

## Making Mental Health Count

Despite the vast burden that mental ill-health imposes on people and on economies, many countries continue to neglect mental health care, and the unmet need for treatment remains high. Making mental health a policy priority would enhance people’s lives, and have significant social and economic benefits.

This report assesses the costs of mental ill-health, and provides recommendations on how governments can improve care for some of society’s most vulnerable people.

### The social and economic costs of mental ill health are very high

Evidence suggests that around 5% of the working-age population has a severe mental health condition, and a further 15% is affected by a more common one. OECD data suggest that one in two people will experience mental ill-health at some point in their life, reducing their employment prospects, productivity and wages.

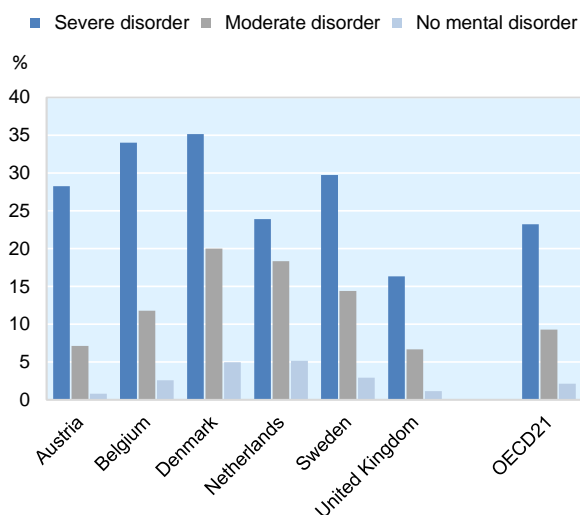
The direct and indirect costs of mental ill-health can exceed 4% of GDP. The direct costs of mental ill-health include medical expenditure, triggered by an increased need for health care, and social care costs such as long-term care. Poor mental health drives up the cost of treating other health problems. It is more expensive to treat diabetes when the patient is also suffering from depression, and people with mental ill-health are more likely to also suffer from cancer and cardiovascular diseases.

Poor mental health also has broader societal impacts. People with mental ill-health experience higher rates of unemployment, are poorer than the general population, have more absences from work, and also suffer more from “presenteeism” – reduced productivity at work. These factors lead to significant indirect economic costs. Indirect costs also include informal care provided by family members, and a full accounting of the costs of poor mental health includes the cost of increased homelessness and crime.

The more “intangible” costs should not be underestimated – the emotional distress, pain and suffering experienced by those with an enduring mental illness.

About half of adults with a mental illness developed it before the age of 15, so early identification and treatment can help reduce these costs. But, as Figure 1 suggests, many in need of treatment continue to go without.

**Figure 1. People in specialist treatment by severity of mental health disorder, 2010**



Notes: Treatment for a psychological or emotional problem in the last 12 months. “Specialist” includes psychiatrist, psychologist, psychotherapist or psychoanalyst. “No specialist” includes general practitioner, pharmacist nurse, social worker or “someone else”.

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

### ***Mental illness and unemployment: a vicious cycle***

Unemployment can lead to mental illness, and those who are mentally ill are often unable to work. People with severe mental health conditions are 6-7 times more likely to be unemployed than people with no mental health condition. Those with a mild-to-moderate condition are 2-3 times more likely to be unemployed. The longer people are unemployed, the more damaging the consequences for their mental health. Greater economic losses are also incurred.

### ***Spending on mental health has grown, but is not matching need***

Mental health spending has generally been rising in OECD countries, now representing between 5% and 18% of total health expenditure in countries that are able to break down total spending. But treating unmet need remains a significant issue. It could even be argued that spending on mental health is too low, given its large overall economic and social burden. For example, mental illness is responsible for 23% of England's total burden of disease, but receives 13% of the National Health Service health expenditure.

The current economic crisis affecting many OECD nations makes effective mental health policy even more urgent. Several countries have imposed austerity measures in health and welfare, at a time when the economic crisis is likely to negatively affect mental health in the form of insecurity, anxiety and depression. Bleak economic conditions make the need to invest wisely in mental health, and to make good resource allocation choices, all the more pertinent.

