

Assessment and recommendations

Poor mental health costs the Austrian economy dear – 3.6% of GDP through lost labour productivity, increased health care expenditure, and social spending on people temporarily or permanently out of work. While the Austrian labour market is in good shape and was comparatively little affected by the recent economic downturn, at least initially, the mentally unwell underperform in the job market. Their unemployment rate is almost thrice the national average and their employment rates are lower.

Moreover, Austria has seen a steep rise in benefit granted for reasons of mental ill-health: from 10% of all disability benefits in the mid-1990s to over 35% in 2013, with wide differences by gender, occupation and region. In fact, benefit dependency generally in Austria remains high, with 20% of the working-age population receiving an allowance. People with a mental disorder are overrepresented in all benefit schemes, including unemployment. And even when they do have jobs, they often struggle at work – hence sickness absences that are more frequent and longer than among employees with no mental health concerns, and more frequent underperformance in the job. Finally, the average retirement age in Austria continues to be low, partly because of the widespread use of the disability route to early retirement, although the practice has shown signs of easing up in the past two years.

Austria boasts a number of labour and welfare strong points:

- a strong labour market
- a stringently managed, stable benefit system
- a comprehensive, easily accessible health care system
- a broad, and broadening, range of school support services
- a well-developed occupational medicine
- a large number of rehabilitative services
- a well-functioning employment service.

The structural fragmentation of systems and responsibilities, however, restricts the federal government's scope for developing coherent occupational health policies. Factors contributing to such fragmentation are the pronounced regional devolution of health and education policies, the highly autonomous and regionally structured branches of social security, and the important role of the social partners. A lack of data on and research into the links between work and mental ill-health compounds matters.

Rigorous implementation of the disability benefit reform is critical

The 2013 disability benefit reform, currently being implemented, has considerable potential for integrating more fully into the labour market people with chronic health problems who still have the capacity to work. The abolition of ineffective measures – like temporary disability benefit – and the restriction of disability benefits to people permanently unable to work should intensify activation and the provision of return-to-work support for the mentally unwell. The reform has also introduced two new types of benefit: a rehabilitation allowance which is paid by health insurance providers and retraining benefit, administered by the public employment service (PES).

The success of the reform hinges entirely on its rigorous implementation. Even then, however, it could fail unless it also addresses certain structural issues, chief among which is the critical need to improve the interface between the different stakeholder institutions. The Pension Insurance Authority (PIA) and the PES must collaborate and communicate better over assessments and retraining, as will the health insurance bodies and the PIA with regard to medical treatment and rehabilitation. What is required is a case management approach across institutions where a single authority – maybe the PES – is in charge of labour market integration.

As regards the new rehabilitation benefit, it needs to go hand-in-hand with new forms of monitoring, activation and intervention. The health insurance providers, which pay out benefit payments, have no real track record of helping people return to work. Moreover, sickness benefits no longer have a formal time limit, even though eligibility is to be reassessed regularly under the terms of the disability benefit reform. Without strong return-to-work action, open-ended sickness benefits could easily lead to higher numbers of disability benefit claims.

In addition, the important role conferred on the PES by the new retraining benefit requires PES caseworkers to show better understanding of the needs of jobseekers who suffer from chronic health conditions, particularly common mental disorders. Retraining schemes will be open only to jobseekers with good prospects of subsequent labour market

reintegration – something that may be difficult to predict for claimants with mental health problems.

The PES will have to broaden its traditional focus on finding jobs for job-ready jobseekers and design new instruments and processes if it is to be equal to the tasks of early identification, intervention and rehabilitation. Local employment agencies are poorly equipped and resourced for coping with their clients' mental health issues. They will have to strengthen their connections with health insurance providers' rehabilitation centres, the PIA and the health system in general.

Early intervention is critical to preventing unnecessary disability benefit claims, of which long-term sickness absence is a strong predictor. The need for early intervention makes health insurance a more important player than currently acknowledged in Austria's social insurance system. The recently implemented fit2work service for workers who have been on sick leave for upward of 40 days is a step in the right direction. Its ability to assist employers and provide psychological therapy for workers is critical. Support for employers and intervention early in sick leave – or even before a worker takes it – must be further expanded. For that to happen, the Austrian practice of employers and employees not discussing sickness matters will have to be revisited.

