Mental Health and Work

SWITZERLAND

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Mental Health and Work: Switzerland

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BETTER POLICIES FOR BETTER LIVES

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Foreword

Tackling mental ill-health of the working-age population is becoming a key issue for labour market and social policies in many OECD countries. It is an issue that has been neglected for too long despite creating very high and increasing costs to people and society at large. OECD governments increasingly recognise that policy has a major role to play in improving the employment opportunities for people with mental ill-health, including very young people especially; in helping those employed but struggling in their jobs; and in avoiding long-term sickness and disability caused by a mental disorder.

A first OECD report on this subject, *"Sick on the Job? Myths and Realities about Mental Health and Work"*, published in January 2012, identified the main underlying policy challenges facing OECD countries by broadening the evidence base and questioning some myths around the links between mental ill-health and work. This report on Switzerland is one in a series of reports looking at how these policy challenges are being tackled in selected OECD countries, covering issues such as the transition from education to employment, the role of the workplace, the institutions providing employment services for jobseekers, the transition into permanent disability and the capacity of the health system. The other reports look at the situation in Australia, Austria, Belgium, Denmark, the Netherlands, Norway, Sweden and the United Kingdom. Together, these nine reports aim to deepen the evidence on good mental health and work policy. Each report also contains a series of detailed country-specific policy recommendations.

Work on this review was a collaborative effort carried out jointly by the Employment Analysis and Policy Division and the Social Policy Division of the OECD Directorate for Employment, Labour and Social Affairs. The report was prepared by Veerle Miranda and Christopher Prinz (project leader) from the OECD and Niklas Baer from the Psychiatric Service of the Canton Basel-Landschaft in Switzerland. Statistical work was provided by Dana Blumin and Maxime Ladaique. Valuable comments were provided by Mark Keese and Stefano Scarpetta. The report also includes comments from a number of Swiss experts, ministries and authorities, including the Federal Social Insurance Office, the State Secretariat of Economic Affairs and the Federal Office of Public Health.

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Acronyms and abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
BSV	Federal Social Insurance Office (*Bundesamt für Sozialversicherungen*)
CHF	Swiss franc
DSM	Diagnostic and Statistical Manual
EDK	Swiss Conference of Cantonal Ministers of Education
ESENER	Enterprise Survey of New and Emerging Risks
FOPH	Federal Office of Public Health
FSIO	Federal Social Insurance Office
FSP	Swiss Federation of Psychologists
GDP	Gross domestic product
GDK	Swiss Conference of Cantonal Health Directors
GP	General practitioner
ICD	International Classification of Diseases
ICF	International Classification of Functioning
IIZ	Inter-Institutional Co-operation
ISCED	International Standard Classification of Education
IV	Disability Insurance (*Invalidenversicherung*)
LAMal	Federal Law on Sickness Insurance
LCA	Federal Law on Insurance Contracts
MAMAC	Medical-vocational Assessment with Case Management
MDD	Major Depressive Disorder
NEET	Not in Employment, Education or Training
PES	Public Employment Service
PPP	Purchasing power parity
SECO	State Secretariat for Economic Affairs
SUVA	Main (semi-) private accident insurer
VAT	Value added tax
VET	Vocational Education and Training
WISA	Integration and Workplace Supports

List of the Swiss cantons

AG	Aargau
AI	Appenzell Innerrhoden
AR	Appenzell Ausserrhoden
BE	Bern
BL	Basel-Landschaft
BS	Basel-Stadt
FR	Fribourg
GE	Geneva
GL	Glarus
GR	Graubünden
JU	Jura
LU	Lucerne
NE	Neuchâtel
NW	Nidwalden
OW	Obwalden
SG	St. Gallen
SH	Schaffhausen
SO	Solothurn
SZ	Schwyz
TG	Thurgau
TI	Ticino
UR	Uri
VD	Vaud
VS	Valais
ZH	Zurich
ZG	Zug

Executive summary

Throughout the OECD, mental ill-health is increasingly recognised as a major issue for social and labour market policy since it creates significant costs for people, employers and the economy at large by harming well-being, lowering employment, raising unemployment and generating substantial productivity losses. The Swiss approach to dealing with this problem presents a mixed picture. Its institutions in the fields of health, education and social insurance are well resourced and therefore provide good opportunities in principle for adequate action. However, policy making in Switzerland is complex due to the involvement of an unusually broad set of stakeholders, including 26 very independent cantons and a large and influential private sector. Policy co-ordination is therefore a difficult task, as reflected in the long and winding process of "inter-institutional co-operation". Despite the pro-active stance of the disability insurance and the significant success of the recent disability benefit reforms, a number of problems remain – as reflected in persistently large and not falling number of disability benefit claims with a mental disorder. Further change is needed in order to improve the situation significantly, and more generally a stronger focus on mental health is required in Switzerland's health, social and labour market policies.

The OECD recommends that Swiss policy makers:

- Strengthen the prevention and management of sickness absences at the workplace in order to foster greater job retention.
- Move the disability benefit system closer to the work sphere with a focus on the role of employers and workplace-oriented early interventions.
- Enhance the capacity of employment services and social welfare offices to deal with the frequent mental health problems of their clients.

- Broaden inter-institutional co-operation by including the health system as an equal partner, building networks with employers and strengthening the financial incentives to co-operate for the main actors.
- Assure that the well-resourced mental health system delivers better employment outcomes also by promoting a better allocation of resources toward adequate doctor training and treatment practice with an employment focus.
- Place a greater emphasis of the education policy on ensuring that students with mental health problems do not leave the education system early as a result of school drop-out or through the take-up of a disability benefit.

Assessment and recommendations

Mental ill-health represents a high cost for the Swiss economy, accounting for roughly 3.2% of GDP through lost productivity of workers and increased health care costs and social spending for those temporarily or permanently out of work. While the Swiss labour market is in good shape, and the impact of the recent economic downturn was comparatively small, people with mental ill-health underperform in the job market: their unemployment rate is almost three times the average level and their employment rates are lower. Moreover, the overall rate of welfare benefit dependence of the working-age population is high in Switzerland at close to 20%, with a gradual shift over the past 15-20 years towards greater reliance on disability and social assistance payments. Importantly, people with mental ill-health are highly overrepresented in all benefit schemes and especially on disability benefit, where they now account for almost 40% of all new benefit claims. In addition, even when employed, people with mental ill-health often struggle in their jobs, as reflected in more frequent and also longer sickness absences than for those without mental health problems.