### **Evidence-based treatment for mild-to-moderate mental illness must be improved**

More common conditions like depression and anxiety are often highly treatable, but many people with a mental health condition do not receive the treatment they need.

International estimates suggest the treatment gap ranges from 32.2% for schizophrenia, to 57.5% for anxiety disorders. The gap is estimated at 56.3% for depression, 50.2% for bipolar disorder, and 57.3% for obsessive compulsive disorder.

Under-treatment contributes to the high social and economic cost of mental ill health. There is not only a moral imperative to invest in effective therapies for people with mild-to-moderate mental illness, but it also makes economic sense. It can save health systems and national economies money in the medium- to long-term, and there are benefits in people being well enough to return to work.

Evidence suggests that psychological treatments, especially cognitive behavioural therapy (CBT), are effective for mild-to-moderate depression and anxiety. In many OECD countries, primary care practitioners are able to refer patients to psychological therapies, although the costs of such therapies are often not reimbursed. When patients have to pay, or there are high co-payments, this is a barrier to access. Improving access to psychological therapies would help close the large treatment gap.

The prevalence of moderate mental health conditions amongst young people in OECD countries is high. Despite this, specialist services are still disproportionately focused on adults.

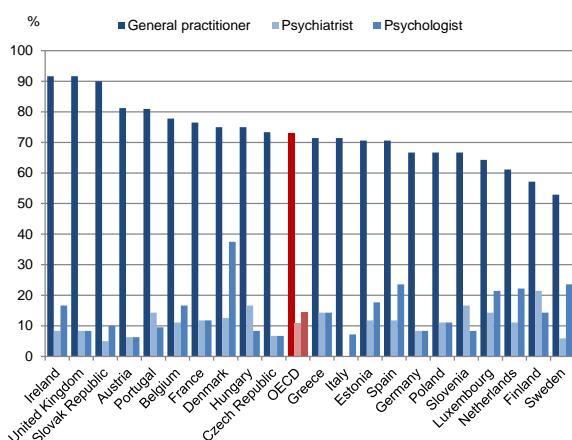
Efforts should therefore also be made to improve treatment for the school-age population, and for young adults. The OECD-wide median age of onset for mental disorders is 14 years, with anxiety and personality disorders beginning at around the age of 11.

Many child and adolescent mental health services are under-resourced, and access to appropriate care is a problem. Evidence from Australia, for example, suggests that only 25% of under 25-year-olds with mental ill health access mental health services. Countries such as Australia, Finland, New Zealand, Sweden and the United Kingdom have rightly made expanding child and adolescent services a priority.

## Strengthening primary care for people with mild-to-moderate disorders

Investing more in primary care is one cost-effective way of treating mild-to-moderate mental disorders. As Figure 2 suggests, in most OECD countries, primary care practitioners are already expected to diagnose, treat and manage these types of disorders and are often the first port-of-call. However, in many cases primary care providers lack the resources, time and expertise to care for mild-to-moderate mental illness effectively.

**Figure 2. Type of provider(s) consulted for mental health problems, selected EU countries, 2010**



Source: *Health at a Glance 2011 – OECD Indicators*, OECD Publishing, Paris, [http://dx.doi.org/10.1787/health\\_glance-2011-en](http://dx.doi.org/10.1787/health_glance-2011-en).

Comprehensive training to diagnose, treat and manage mental illness, as well as continuing professional development and best practice guidelines, can ensure practitioners are up-to-date on best evidence-based practice. Where primary care is not effectively engaging with mental illness, there is a need for incentives to provide often complex and time-consuming care.

There is also potential for primary care to deliver evidence-based programmes such as Cognitive Behavioural Therapy (CBT). In Norway, GPs can be trained in, and be reimbursed for providing, CBT. But in countries with weak primary care systems and where there are high levels of stigma around mental illness, CBT in primary care is not likely to be the most efficient use of resources.

