in Panel A are percentages of GDP expressed as millions of Purchasing Power Standard (PPS) for European countries. For Australia and the United States costs are expressed as percentages of GDP in current prices. Data for the United States are from 2005.

a. Cost estimates were prepared on a disease-by-disease basis, covering all major mental and brain disorders. This chart includes mental disorders only.

Source: OECD compilation based on: Gustavsson, A. et al. (2011), "Cost of Disorders of the Brain in Europe 2010", *European Neuropsychopharmacology*, No. 21, pp. 718-779 for European countries; Medibank Private Limited and Nous Group (2013), *The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design* for Australia; and Bayer, R. (2005), *The Hidden Costs of Mental Illness*, Upper Bay Counselling and Support Services for the United States.

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Although the study's estimate of 3.5% of GDP is considerable, it is still on the conservative side for two main reasons. First, it did not include disorders related to substance abuse. Second, the only indirect costs it covered were sickness and disability benefit spending. It did not consider expenditure generated by mental illness in other benefit systems not related to health. Similarly, it counted the productivity losses only of workers actually suffering from poor mental health, not the effect they had on the productivity of their co-workers.

The European study also illustrated the shares of different mental illnesses in total costs. The biggest drivers are mood, psychotic, and anxiety disorders. Psychotic disorders show a high per-person cost, while the sheer prevalence of mood and anxiety disorders account for their high costs. The per-person costs of mood complaints are only about one-sixth of those associated with psychotic conditions, and per-person costs are even lower for anxiety-related problems. Personality disorders have the second highest per-person cost, almost exclusively indirect (Figure 1.1, Panel B).

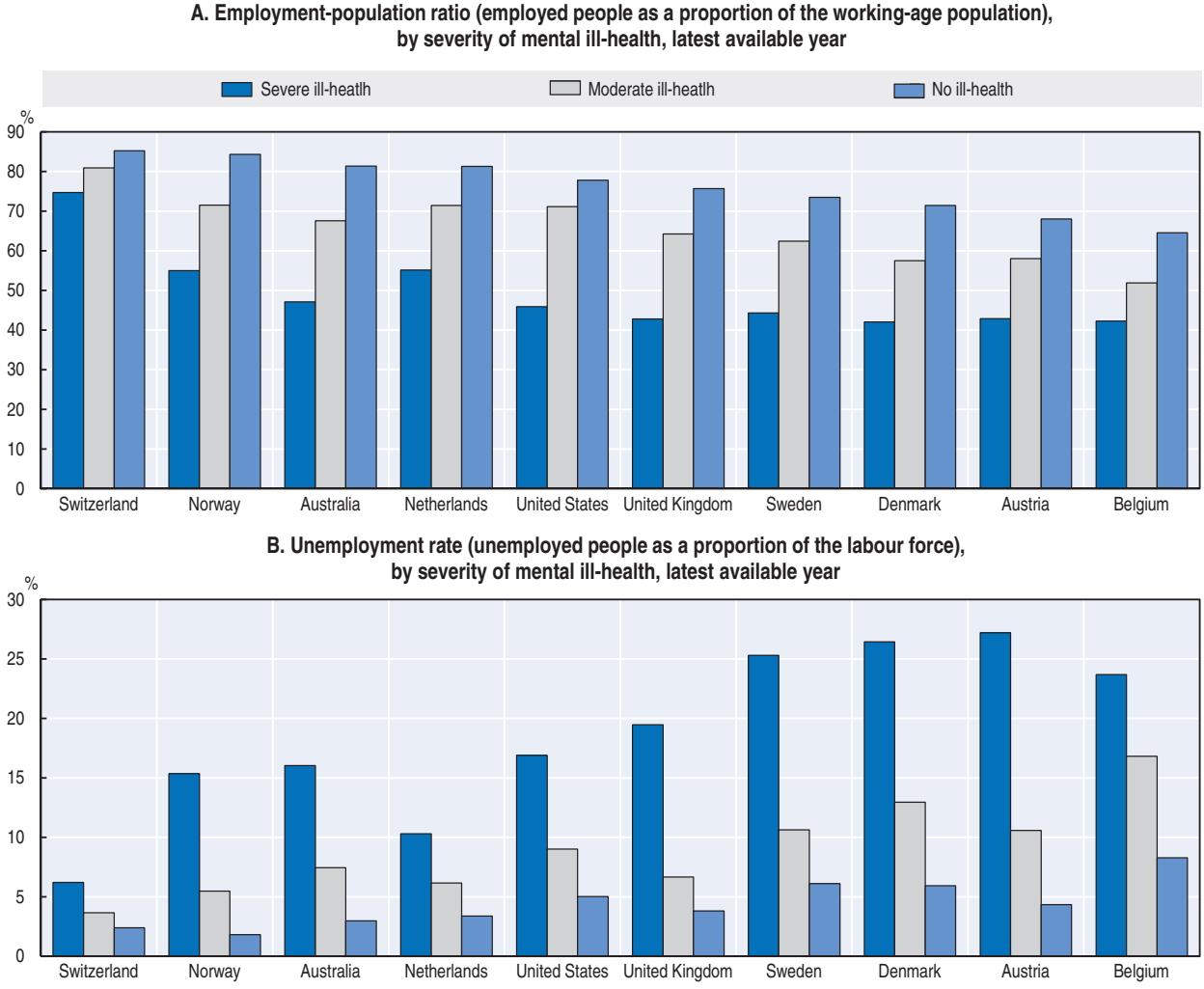
The high indirect costs of mental health problems are, to some extent, the result of insufficient investment in mental health care. Mental illness is responsible for 23% of the United Kingdom's total burden of disease, for example, but accounts for only 13% of National Health Service expenditure (OECD, 2014).