The Swiss system provides good opportunities to tackle the challenges of mental ill-health and work

Switzerland's institutions in the fields of health, education and social insurance are well resourced and generally producing good outcomes. The country's strengths include: an education system with a range of effective tools at hand; a quite accessible mental health system; a flourishing employment service market; a flexible social protection system that also offers partial benefits; and a flexible labour market that allows a gradual return to work. Related to some of these strengths, employment rates of people with mental ill-health in Switzerland are high compared with other countries.

Even so, Swiss spending on sickness and disability benefits remains high, and is increasingly driven by mental illness. Further improving the labour market inclusion of people with a mental illness and reducing their

welfare benefit dependency will require removing loopholes in the system, reallocating resources, and strengthening the incentives of the stakeholders involved.

The multitude of involved stakeholders slows down structural reform

The large number of stakeholders involved in dealing with both mental health and employment issues adds to the challenge, in at least three ways. First, the 26 highly autonomous cantons have significant responsibilities in policy making and policy implementation. As a result, not the least because of weak national control and supervision, there is significant variation across Switzerland in policy, behaviour and outcomes. In this context, there is considerable room for learning from good practices among the cantons but this is hindered by a lack of rigorous evaluation and stocktaking of activities.

Second, there is a large (non-profit and for-profit) private sector which can be powerful and influential, including private health and sickness benefit insurers and private providers of contracted employment and other services. The result is significant variability in service provision and service quality, multiplied by the fact that these private markets can differ widely across cantons.

Third, there is also significant variability in the behaviour of employers which are key players in terms of prevention of mental ill-health and sickness and return-to-work management. Employers have limited financial incentives to do better, and there is only a slow recognition of their importance as key partners in managing and preventing mental ill-health.

Thus, for any substantial reform to take place, a large number of actors have to be brought to the table, slowing down the reform process. For instance, inter-institutional co-operation took off very slowly in 2001 and yet even twelve years later in 2013 it has delivered only marginal improvements in outcomes despite considerable investment.

Comprehensive reform is also difficult in Switzerland because of the need to seek support by the majority of the population and the cantons. Reforms of the disability insurance system over the past decade are a good example. Support for reform was generated by stressing the financial non-sustainability of the benefit system that was headed towards bankruptcy. This has enabled comprehensive change of regulations and also of the behaviour of most actors. When the immediate pressure for reform was released, however, the last part of a series of disability reforms, though well prepared, was rejected by parliament in June 2013.

Strengthening actions taken at the workplace

Evidence across OECD countries including Switzerland shows a negative relationship between mental health and employment outcomes. The Swiss labour law requires employers to take appropriate measures necessary to protect the health of employees, including their mental health. Yet, available evidence suggests that Swiss employers overall devote less attention to the management of psychosocial risks at work than companies in many other countries and pressure from the labour inspectorate is perceived as less important.

Sickness monitoring and return-to-work management are critical for dealing with mental health issues promptly. Swiss employers, however, have no legal requirements in this regard and their financial responsibility over sick employees depends on the employee's individual contract and, if any, collective agreement and insurance contract. Many insurance providers offer prevention and reintegration services, but the use of such services differs widely across companies. Since insurance coverage – including the benefit payment level and duration – is affected by tenure, workers with mental ill-health face disadvantages as they tend to have more frequent job changes than the average worker.

Moving the disability benefit system closer to the work sphere

Only a few years ago, disability insurance was a passive player getting involved at a very late stage (when all other benefit options were exhausted); taking years for the assessment process; and reimbursing ex-post any costs occurring to other benefit systems because of a disability. Not surprisingly this setup resulted in a sharp increase in the disability benefit caseload until the mid-2000s.

Through a series of reforms in the past decade, the disability benefit system is gradually being transformed from a passive benefit administration into a pro-active rehabilitation agency. The reforms are based on the idea that no other player (i.e. those involved earlier) has any incentive to prevent disability benefit claims and included a focus on early intervention, a strengthening of medical assessments and reassessments, and the introduction of new vocational measures coupled with more obligations for claimants. The reform process has reduced the number of new claims significantly, but has not fully stopped the benefit caseload due to mental disorders from increasing.

Several factors contribute to this situation. First, medical assessments are still predominantly focusing on benefit eligibility instead of the person's work capacity and medical-vocational assessments are rare; this makes

rehabilitation intervention planning difficult especially for mental illness that is often characterised by significant fluctuations in work capacity. Second, the new early intervention measures are not sufficiently geared towards job retention in the regular labour market, and they do not reach claimants with a mental disorder in large enough numbers. Third, the possibility for "early registration" with the disability insurance of people with longer sickness absences is used far too little; the threshold of 30 days of absence for an early registration is too high because many workers with a mental disorder are not even taking absences but would still need counselling (employer and employee counselling was planned to be introduced with the reforms that were rejected in 2013). Fourth, financial disincentives to work remain substantial, especially among the low-income groups of the population with mental illness and even more so for youth. Disincentives arise from high replacement rates further raised by supplementary cantonal benefits and the existing thresholds in the disability benefit scheme making it unattractive to increase work hours for those already on benefit (abolishing these thresholds was also foreseen in the reforms rejected in 2013). Finally, the early identification and intervention measures do not reach young people who never entered the open labour market. For this group, other means and tools will have to be developed – with schools and transition services taking the role of employers and sickness insurers.

Building capacities to deal with mental health problems in employment service and social welfare offices

The strengthened activation stance adopted by the Swiss unemployment insurance in the early 1990s has resulted in a shift in the focus of the Public Employment Service (PES) towards people ready and available for work. This has led to a situation whereby more difficult-to-place jobseekers with more complex labour market problems were not considered as central PES clients any longer. This is reflected in a high share of long-term unemployment in Switzerland despite a low overall unemployment rate.

One consequence of this development was that people not fully ready to work, including many with substantial mental health problems, were increasingly shifted to disability benefits and the social welfare scheme. Only few people experience repeated transitions between different benefit schemes, but many of those exhausting their unemployment benefit entitlement move onto social assistance and many of those on social assistance apply for a disability benefit at some stage.

The lack of awareness by staff in many PES offices of the high share of unemployed with common mental illness among their regular clients is a

major issue that should be addressed in order to stimulate rapid re-activation and avoid potential labour market withdrawal of these jobseekers. While social welfare case workers are more aware of the high prevalence of mental disorders in their clients, both the PES and the social welfare offices lack the capacity to deal with such disorders adequately and quickly.

Redefining inter-institutional co-operation

In response to these shortcomings, inter-institutional co-operation (IIZ) arose as a critical objective, initially to help clients with complex needs who were most at risk of being shifted back and forth between the unemployment, the disability and the social welfare scheme. IIZ efforts were strengthened considerably in the past decade and significant resources were invested – though with huge differences across the country – to develop cantonal and regional co-operation tools and mechanisms. The forms and scope of IIZ have been broadened continually because the first evaluations have shown that only a very small number of people benefitted from these new approaches.