Mental health workforce shortages underscore the need for primary care to play a bigger role. Shortages have provided an impetus for the introduction of new professional roles, such as mental health nurse practitioners in Australia and advanced practice psychiatric nurses in the United States. These nurses have enhanced roles such as prescribing, historically the domain of physicians. In more rural areas, where the workforce shortages are more urgent, telehealth offers the potential for professionals to see patients through video conferencing.

## Strive for better mental health outcomes

There is a need for a more complete understanding of what constitutes good mental health care outcomes for people with mild or moderate disorders, and for severe disorders. In other areas of health care, this is easier, as it is possible to measure better survival rates and reduced symptom severity. This can be done for mental health, too. But the high complexity of treating mental disorders, and their often very chronic nature, make it more difficult to define a good treatment “outcome”.

A big information gap is part of the problem. Mental health care outcomes are too rarely measured and monitored, often due to a lack of good indicators. When information is available a lack of agreement over which measures to use has slowed progress. To move towards better outcomes, an agreed conceptual framework is necessary.

A broad conceptualisation of a good “outcome” is also important. For instance, most people with a mental illness can work. Employment is often overlooked as an important outcome, but its inclusion is all the more pertinent given the high economic cost of mental ill health.

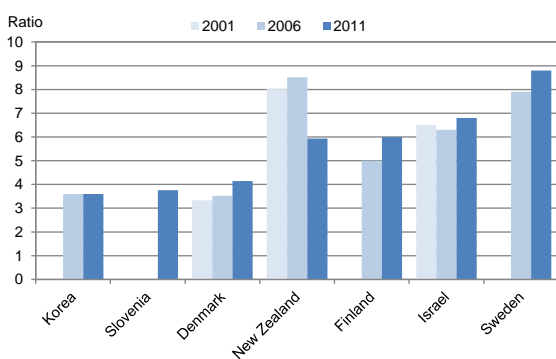
A number of countries have made progress in measuring a broader range of outcomes for mental ill-health, for example the ‘Good Care’ quality framework for services in Sweden, and the new Clinical Commissioning Group Outcomes Indicator Set in England.

**The rate of physical ill-health in people with severe mental illness is unacceptably high**

OECD countries should prioritise improving the poor physical health amongst people with severe mental illness.

People with mental illness often have physical health problems that can lead to increased mortality, poorer health outcomes, and are more expensive for the health system. Individuals with severe mental illnesses, such as acute depression, bipolar disorder and schizophrenia, die, on average, 20 years earlier than the general population. In Nordic countries, those admitted to hospital for a mental disorder have a mortality rate two to three times higher than the general population. In Australia, men with psychiatric disorders die almost 16 years earlier than the general population, while the gap is 12 years for women.

**Figure 3. Excess mortality from schizophrenia, 2006 and 2011 (or nearest year available)**



Source: OECD Health Statistics 2013, <http://dx.doi.org/10.1787/health-data-en>.

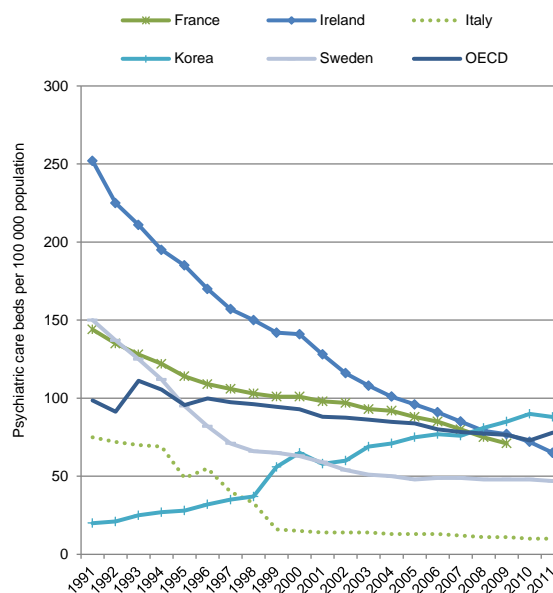
As Figure 3 suggests, people with severe mental illnesses have higher age and sex-adjusted mortality rates than members of the general population. Data from England show a premature mortality rate among people with severe mental illness that is three-fold higher compared with the general population.