Mental ill-health impedes full labour market participation

Most people with poor mental health are in work. Even among those with severe disorders some 50% have a job (only in Switzerland is the rate much higher). The employment gap is nevertheless significant (Figure 1.2, Panel A). It stands at 10-15 percentage points for people with mild-to-moderate complaints and 25-30 percentage points for those suffering from severe complaints (again, Switzerland is an exception). Although little is known about the impact of the recent economic downturn on the mental health employment gap, it did in fact widen in most countries during the decade prior to the crisis (OECD, 2012).

Many people who suffer from mental ill-health want to work but cannot find jobs. Across the OECD, people with mild-to-moderate mental illness are twice as likely to be unemployed, while jobless rates among people with severe disorders are, in many countries, four or five times as high as those with no mental health issues (Figure 1.2, Panel B). Again, there is a lack of data on the impact of the recent economic downturn on people with mental health problems. As long-term unemployment has increased, however, they are probably even less likely than others to find a new job.

Figure 1.2. **Employment and unemployment gaps are considerable for people with mental ill-health**



Source: National health surveys. Australia: National Health Survey 2011-12; Austria: Health Interview Survey 2006-07; Belgium: Health Interview Survey 2008; Denmark: Danish National Health Survey 2010; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Living Conditions Survey 2009-10; Switzerland: Health Survey 2012; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey and 2008.

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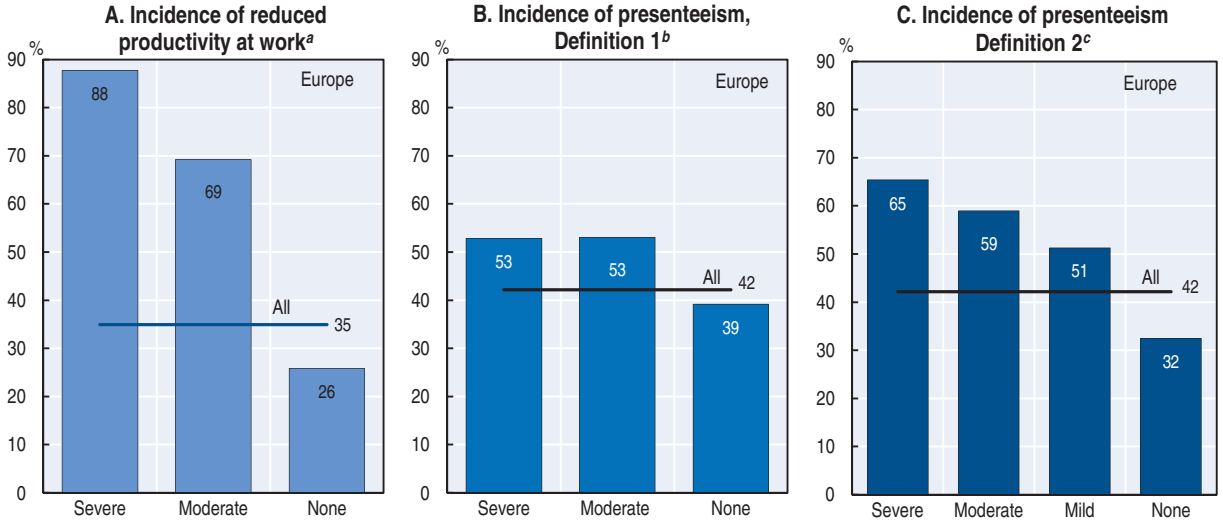
Employers also pay a high price for mental ill-health