The IIZ process is a step in the right direction but still has a long way to go to overcome – through better co-operation – the often inadequate distinction between able to work, socially needy and disabled. The IIZ process suffers from its institutional focus and the often conflicting incentives among the institutions involved. But getting the incentives right is difficult. Another weakness of the IIZ procedure is the lack of involvement of the health sector – particularly critical for clients with mental health problems – and the absence of contacts with employers. Finally, co-operation cannot easily assure a real integration of for example health and workplace services, which is critical for clients with mental health problems and is often more easily put in practice within institutions themselves.

Delivering better employment outcomes with a well-resourced mental health system

The Swiss mental health care system provides a broad range of accessible and diversified services including considerable inpatient and outpatient treatment facilities, the largest number of psychiatrists per capita among OECD countries (double the rate of the second highest country) and a high number of qualified psychotherapists. Despite these considerable resources, however, the specialised mental health care system treats only around 7% of the population in a given year which seems a low rate compared to a 12-months prevalence of mental disorders of about one-third of the population. This suggests that a relatively small number of people is provided with high-level costly treatment but raises concerns about the effectiveness of this resource allocation in view of considerable

undertreatment. Large cantonal differences in treatment prevalence suggest that treatment use is strongly supply-driven and not based on clear criteria for specialised mental health care. In addition, general practitioners, despite a high prevalence of mental disorders among their clientele, treat only one in ten patients with a mental health problem and rarely make referrals to psychiatrists.

While psychiatric services are accessible and provide effective treatments, there is still a considerable lack of awareness within the mental health care system of employment-related problems of patients. Despite employment having a strong positive impact on treatment duration and effectiveness, and although a lot of inpatients and outpatients are employed albeit struggling at work, psychiatrists usually do not have any contact with employers. This reflects a narrow understanding of treatment and a professional uncertainty about how to intervene in problematic work situations of patients. Another barrier to implement an employment focus within the mental health care system is the lack of an integrated steering or governance system at the national level. Health insurers are also not interested in financing special work-related mental health care measures. Thus, employment-related issues are neither a topic in the doctor training at medical schools nor in their service activities.

Putting a greater focus on the transition from school to work

Switzerland has a wide range of services for children with special needs both in specialised schools and classes and in the mainstream school system, including psychological and psychiatric services, social work services, as well as therapeutic and pedagogical measures. Children with a diagnosed mental illness in need of support are thus likely to have access to specialised services, although with large differences across schools. Swiss youth also experience little difficulties in general in transitioning from school to work, in part thanks to the well-developed vocational education system and the tendency to combine school and work.

However, three aspects of the school-to-work transition have been little addressed so far. First, labour market outcomes are poor and have worsened over the past decade for low-skilled youth, a group with a much higher prevalence of mental disorders. Secondly, new claims into the disability benefit system keep rising among youth in contrast to other age groups; many of these claims are due to a mental illness. Thirdly, services for those who drop out from upper-secondary or vocational school – a group among which youth with common mental illness is overrepresented – are underdeveloped and the few services that are available do not address the problems in an integrated form or with a broader perspective on transition to the labour market. These issues call for more attention to the needs of youths with mental disorders.

Summary of the main OECD recommendations for Switzerland

Key policy challenges	Policy recommendations
1. Employers are not well-equipped to deal with mentally-ill employees and sickness monitoring and management practices are highly variable.	• Give employers adequate tools and supports to address psychosocial risks at work. • Monitor workplace *outputs* (e.g. staff turnover and sickness absence) rather than *inputs* (e.g. working conditions). • Strengthen financial incentives for employers through greater adoption of experience-rated insurance premiums. • Consider recognising mental illness as an occupational disease.
2. The disability system is still giving too little attention to the role of employers and the work incentives of employees.	• Take action to assure that a larger share of employers informs the disability insurance when workers face mental health problems. • Expand early intervention measures that are workplace-oriented and increase the use of early intervention among the mentally-ill. • Give more attention to multidisciplinary medical-vocational assessment and improve the quality of medical assessments as well as reassessments in general. • Make work pay for remaining in work or increasing hours of work, also by making better use of partial benefits and removing thresholds in the benefit payment schedule.
3. Public employment services (PES) and social welfare offices provide limited support to people with mental disorder.	• Seek to improve identification of mental health problems of PES clients and address them promptly, while also developing knowledge of these problems among case managers. • Broaden the PES performance framework to encourage a stronger focus on clients with mental illness, the sick unemployed and benefit exhaustees. • Strengthen the capacity of the social welfare sector to deal with mental health issues, including through new regional or cantonal services for small communities.

Summary of the main OECD recommendations for Switzerland *(cont.)*

Key policy challenges	Policy recommendations
4. Inter-institutional co-operation (IIZ) falls short of the actual problems.	• Strengthen and align financial incentives for greater co-operation among the main IIZ partners (PES, social welfare office, disability insurance office). • Bring the health system in the IIZ partnership to foster across-the-board collaboration and build better networks between IIZ case teams and employers. • Complement service co-operation by service integration *within* the institutions involved.
5. The large resources available in the mental health care system should be allocated so as to deliver better outcomes.	• Strengthen employment-related modules in the initial training of physicians in medical schools. • Introduce work-related guidelines for mental health treatment and strengthen co-operation with employers. • Shift the balance away from inpatient care to more outpatient care and day hospitals, with more focus on work-related problems. • Reduce undertreatment through improved collaboration and defined referral streams between general practice and psychiatry and better reimbursement for psychotherapists.
6. Ineffective use of school resources to address school drop-out and frequent transitions onto disability benefit.	• Provide information to schools about the set of services they should have and how these could best be used to prevent and address mental health problems of students. • Tackle drop-out from upper-secondary and vocational education through systematic follow-up and better co-operation with the PES, the social insurance office and mental health services. • Reduce the flow onto disability benefit with better work incentives for youth at risk.