**Continue the push towards care in the community**

While the prevalence of severe mental illness is small relative to mild-to-moderate mental illness, it tends to dominate the organisation of mental health systems in OECD countries, and consume most of the resources.

The overarching policy direction for mental health in OECD countries has been “deinstitutionalisation” – moving people out of psychiatric hospitals towards care in the community, as shown in Figure 4. In some OECD countries, such as Italy, the United Kingdom, and the United States, the de-institutionalisation process started over 50 years ago.

**Figure 4. Psychiatric care beds per 100 000 population, 1991-2011**



Source: OECD Health Statistics 2013, <http://dx.doi.org/10.1787/health-data-en>.

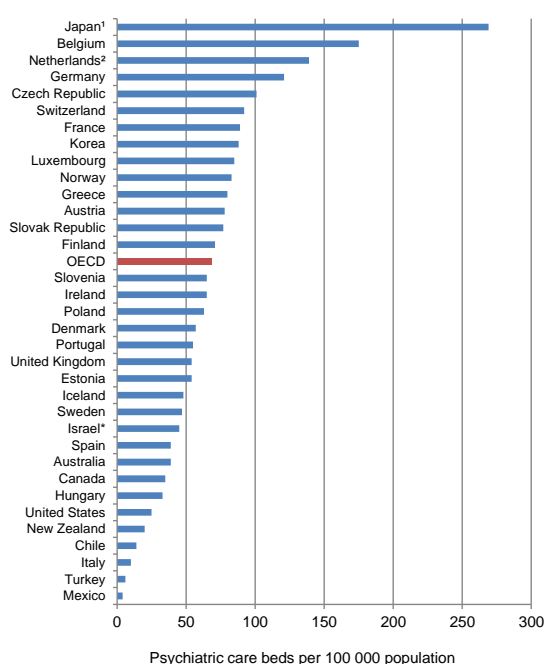
Italy has a rate of ten psychiatric care beds per 100 000 population – approximately seven times less than the OECD average – and has historically demonstrated significant leadership in moving mental health care for people with severe mental illness from institutions to the community.

Nonetheless, there are wide variations in psychiatric bed numbers, as Figure 5 shows. Countries such as the Czech Republic, Japan and Korea have just recently started to move care away from hospital settings.

Countries use psychiatric beds differently, often based on how many they have. Those with fewer beds tend to reserve hospital care for emergency situations, a “last resort”, or for a brief stay to stabilise a patient during an acute phase of illness.

Countries with more psychiatric beds often use them for less acute treatment, or for long-stay patients. As Figure 4 shows, Korea is the only OECD country where psychiatric care bed numbers have steadily risen. The Korean Mental Health Promotion Comprehensive Plan notes that hospital care is far more prevalent in Korea than community care. This is in part because of a shortage of community services and a high number of hospital beds. Hospital care is used to treat disorders that other countries usually manage in a community setting, such as alcohol addiction disorder.

**Figure 5. Psychiatric care beds per 100 000 population, 2011**



1. In Japan, a high number of psychiatric care beds are utilised by long-stay chronic patients.

2. In the Netherlands, psychiatric bed numbers include social care sector beds that may not be included as psychiatric beds in other countries.

\* Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Statistics 2013, <http://dx.doi.org/10.1787/health-data-en>.

Many people needing mental health care have fared well from de-institutionalisation, with patients preferring to live in more independent community settings, but problems persist. Experiences from some countries suggest deinstitutionalisation has, in some cases, had unintended consequences. When psychiatric hospitals have not been replaced by accessible and affordable community services, people with severe mental illness have in some cases

suffered from homelessness, inappropriate incarceration and frequent admissions to hospital. Many governments also struggle to find the right balance between hospital and community-based care for those with the most severe mental illness, who would have previously been hospitalised.