Better balanced workplace interventions are necessary

The workplace is the ideal place to tackle the increase in sickness absences and disability benefit claims for reasons of poor mental health. Public awareness of the issue has risen in recent years and the Labour Protection Act has accordingly broadened its scope to strengthen occupational medicine and support the use of occupational psychologists. All this has been achieved within a short period of time and through close collaboration between the social partners, social insurance providers and the authorities.

The shared aim of all involved parties seems to be to improve working conditions and minimise the health damage caused by work. However, general prevention and health promotion activities can be no substitute for action to support employers contending with mentally ill employees. Austria ranks second-highest in Europe, according to the European Working Conditions Survey, when it comes to the share of mentally unwell workers present in the workplace but whose poor health lessens their productivity.

Supporting employers more effectively, especially in underserved small and medium-sized enterprises (SMEs), calls for:

- further intensification of fit2work’s employer focus
- a greater role for occupational doctors and psychologists
- a more extensive knowledge base within the Accident Insurance Authority, which is still oriented towards workplace accidents and is SMEs’ main partner in occupational health and safety.

In Austria, the sickness absence rates of employees with a mental health condition are significantly above the OECD average. In addition, the share of those caused by mental disorders has increased substantially since the mid-1990s. Yet the legislation governing sick leave is restrictive and ineffectual, and the social partners have not yet managed to agree on procedures which would allow effective sickness absence monitoring and back-to-work intervention. Confidentiality is a high priority, ruling out contact between employers and sick-listed employees. Nor is there such a thing in Austria as partial sick leave that incorporates a stepwise back-to-work process. The wait-and-see culture is dominant in enterprises, leaving little or no room for contact between employers or case managers and treating physicians. The principle of “first cure, then work” minimises the success of return-to-work intervention, particularly as employees grow into their role as a sick person and develop avoidant behaviour.

Mental health care is variable and far removed from the workplace

In order to help psychologically unwell employees keep their jobs or re-enter the labour market, the health services must be responsive to the symptoms and consequences specific to mental health disorders – their early onset and enduring course, the frequent co-morbidity and lack of insight, and the stigma which attaches to them in the workplace. Health services should be able to:

- intervene early and sustain support
- offer an integrated provision of varying intensity that brings together inpatient and outpatient care and specialised and generalist treatment
- integrate psychiatric and physical treatment to tackle comorbidity
- intervene actively in difficult situations in the workplace to mediate between patients and employers.

There is some evidence that mental health services in Austria do not score so well on any of the four points for regional and structural reasons.

Around half of all psychiatrists work in the capital, while rural areas are often underserved. Responsibility for inpatient care is scattered across the different regional authorities, while health insurance providers manage private practitioners and outpatient care, and PIA handles medical rehabilitation. There are no systemic links or referral routes between those components of the system, which results in uncoordinated treatment courses. And with general practitioners (GPs) having no gate-keeping function, there is no-one to steer patients towards the right mental health care providers.

Furthermore, resources are poorly distributed. While Austria has the second highest proportion of physical disease specialists in the OECD and boasts many expensive hospital beds, the ratio of psychiatrists to the population is below the OECD average. Outpatient mental health care is dogged by lengthy waiting times and restricted choice of treatment provider. There is limited capacity in child and adolescent mental health care and, unsurprisingly, psychiatric treatment focuses on diagnostics and medication, not therapy.

Psychotherapy is under-subsidised by health insurance – the annual capped quota is too low and used up long before the end of the calendar year. Criteria for determining who is entitled to subsidised psychotherapy vary by region and generally favour patients with severe illness. Most people with work problems related to mild-to-moderate mental disorders can therefore receive psychotherapy only at their own expense. The fit2work service is an attempt to plug some of that gap by providing quick, free access to counselling and therapy.

The potential of trained GPs is not fully exploited. To make up for the lack of psychiatry and psychiatric rehabilitation in general medical training, the Austrian Medical Association has created a system of further education, the so-called “PSY Diploma” that trains GPs to provide psychotherapy. In practice, however, GPs generally intervene only in a brief one-off manner.

Most people with mental health problems are seen by a GP, but those problems often go unaddressed. GPs should also be empowered to discuss work with their patients and to communicate with their patients’ line managers – in other words, support supervisors with the right information about how to behave with sick employees and adapt the workplace accordingly. GPs should be trained, too, to draft sickness absence certificates geared to helping patients back to work. And health insurance should reimburse GPs’ workplace-oriented counselling.