Chapter 1

Mental health and work challenges in Switzerland

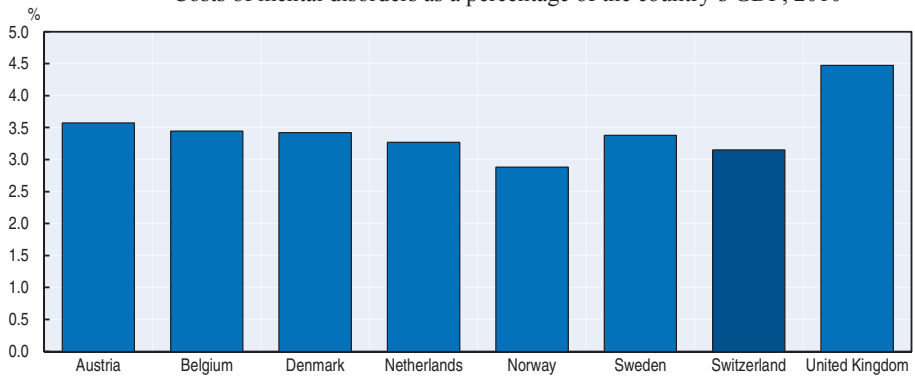
Building on the findings in the recently published OECD report "Sick on the Job?" *this chapter highlights the key challenges facing Switzerland in the area of mental health and work. It provides an overview of the current labour market performance of people with a mental disorder in Switzerland compared 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.

StatLink http://dx.doi.org/10.1787/888932929834

Definitions and objectives

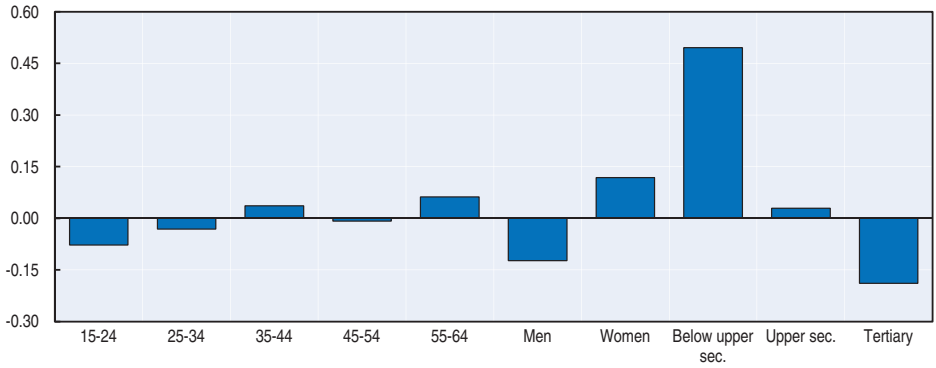
According to the OECD report *Sick on the Job? Myths and Realities about Mental and Work* (OECD, 2012a), the high costs of mental ill-health needs to be tackled by policy that improves the labour market inclusion of people with mental illness. This in turn required that more attention is given to: mild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

StatLink http://dx.doi.org/10.1787/888932929853

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.

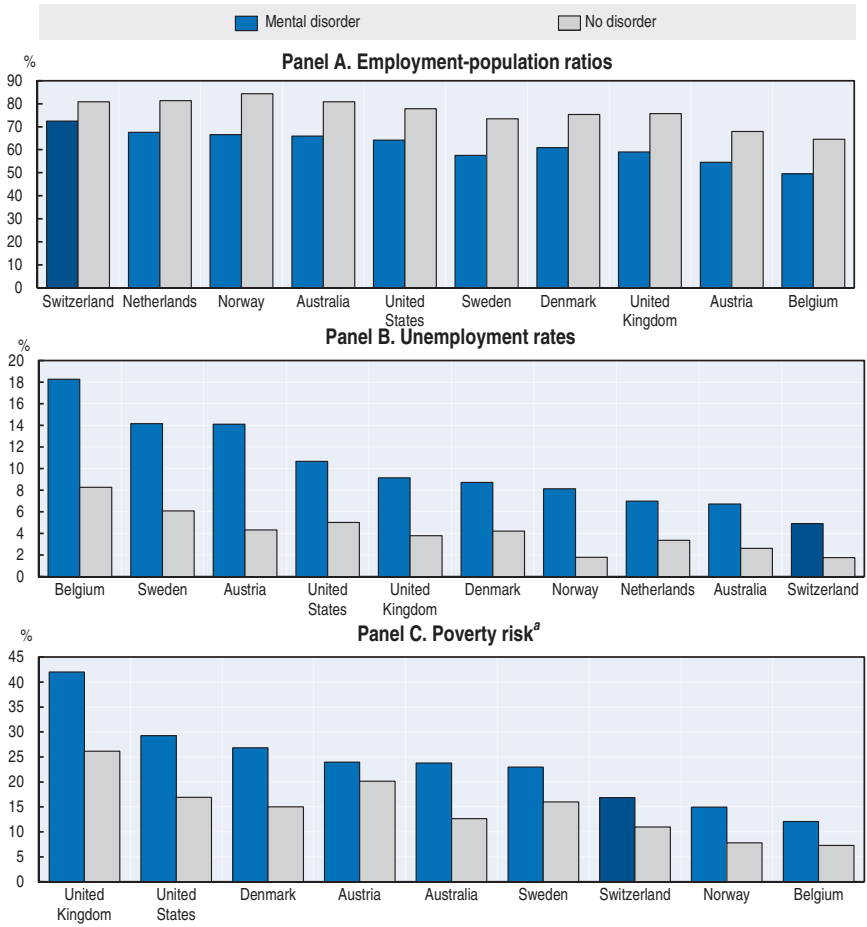
Key trends and outcomes

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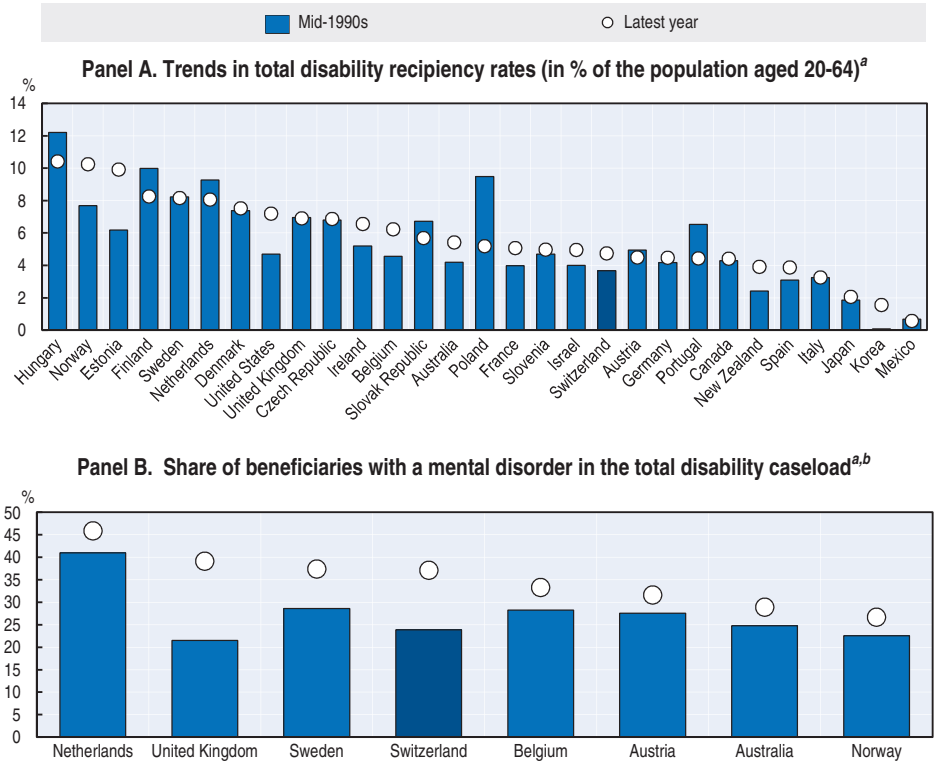
Figure 1.4. **Fast increase in the share of disability benefit recipients with a mental disorder**