When care is predominantly delivered away from hospitals, coordination becomes a bigger challenge; individuals often have a range of health and social needs that must be organised by a range of care providers, unlike the single care setting of the psychiatric hospital.

To help deal with this coordination challenge there is scope for GPs to be involved in the ongoing care of people with severe mental illness. GPs or other primary care providers can ensure that attention to the physical health of individuals with mental ill-health is provided in an appropriate manner. With primary care focusing on the ensemble of the patient's health needs, some of the excess mortality for patients with bipolar or schizophrenia might be eliminated.

***Community Treatment Orders can be a less restrictive approach to managing involuntary patients outside of hospital***

A growing number of OECD countries allow people with a mental illness to be placed under a Community Treatment Order (CTO). These orders legally compel people with experiencing severe mental ill-health to comply with treatment, without being detained in hospital. This is a less restrictive alternative to traditional in-patient involuntary treatment orders, which tend to hospitalise patients. CTOs allow patients to live in the community while ensuring they comply with treatment.

CTOs should result in reduced hospital admission rates. Other potential benefits include helping to maintain regular contact between community services and patients, improving medication adherence, allowing greater involvement of patients in their own care, and easier detection of relapses.

While patients and professionals view CTOs favourably, there is a need to undertake further evidence-based research to show the impact of CTOs on patient outcomes such as recovery, treatment adherence and satisfaction.

### Align provider incentives with desired mental health outcomes

Policy makers must improve their use of incentives to encourage good mental health care. While outcomes and good incentives are a key issue across health systems, this focus is often missing, and almost universally lagging behind other areas of health.

At a primary care level, financial incentives can encourage the provision of appropriate services for mental disorders. Provider payments for specialist care should encourage integrated care in hospitals and community-based settings. In reality, payment systems remain fragmented and differ according to care settings. Poorly designed payment systems can lead to undesirable outcomes; for example, paying for inpatient bed days can drive up length of stay without promoting effective treatment or timely discharge.

Provider payment for mental health is mainly through global budgets, which give few incentives to improve quality. The other way is fee-for-service or per diem rates, which can drive the overuse of in-patient beds and push up average length of stay.

Payment using Diagnosis Related Groups (DRGs), which has been widely introduced in OECD countries as an alternative to global budgets or fee-for-service for many health services, has proved tricky to adapt to mental health care. Diagnosis is not a good predictor of the costs of hospital mental health care, as the same psychiatric diagnosis can be associated with differing severities of illness and lengths of stay and subsequent costs of care. The use of DRGs can lead to a risk that mental health care is underfunded, as reimbursement rates have not always fully taken into account all the costs associated with chronic mental health problems.

In the wake of deinstitutionalisation the challenge for mental health policy makers is to implement payment systems that are not tied to a particular setting and that encourage high-quality, efficient and integrated care. Implementing a payment system that spans care settings requires designing a classification that goes beyond diagnosis to fully account for cost differences. It also requires defining a product or unit for which payment is paid, attaching a tariff to the product, and implementing additional payment mechanisms that reduce negative incentives. Box 1 illustrates how some countries are striving to do this.

#### Box 1. Payment systems, an OECD selection

- Germany is reorganising its per diem payment system for providers to take account of severity of illness and complexity of treatment. It will introduce a performance-orientated and fixed rate reimbursement system on the basis of day-related charges.
- England's "Care Pathways and Packages Approach" uses individualised care packages encompassing different care settings to reduce incentives for "re-institutionalisation" or neglect of community-based care. Severity and need underpin the classification system.
- In the Netherlands, the first year of in-patient medical psychiatric care and psychiatric care in other settings is reimbursed by a DRG-based system. Longer-term mental health care is funded under the mandatory national long-term care insurance scheme. The country plans to further refine the episode-based payment system to take account of care intensity and outcomes for secondary mental health care.
- Australia's Mental Health Classification and Service Cost project focuses on factors such as psychiatric diagnosis, severity, focus of care and legal status. The project explored the relationship between patient attributes or needs and service costs, and if it could be used for funding purposes.