Although most people with mental health problems have a job, many of them struggle to perform well – at a considerable, and increasingly acknowledged, cost for employers. Measuring performance problems and productivity losses is difficult, however.

Indirect measures based on employee responses suggest that productivity losses at work are substantial and the incidence of "presenteeism", i.e. being at work despite illness, is high. According to Eurobarometer 2010, three in four workers who have not taken sick leave despite their mental ill-health report having accomplished less than they would have wished. The ratio is only one in four among their peers with no such health problems (Figure 1.3, Panel A). The disparity is consistent across European OECD countries (Figure 1.3, Panel D).

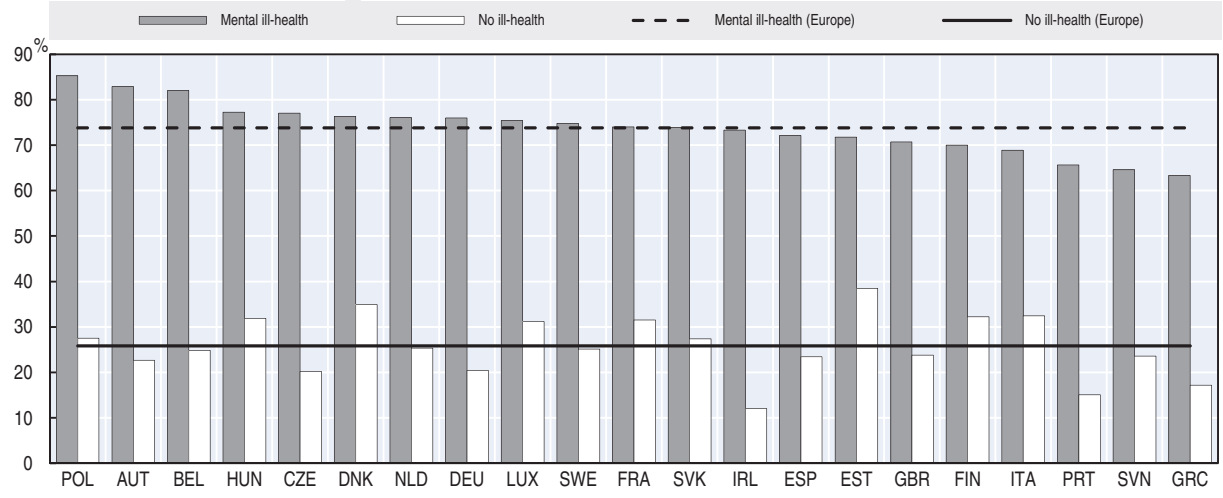
Figure 1.3. **Workers suffering from mental ill-health who attend work show less productivity**

Average incidence over a selection of European countries, 2010



D. Productivity loss through mental ill-health

Workers who have not taken sick leave but show reduced productivity (in the previous four weeks), due to an emotional or physical health problem, by mental health status and country



a. Percentage of workers not absent in the previous four weeks but who accomplished less than they would have liked as a result of an emotional or physical health problem. The data are an average of the 21 countries in the 2010 Eurobarometer.

b. Definition 1: The mental disorder variable is based on a set of five items: feeling cheerful; feeling calm; feeling active; waking up fresh and rested; feeling fulfilled. The data are an average of the 24 countries in the 2010 European Working Conditions Survey.

c. Definition 2: This mental disorder variable is based on three answers to the question, "Over the past 12 months, did you suffer from any of the following problems: depression or anxiety; overall fatigue; insomnia or general sleep difficulties?" The data are an average of the 24 countries in the 2010 European Working Conditions Survey.

Source: OECD estimates based on the Eurobarometer 2010 for Panels A and D, and the European Working Conditions Survey 2010 for Panels B and C.