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

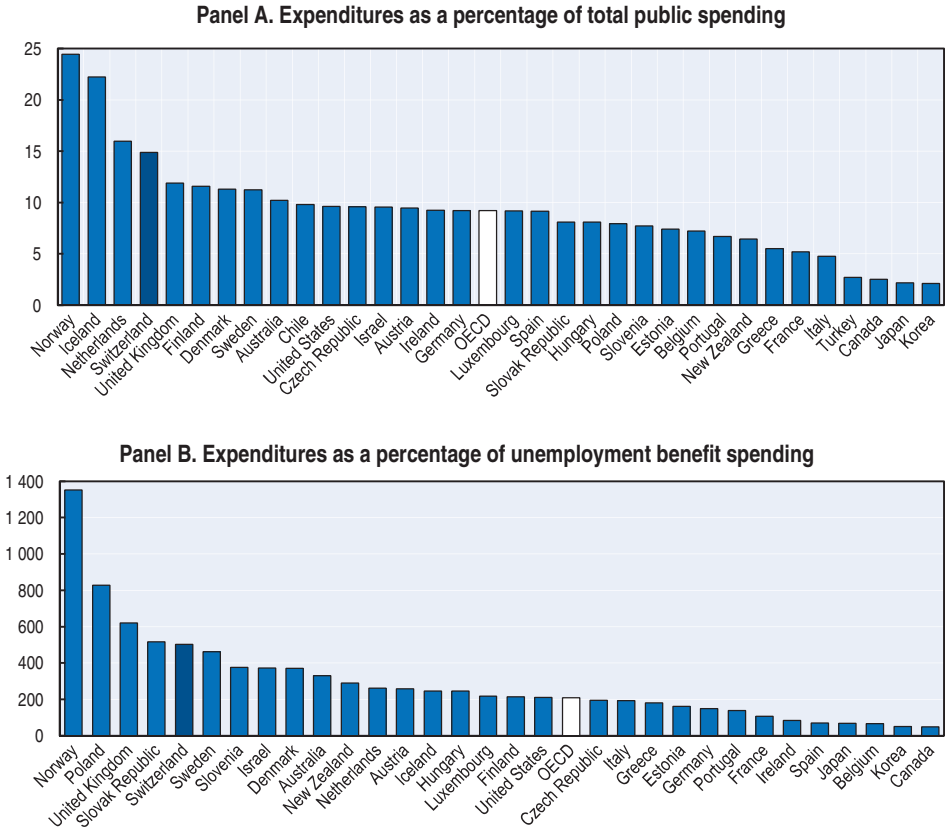
b. Data for Belgium, the Netherlands and Sweden include mental retardation, organic and unspecified disorders (categories which are not otherwise covered in this report).

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

StatLink http://dx.doi.org/10.1787/888932929891

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**

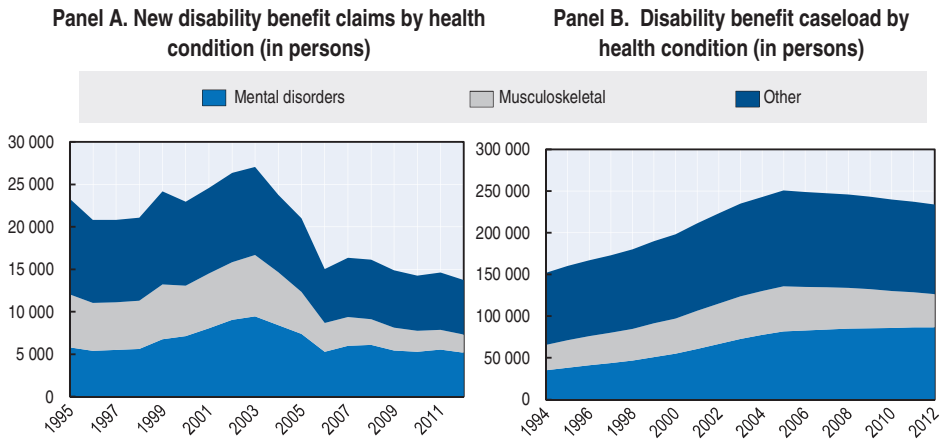


Note: Sickness benefits include all public and mandatory private paid sick-leave programmes (occupational injury and other sickness daily allowances); disability benefits include all public and mandatory private disability benefit programmes, such as in the case of Switzerland public disability insurance 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.

StatLink http://dx.doi.org/10.1787/888932929910

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.

StatLink http://dx.doi.org/10.1787/888932929929

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

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Chapter 2

Working conditions and sickness management in Switzerland

Employers are ideally placed to help people in the workforce to deal with mental health problems and retain their jobs. This chapter first describes the link between mental ill-health and working conditions, reduced productivity and sick leave. It then discusses prevention strategies to address psychosocial risks at work as well as sickness management strategies of Swiss companies. The chapter ends with a review of the financial responsibility of Swiss employers in the case of sickness absence.

There is increasing evidence that employment has positive effects on people's mental health by providing a social status, income security, a time structure and a sense of identity and achievement. Yet, jobs of poor quality or a psychologically unhealthy work climate can erode mental health and, in turn, lead to a more precarious labour market situation. Therefore, the working environment is a key target for improving and sustaining labour market inclusion of those with mental illness, and fast action in case of sickness absence is critical.