More robust support for vulnerable students and their teachers

The education system has an important role to play in early identifying mentally unwell young people early and bringing support to bear. Little is known in Austria about how young people with mental health problems fare in the education system and the labour market transition, because such problems are not identified in any ordered way. Austria has a range of support in place to help schools and teachers, such as psychopedagogues, school social workers, school psychologists, youth coaches and external school doctors. However, support services taken as a whole are still insufficient and, although they are constantly expanding, Austria ranks poorly in the OECD when it comes to professionals able to dispense pedagogical support. School leaders increasingly call for more such support. There is also a need for better co-ordination and experts permanently on site in schools who can act as case managers. The inadequate interface between schools and the health care system also needs strengthening to make sure that pupils who need mental health treatment get it.

Poor education outcomes lead to poor labour market outcomes. Helping young people to achieve levels of attainment that match their cognitive abilities is critical: those who complete school or an apprenticeship have a much better chance of finding a job. In that respect, a recently implemented national scheme showed good results in its trial phase and has now been expanded nationwide. It is the Youth Coaching scheme, a three-step counselling process to pre-empt early school leaving that kicks in when teachers detect signs early. The recent shift to greater use of case management – a characteristic of the work of youth coaches – should be continued. Social, behavioural and mental health problems are so multifaceted that universal approaches are of little help. It is important to address multidisciplinary problems with equally multidisciplinary solutions.

Young people with mental health conditions are among those who struggle most to find work. Since the beginning of the Great Recession, the situation has deteriorated to the point where youth unemployment is now almost 2.5 times as high as among adults. There has to be a greater effort, especially by the PES, to help young people with poor mental health who do not finish school to improve their skills (by providing non-classroom training) and secure a foothold in the labour market. Apprentice Coaching, a scheme similar to Youth Coaching, should be widened to the whole country, with the PES a driving force.

OECD recommendations for Austrian policy on mental health and work

Key policy challenges	Policy recommendations
<p>1. The disability benefit system has some features that prevent people with mental ill health from being better integrated in the labour market</p>	<ul style="list-style-type: none"> • Address the rise in disability benefit by preventing claims and rejections through early intervention, improved assessments, equality of access, and greater research-based knowledge. • Rigorously implement the 2013 disability benefit reform to ensure flexible support that helps people stay in or return to work and do not just stay on benefit with a different name. • Rapidly expand recent changes to the entire labour force regardless of age and including farmers and civil servants.
<p>2. Health insurance and the public employment service (PES) are not doing enough to improve labour market outcomes for mentally unwell workers</p>	<ul style="list-style-type: none"> • Equip health insurance providers with the tools and competent staff for monitoring risk groups and supporting doctors and patients, so turning sickness benefit into a return-to-work instrument. • Rapidly develop the ability of the PES to attend to clients with health-related work barriers who are likely to grow in number in the wake of recent benefit reforms. • Modify PES procedures to ensure that it serves those clients adequately with more counselling and case-management time.
<p>3. Workplace-related policies fail to address productivity losses and sickness absences caused by mental ill-health</p>	<ul style="list-style-type: none"> • Help employers to retain mentally unwell workers through support that includes fit2work's services and improve the ability of occupational medicine to address mental health issues. • Tackle rising sickness absence through systematic employer monitoring of sick-listed workers, improved health insurance competencies, and the use of partial sick leave or partial return to work. • Strengthen the capacity of fit2work to support job retention and returns to work and strengthen its links with the health system, rehabilitation services and the PES.

OECD recommendations for Austrian policy on mental health and work *(cont.)*

Key policy challenges	Policy recommendations
<p>4. High education spending should achieve better education and labour market outcomes for young people with common mental health problems</p>	<ul style="list-style-type: none"> • Reorient education resources to increase qualified professional support for teachers and students, and ensure that teachers are literate in mental health and well supervised. • Expand the case-management approach of youth coaches and integrate available support effectively, which should include building closer links with the health system. • Secure sustainable transitions into the labour market for low-skilled, disadvantaged young people, who often suffer from mental illness, with a much-strengthened role for the PES.
<p>5. The health system gives too little credence to the importance of good, workplace-oriented mental health care for people who suffer from common mental disorders</p>	<ul style="list-style-type: none"> • Shift resources to improve mental health care, especially outpatient and primary care, child psychiatry, psychotherapy and the care provision in rural areas. • Give general practitioners a greater role and increase their competency in mental health care with a stronger focus on work. • Change the subsidised funding system for psychotherapy to increase ease-of-access for the mentally unwell, and match therapies more closely to needs to avoid driving costs up too much.