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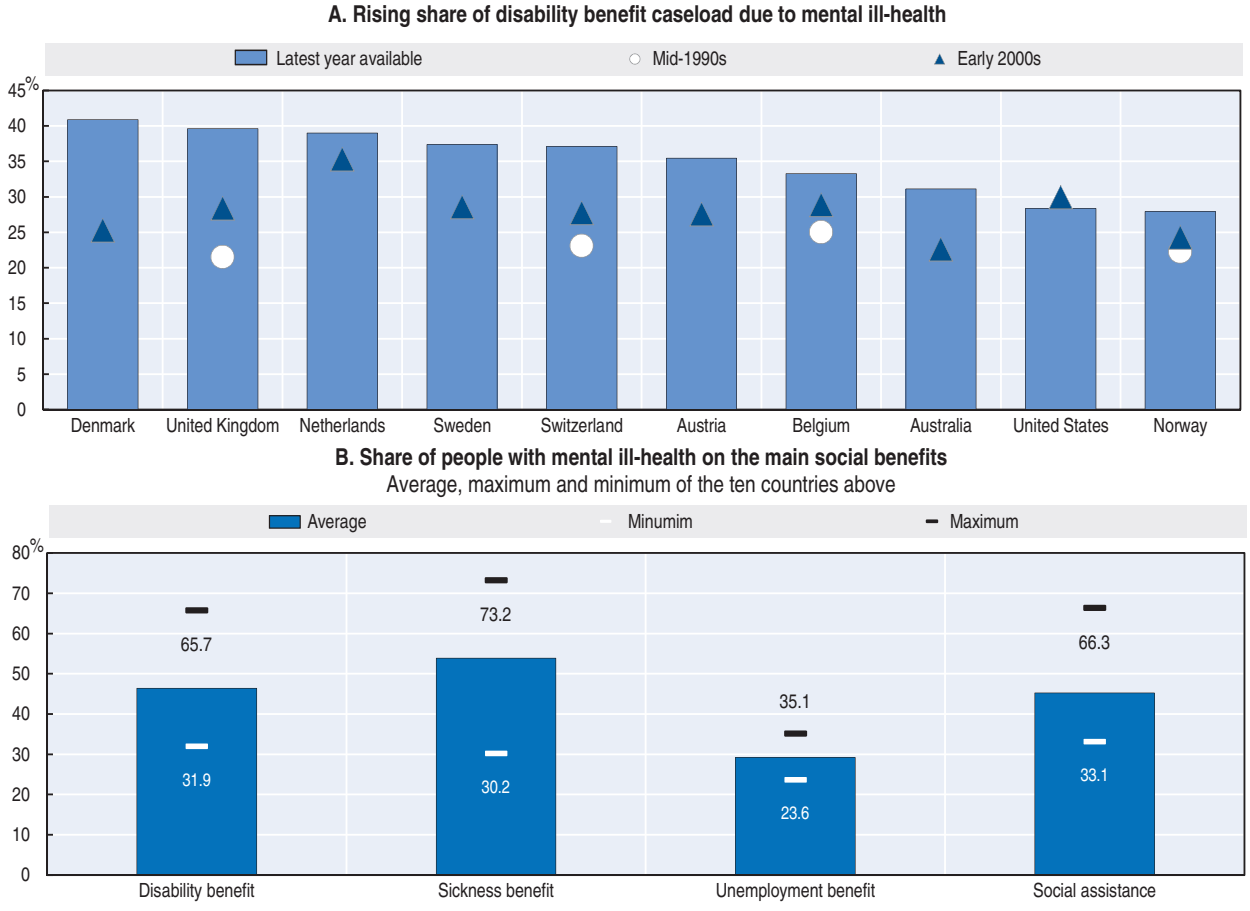
Similarly, data from the European Working Conditions Survey suggest that workers who suffer from poor mental health are more likely than not to attend work despite being sick (Figure 1.3, Panels B and C).

Substantial costs are incurred by social protection systems

Because workers with mental health problems tend to be more disconnected from the labour market than their mentally healthy peers, it is not surprising that social protection systems bear the brunt of the indirect costs of mental ill-health. In all OECD countries, people diagnosed with a mental disorder account for 30%-40% of disability benefit caseloads (Figure 1.4, Panel A). Total disability benefit expenditure stands at around 2% of GDP on average (OECD, 2010), with mental ill-health alone therefore accounting for around 0.7%. The significant rise of mental ill-health in benefit caseload OECD-wide over the past decade is attributable predominately to the growing recognition of mental illness.