Working conditions and mental ill-health

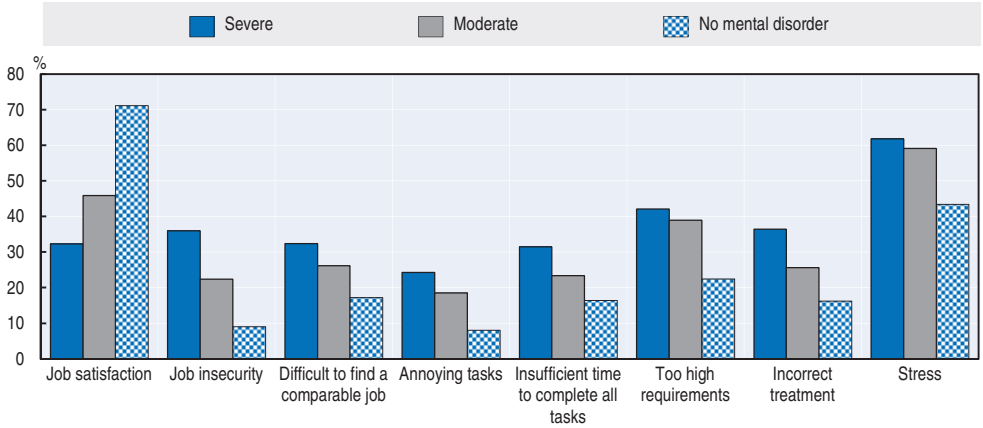
Based on the evidence available for a range of OECD countries, the OECD's report on mental health and work, *Sick on the Job?* (OECD, 2012) concluded that: i) workers with a mental disorder perceive their jobs as qualitatively poor; ii) job strain can have a significant negative impact on the worker's mental health; iii) self-reported job strain has increased in most occupations over time; and iv) good management is one of the key factors in assuring quality employment and mitigating workplace mental health risks.

Data from the Swiss Health Survey of 2007 are in line with these findings. People with a severe or moderate mental disorder are on average much less satisfied with their jobs, they feel higher job insecurity and they seem to experience stress at work more often (Figure 2.1). They are also more likely to report that it would be very difficult to find a comparable job in case they were dismissed. Moreover, workers with a mental disorder more often report doing annoying or repetitive tasks; having insufficient time to complete all tasks; facing job requirements that are too high; and being treated incorrectly.

Simple associations between working conditions and the mental health status, however, do not prove causality. They could instead illustrate that workers with poor mental health are less likely to find high-quality jobs or perceive their working conditions to be of poorer quality. Nevertheless, extensive academic literature on this topic (see for example the meta-analysis by Stansfeld and Candy, 2006) provides consistent evidence for the causal effects of high job-strain and other working characteristics on mental health.

Figure 2.1. **Workplace factors show a systematic link with mental health**

Share of persons who replied positively to various working conditions, by mental health status, 2007



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

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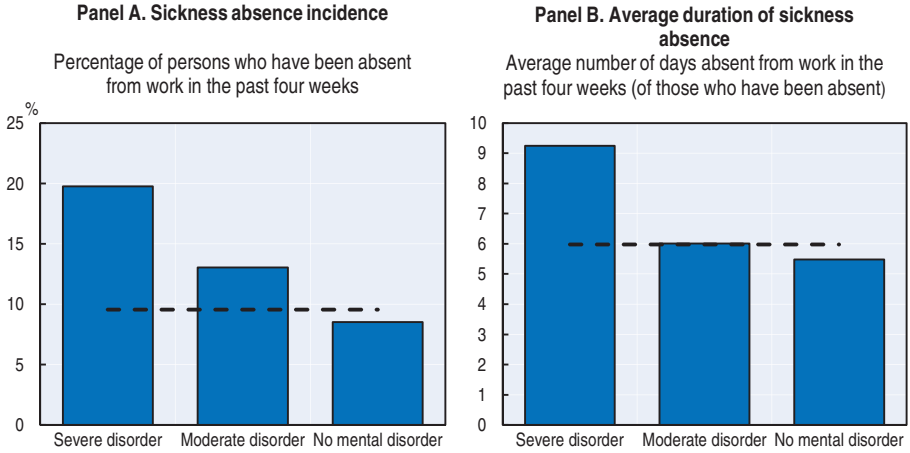
In turn, mental ill-health has a number of repercussions on workers' productivity. Data from the Swiss Health Survey illustrate that workers with a severe mental disorder take more sick leave than people without mental health problems: in a period of four weeks, the incidence of sick leave is higher (20% compared to less than 10% for those without a mental disorder) and its duration longer on average (nine days compared to 5.5 days) (Figure 2.2). However, for employees with moderate mental disorders, the incidence and duration of sick leave is much closer to those of people without mental disorders. Data for other OECD countries further suggest that reduced productivity while at work (i.e. for people not taking sick leave) is much more frequent among people with a severe or moderate mental disorder (OECD, 2012). Moreover, their managers come under greater strain and team cohesion is affected (Baer et al., 2011).

Figure 2.2. **Absence incidence and duration increase with mental ill-health**

Incidence of sickness absence (in percentage) and average absence duration (in days), by mental health status, 2010



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

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As a result of little understanding by management and co-workers (and often also by the individuals concerned themselves) of mental illness and the needs of workers with a mental disorder, their weaker performance is often interpreted as a lack of motivation or competence, thus increasing the risk of dismissal. Yet, good leadership and appropriate management have been recognised as some of the most critical factors in promoting a good working environment (Kelloway and Barling, 2010), a finding which is echoed in a recent newsletter of the Swiss Federal Coordination Commission of Occupational Safety (CFST, 2012). As discussed in *Sick on the Job?* (OECD, 2012), the role of the manager is even more critical for people with mental disorders as they are more likely to feel that they receive little respect and recognition at work. Yet, a survey among managers in the Cantons Basel-Stadt and Basel-Landschaft by Baer et al. (2011) illustrates that managers have great difficulties in dealing with employees with mental issues and too often "solve" the situation by dismissing the worker. Their study also suggests that managers lack support and information on how to retain employees with psychological problems.