## Better data collection to track quality of mental health treatment

Governments cannot fully quantify the cost of mental illness, as few countries systematically measure the resources they devote to mental health. The lack of data on costs, quality and outcomes inhibits a complete assessment of mental health system performance. The result is poor policy, and an inability to direct scarce resources to areas of need.

The inadequate identification of people who need care perpetuates undertreatment. To understand where treatment gaps exist and improve quality, governments must improve their data collection on prevalence. National surveys are a useful tool to estimate prevalence, and are preferable to estimates that are based on use of services. However, the design and content of such surveys vary across countries and standardised cross-country measurement tools are limited.

There is also a need for better reporting on quality and outcomes. Suicide and premature mortality can give an indication of mental health outcomes at a population level, but are biased towards severe mental illness. Important health system measures that should be included are premature mortality, suicides of patients who have contact with mental health services, and hospital bed numbers.

Measuring quality must move beyond traditional health indicators to encompass social outcomes, such as education, employment, housing, and social inclusion.

The Nordic countries are among the high achievers in measuring the quality of mental health services. These countries have unique opportunities to measure quality because of well-established health-related registries, and because data can be collected that are linked to individual patients.

The quality of mental health care will continue to trail behind that of other diseases until appropriate indicators are used to measure quality, and appropriate data is collected.

**Table 1. OECD's recommended indicators for monitoring the quality of mental health care (ranked by availability)**

Indicator	Number of countries readily available	Not available (number of countries)
Hospital re-admissions for psychiatric patients	13	5
Length of treatment for substance-related disorders	12	6
Mortality for persons with severe psychiatric disorders	12	6
Use of anti-cholinergic anti-depressant drugs among elderly patients	9	9
Continuity of visits after hospitalisation for dual psychiatric/substance related conditions	6	12
Continuity of visits after mental health-related hospitalisation	6	12
Timely ambulatory follow-up after medical health hospitalisation	5	13
Case management for severe psychiatric disorders	5	13
Continuous anti-depressant medication treatment in acute phase	4	14
Continuous anti-depressant medication treatment in continuation phase	4	14
Visits during acute phase treatment of depression	3	15
Racial/ethnic disparities in mental health follow-up rates	3	15

*Source:* Information compiled by the OECD based on feedback from countries as part of the OECD HCQI Sub-group for Mental Health.

### Did you know? Key facts about mental health in OECD countries

- 5% of the working-age population has a severe mental health condition, and a further 15% is affected by a more common one; one in two people will experience mental ill-health at some point in their life.
- There is evidence that mental wellbeing fell during the early years of the economic crisis. Europeans reported feeling “more negative” in 2010 than in 2005-06, according to the Eurobarometer Survey.
- The direct and indirect costs of mental ill health can exceed 4% of GDP.
- Individuals with severe mental illnesses, such as acute depression, bipolar disorder and schizophrenia, die, on average, 20 years earlier than the general population, typically of chronic physical conditions such as cardiovascular disease.
- People with severe mental health conditions are 6-7 times more likely to be unemployed than people with no mental health condition. Those with a mild-to-moderate condition are 2-3 times more likely to be unemployed.
- Since 1990 suicide rates have decreased by more than 20% across OECD countries, with sharp declines in countries like Hungary (fell by 40%) and Estonia (down by 50%). Conversely deaths from suicide have increased by 100% in Korea since 2000.
- OECD countries had, on average, 16 psychiatrists per 100 000 population in 2011. Switzerland had the highest ratio, with 45 psychiatrists per 100 000 population. Turkey and Mexico had fewer than five psychiatrists per 100 000 population.
- There were, on average, 50 mental health nurses per 100 000 population in 2011. The Netherlands, Ireland and Japan had more than 100 mental health nurses per 100 000 population. Mexico had 3 and Turkey had 2 per 100 000 population.

#### Further Reading

[Sick on the Job? Myths and Realities about Mental Health and Work](#)

[Country report series - Mental Health and Work](#)

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