Figure 1.4. **The costs of mental ill-health for benefit systems are high**



Note: Data in Panel A refer to new claims for Denmark and the United States (caseload data are unavailable). They exclude the temporary benefit in Norway and the special benefit for people with congenital or adolescent disability in the Netherlands.

Source: Panel A: OECD questionnaire on mental health; Panel B: national health surveys. Australia: National Health Survey 2011-12; Austria: Health Interview Survey 2006/07; Belgium: Health Interview Survey 2008; Denmark: Danish National Health Survey 2010; Netherlands: POLS Health Survey 2007-09; Norway: Level of Living and Health Survey 2008; Sweden: Living Conditions Survey 2009/10; Switzerland: Health Survey 2012; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

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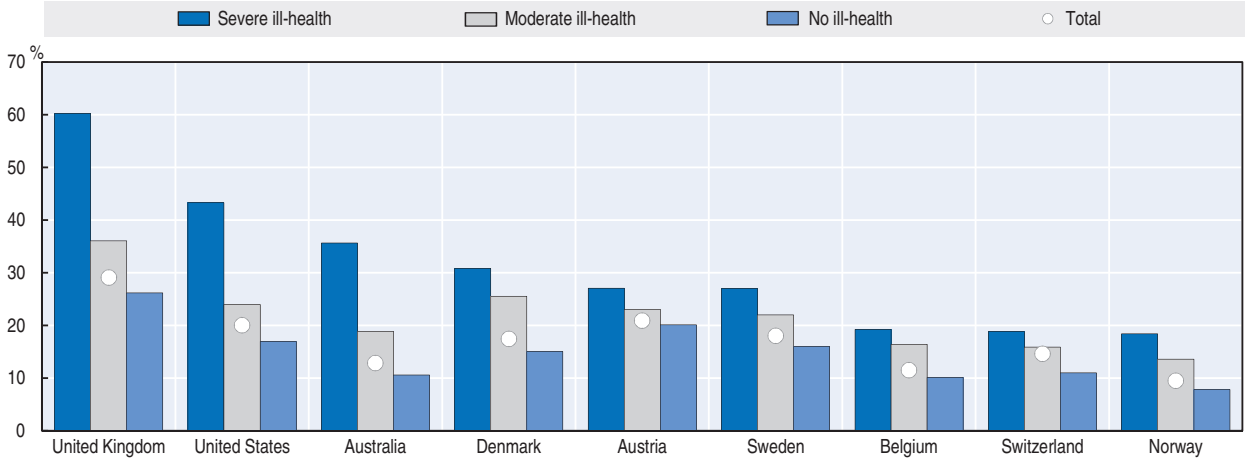
Mental illness does not put a great strain on the disability benefit system alone. It costs sickness benefit regimes and social assistance as much, if not more. Data from national health surveys across a number of countries reveal that some 45%-50% of all beneficiaries of such systems suffer from mental illness (Figure 1.4, Panel B). What's more, around one-third of unemployment benefit recipients suffer from mental ill-health – a share that is much higher among the long-term unemployed. People often suffer from illnesses that have not been formally diagnosed or assessed, but which are nevertheless a considerable impediment to successfully returning to the labour market.

Mental ill-health can push individuals closer to poverty and into poor quality jobs

The personal costs of mental ill-health are also high. They include, for example, material deprivation due not only to no or low income from work, but to benefit payments that cannot fully offset lost earnings. Data that consider individuals' revenues from work, benefits, and sources like private capital, and those of household members, tell a stark story. People suffering from mental ill-health run a significantly higher risk of living in low-income households. For people whose mental ill-health is mild-to-moderate the risk is around one-third higher than for their peers with no mental health complaints, while among those with severe problems it is often twice as high or more (Figure 1.5).

Figure 1.5. **The personal costs of mental ill-health are also high**

People in low-income households (at risk of poverty) by mental health status, latest year available



Note: Per person net income adjusted for household size. For Australia, Denmark and the United Kingdom data refer to gross income. 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. The low-income threshold for determining poverty risk is 60% of median income.