Addressing psychosocial risks at work

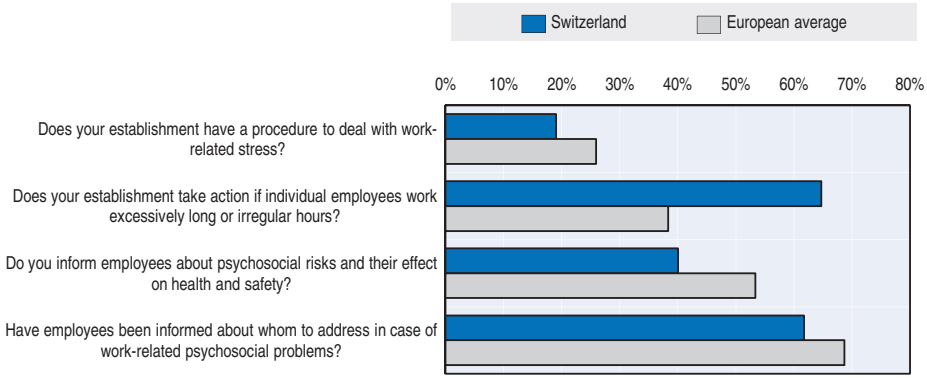
Employers are required by law to take all appropriate measures that are necessary to protect the health of employees (Art. 6 of the Swiss Federal Labour Act). The protection of *mental* health is specifically mentioned and risk factors for psychosocial problems, including job strain, and their potential effect on mental health are discussed in detail in this legislation (Ordinance 3 relative to the Federal Labour Act, Art. 2).[1] Yet, contrary to physical risks, there are no explicit provisions in the labour law on how employers should identify or evaluate mental health risks in the workplace. Practices thus vary greatly across firms.

The control of labour law compliance is largely in the hands of the cantons,[2] but their monitoring of psychosocial aspects in the workplace is very limited. The cantons employ 194 labour inspectors and are co-ordinated by the State Secretariat for Economic Affairs (SECO). Following a number of studies on the negative consequences of a psychologically unhealthy work climate (e.g. Ramaciotti and Perriard, 2000, and Strub and Schär Moser, 2008), SECO developed in 2009 a guide for cantonal labour inspectors to train them in identifying mental health risk factors in a company and dealing with enterprises in breach of the labour legislation (SECO, 2009). When there is evidence that the health of employees is negatively affected by working conditions, the labour inspector can request a consultation with a prevention specialist. However, as psychosocial stress factors are generally not easily identified by inspection methods, it remains very difficult for labour inspectors to detect problems during their control visits and it is rarely possible to prove inappropriate management practices or negligence by the employer. In addition, only about 7% of the firms are visited by labour inspectors each year, mainly in sectors with a high accident risk. Overall, pressure from the labour inspectorate in urging companies to address psychosocial risks at work is perceived much less important than in other EU countries (European Agency for Safety and Health at Work, 2010).

A survey conducted by the European Agency for Safety and Health at Work (2010) explores the extent to which companies in Switzerland and other European countries manage psychosocial risks at work. The results illustrate that less than one in five Swiss companies have a procedure to deal with work-related stress, compared to one in four companies in Europe on average (Figure 2.3). Swiss companies are also less likely than elsewhere to inform their employees about psychosocial risks at work and their effect on health or on whom to contact in case of work-related psychosocial problems. On the other hand, Swiss companies much more often undertake action if employees work excessively long or irregular hours.

Figure 2.3. **Swiss companies devote less attention to the management of psychosocial risks than companies in other countries**

Share of companies which replied positively to the respective questions, 2009



Source: OECD compilation based on the 2009 European Survey of Enterprises on New and Emerging Risks (ESENER) of the European Agency for Safety and Health at Work; https://osha.europa.eu/sub/esener/en.

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The report also mentions that on average only 3% of all companies in the sample (all EU countries taken together) report implementing a full range of psychosocial risk management,[3] while establishments not implementing any aspect account for 12%. For the management of physical risks, the percentages are respectively 13% and 2%. The management of psychosocial risks thus appears to be less well addressed at an organisational level than general risks.

Several country-wide awareness campaigns and initiatives on stress and sexual harassment at work have been organised in Switzerland in the past, but very little is done around mental health and work issues more broadly. In 2008, SECO, SUVA and the Swiss Federation of Psychologists (FSP) created an internet platform dedicated to stress at work with information for employers and employees.[4] In addition, Health Promotion Switzerland – a public semi-autonomous foundation active in health promotion – and the accident insurer SUVA provide management guidelines and courses on dealing with stress at work and on burnout prevention. SUVA also offers a company-specific resource and stress analysis which would form the basis for preventive management actions. Finally, Health Promotion Switzerland introduced a "Friendly Work Space" label for firms that are particularly active and successful on this front,[5] and supports a network where companies can share good practices in the field of health promotion at the workplace (including psychosocial health aspects).[6]

Despite these initiatives, there is still room for improvement. Swiss accident insurers do not in general deem mental disorders as a compensable occupational illness (i.e. eligible for compensation). In fact, a mental illness could only be judged as occupational if it can be proven that work is the dominant cause of the illness – dominant meaning at least 75% of the cause (compared to 50% for recognised occupational diseases). This is virtually impossible to prove for almost any mental illness, including all stress-related illnesses (for the same reason, muscular-skeletal complaints are also seldom recognised in Switzerland as an occupational disease). SUVA refers to these illnesses as "work-associated health complaints", i.e. health problems which are affected and potentially worsened but not caused by work. For all these illnesses, the focus is on prevention whereas they do not generate any work injury payments. This is quite different in some other countries, which have seen a gradual shift in recent years towards mental illnesses becoming the main compensable occupational illnesses. In Australia, for example, one-third of the costs of the workers compensation schemes in 2011 were due to mental illness.

Sickness management at the workplace

Most often, problems only become visible when employees take repeated and/or extended work absences. Yet, frequent and prolonged sick leaves can easily become a main hindrance for beneficiaries to remain in, or return to, the workplace. An in-depth analysis of the disability beneficiary stock with mental disorders by Baer et al. (2009) illustrated that the most common early warning signals for future disability benefit claims were, besides the onset of psychological or somatoform symptoms, absenteeism, interpersonal problems with co-workers and unusually frequent changes of employer. Systematic monitoring of sick-leave behaviour and early intervention are thus needed to prevent labour market detachment and potentially long-term disability benefit dependence of people with mental disorders. The earlier support is given, the more likely it is that higher severity of mental illness and co-morbidity with somatic or other mental illness can be avoided – two factors making labour market reintegration particularly difficult. Acknowledging this, the recent reforms of the disability insurance focused on early identification and early intervention (see Chapter 3).

In Switzerland, there are no legal requirements for employers to actively engage in sickness management or support employees in their return to work after a long period of sickness absence. While sickness and disability management is becoming increasingly widespread in Switzerland, human resource practices vary greatly across companies. A survey among eight companies from different sectors and of varying sizes suggests that, while many companies may start case management after around one month of absence, others may wait two or even three months before taking any action (Geisen et al., 2008). The study also found that it is very important for

companies to systematically register and monitor sickness absences of their employees. Yet, research on sickness management illustrates that multiple short-term absences are often not registered (Kern et al., 2009).

Sickness insurance providers often offer a range of prevention and reintegration services – see Box 2.1 for one good-practice example from Helsana, the largest Swiss health insurer. However, anecdotal evidence suggests that with the recent strong focus on early detection by the public disability insurance (see Chapter 3), private sickness insurers have become less active again.