Source: National health surveys. Australia: National Health Survey 2011-12; 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: Living Conditions Survey 2009 10; Switzerland: Health Survey 2012; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

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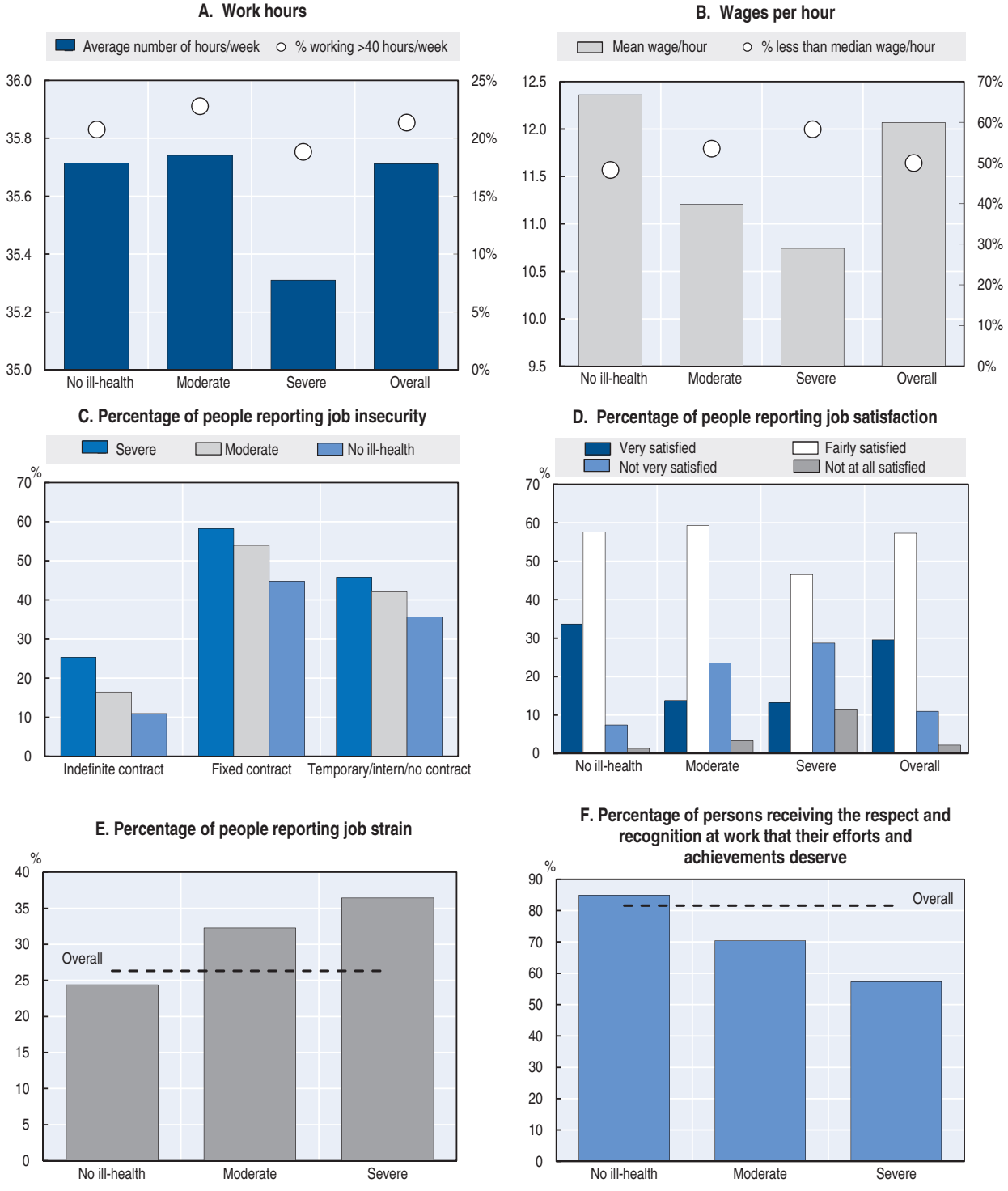
There is a clear link between mental health problems and poor job quality. Figure 1.6 shows that people with mental health issues earn less per hour (Panel B), have less secure jobs (Panel C), are less satisfied with their jobs (Panel D), report strain more often (Panel E), and enjoy less respect or recognition for their work (Panel F). People with mild-to-moderate disorders seem to work the most (which may cause stress and dissatisfaction), while those with severe problems work the shortest hours (Panel A).

Figure 1.6. **Workers with mental ill-health work in jobs of poorer quality**

Average outcomes over a selection of European countries, 2010



Note: Data refer to the country averages established by Eurobarometer and the European Working Conditions Survey.
Source: OECD calculations based on Eurobarometer 2010 (Panels A, E and F) and the European Working Conditions Survey 2010 (Panels B, C and D).

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Overall, then, the working conditions and job quality of people with mental health problems appear only somewhat worse. Still, for some workers they may be large enough to contribute to a further worsening of their condition and heighten the risk of job loss, so neutralising any of the positive effects of employment. Differences in job satisfaction, however, are relatively wide, with people who suffer from mild-to-moderate illness as broadly dissatisfied as those with severe disorders. Thus, while boosting employment is the only way to square income discrepancies, it is equally important to ensure access to high-quality jobs that offer good working conditions and are sustainable and adequately paid.

Evidence suggests that there are two problems: employment and unemployment gaps on the one hand, and job quality and work performance issues on the other. Policy makers must address both if they are to increase productive employment among people with mental health problems, thereby lowering the price paid by individuals, employers, benefit systems, and the economy as a whole.

Policy can make a difference

Outcomes and policy challenges are very similar in all OECD countries. What can be done and how can policy change to ease the high costs to individuals, the labour market and the economy arising from mental illness? The series of country reports published by the OECD between 2013 and 2015 demonstrate that countries are only just beginning to address those challenges (as shown by the policy examples provided at the end of each chapter of this report).

Because of the considerable stigma that attaches to mental illness and the widespread ignorance of its economic impacts, this issue has received little attention from labour market policies. Yet the multi- and bi-directional ties between mental health and work, and the evidence supporting them, are increasingly clear and widely understood. Indeed, research has consistently shown that employment is good for health, especially mental health, whilst unemployment has an adverse effect (OECD, 2008). Importantly, good-quality employment can also help recovery from mental illness. And, although policy, too, could make a difference, it is not yet doing so. Social and labour market policies neglect the issue to a large extent (OECD, 2012), and even health policies fail to address it adequately (OECD, 2014).

Investing in and prioritising policies that strive to improve the inclusion of people with mental ill-health in the labour market and support the building of a mentally resilient, productive workforce will be important as populations continue to age rapidly and working environments change at ever faster rates. Good policy making requires sound knowledge, high-quality data, and strong evidence as to the impact of policies, services, and institutions. Although the mental health and work policy evidence base is still meagre, it is nevertheless growing. This report seeks to contribute to that evidence and to the development of a comprehensive policy framework for the coming decades.

The following chapters look in depth at the challenges in four main policy domains: education and youth, health care, the workplace and employers, and benefits and employment services. Policy makers in each of those areas must strive for early, integrated action which involves front-line actors.

REFERENCES

Bayer, R. (2005), *The Hidden Costs of Mental Illness*, Upper Bay Counselling and Support Services.

Gustavsson, A. et al. (2011), "Cost of Disorders of the Brain in Europe 2010", *European Neuropsychopharmacology*, No. 21, pp. 718-779.

Medibank Private Limited and Nous Group (2013), *The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design*.

OECD (2014), *Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care*, OECD Publishing, Paris, http://dx/doi/org/10.1787/9789264208445-en.

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

OECD (2010), *Sickness, Disability and Work: Breaking the Barriers,* OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264090606-en.

OECD (2008), *OECD Employment Outlook 2008*, Chapter 4 "Are All Jobs Good for Your Health? The Impact of Work Status and Working Conditions on Mental Health", OECD Publishing, Paris, http://dx.doi.org/10.1787/empl_outlook-2008-en.

Whiteford, H. et al. (2013), "Global Burden of Disease Attributable to Mental and Substance Use Disorders: Findings from the Global Burden of Disease Study 2010", *The Lancet*, Vol. 382, No. 9904, pp. 1575-1586.

From:

Fit Mind, Fit Job

From Evidence to Practice in Mental Health and Work

Access the complete publication at:
https://doi.org/10.1787/9789264228283-en

Please cite this chapter as:

OECD (2015), "Mental health and work: The case for a stronger policy response", in *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/9789264228283-5-en