Box 2.1. **Prevention and reintegration services offered by Helsana**

Helsana, the largest private health insurer in Switzerland, provides prevention and reintegration services to its clients, i.e. enterprises. Companies are offered support to develop a healthy work environment through the assessments of risk factors (including factors that can generate mental health problems) and the development of a prevention plan. Helsana also provides case management for employees who face difficulties in returning to work after an accident or sickness, on demand of either the employer or the employees themselves. After 30 days of sickness absence, a case manager of Helsana would typically contact the employee to support him or her in the return to work. Such support mainly consists of ensuring co-ordination between the different players involved, i.e. the employee, the employer, the doctors and the relevant insurance provider, as well as job coaching (partly in collaboration with the disability insurance offices), adaptation of the job or the work environment, support in career transitions and retraining.

There are no statistics on the number of companies making use of these services offered by Helsana, but anecdotal evidence suggests that mainly companies with high costs due to high absence rates, high staff turnover, high health care costs or recruitment problems are interested in their insurer's prevention and reintegration services.

Companies now have the possibility to inform the disability insurance about potential disabling illnesses. Despite the potential benefits – employers can expect a reduction in absence rates and a faster return of sick employees (Müller, 2007) – this option is rarely used in the case of psychological problems (Baer et al., 2011). A representative survey undertaken by the Swiss Federal Social Insurance Office suggests that the majority of Swiss employers are aware of the reintegration role of the disability insurance, but only few of them have a good knowledge of the incitements to reintegration from which they can benefit (OFAS, 2012). In particular, disability insurance offices can give advice and support, as well as a reimbursement of the increase in premium rates for the daily sickness insurance (see below). Since personal contact with the cantonal disability offices seems to positively affect the reintegration rates, the Federal Social Insurance Office has started an information campaign for employers to

improve their knowledge of the vocational reintegration instruments, their image of the disability insurance and their personal contacts with the offices.[7]

Financial responsibility of the employer

When an employee becomes sick, the employer is obliged to continue paying the employee's wage, with the minimum duration depending on the employee's tenure (Table 2.1). The continued wage payment cannot be cut in case of dismissal, unless the dismissal is the employee's fault. At the same time, the Swiss Civil Code (Art. 336c) does not allow an employer to dismiss an employee – after the probation period – if the employee is fully or partially unable to work due to an illness or an accident during: i) 30 days for employees with a tenure of less than one year; ii) 90 days for employees with a tenure of one to five years; and iii) 180 days for employees with a tenure of six years and more. These periods are as long as, and typically longer than, the continued wage payment period.

Table 2.1. **Continued wage payment in case of sickness varies with tenure**

Duration of continued wage payment in Switzerland by tenure, three different scales

Tenure	Bern scale[a]	Zurich scale[b]	Basel scale[c]
3-12 months	3 weeks	3 weeks	3 weeks
2 years	4 weeks	8 weeks	9 weeks
3 years	9 weeks	9 weeks	9 weeks
4 years	9 weeks	10 weeks	13 weeks
5 years	13 weeks	11 weeks	13 weeks
6 years	13 weeks	12 weeks	13 weeks
7 years	13 weeks	13 weeks	13 weeks
8 years	13 weeks	14 weeks	13 weeks
9 years	13 weeks	15 weeks	13 weeks
10 years	17 weeks	16 weeks	13 weeks
11 years	17 weeks	17 weeks	17 weeks
15 years	22 weeks	21 weeks	17 weeks
20 years	26 weeks	26 weeks	22 weeks
21 years	26 weeks	27 weeks	26 weeks
25 years	30 weeks	31 weeks	26 weeks
30 years3	33 weeks	36 weeks	26 weeks
35 years	39 weeks	41 weeks	26 weeks
40 years	39 weeks	46 weeks	26 weeks

a. The Bern scale is used in the following cantons: Bern, Lucerne, Zug, Fribourg, Solothurn, St. Gallen, Aargau, Vaud, Valais, Geneva, Neuchâtel, Jura, Obwalden, Nidwalden, Schwyz, Glarus, Uri, Ticino, Graubünden.

b. The Zurich scale is used in the following cantons: Appenzell Inner Rhodes, Appenzell Outer Rhodes, Zurich, Schaffhausen, Thurgovia.

c. The Basel scale is used in the following cantons: Basel-Country, Basle-Ville.

Source: Conseil Fédéral (2009), *Évaluation du Système d'Assurance d'Indemnités Journalières en Cas de Maladie et Propositions de Réforme*.

StatLink http://dx.doi.org/10.1787/888932930442

Better conditions than those required by law with respect to both the continued wage payment and protection against dismissal can be fixed in individual employment contracts or collective labour agreements. According to the Federal Statistical Office's 2009 Survey on Collective Labour Agreements in Switzerland, 67% of the collective agreements covering at least 1 500 employees (not necessarily in the same company) offer better conditions in terms of continued wage payment. They apply to 74% of employees covered by such agreements, representing about 25% of all employees in Switzerland. In most cases, the duration of continued wage payment would be independent of tenure and cover either the full wage (in 27% of all collective agreements covered in the survey) or a decreasing part of it (in 28% of all agreements). Additional protection against dismissal in case of sickness is less widespread: only 31% of collective agreements offer better conditions in this regard, applying to barely 7% of all employees in Switzerland (Table 2.2).

As a result of the potentially long financial responsibility for sick employees, the employer is typically insured against the risk of continued wage payment through a collective insurance contract, even though some large firms and government departments opt not to insure themselves as they can manage the risk internally (Conseil Fédéral, 2009). Daily sickness allowance insurance is regulated by two legislations, the Federal Law on Sickness Insurance (LAMal) and the Federal Law on Insurance Contracts (LCA), but there is no "standard" case as the insurance provisions vary substantially across companies and employees, depending on the insurance and employment contract, as well as collective agreements (see Box 2.1 for more details). It is also not possible to estimate a coverage rate of daily sickness allowances among employees, since insurers only receive information on the total wage bill of the company. Nevertheless, from the 2009 Survey on Collective Labour Agreements it is known that 82% of the collective agreements covering at least 1 500 employees oblige companies to take out a collective insurance contract, which applies to about 22% of all employees in Switzerland (see the table in Box 2.2). Another 13% of collective agreements recommend such collective insurance to its member companies.

Individuals may also voluntarily take out an individual insurance for daily sickness allowances – for instance, self-employed people who are not covered by a collective insurance or employees who want additional coverage – but premiums are typically much higher for individual contracts than for collective contracts since the risk can be spread over a large group in the latter case (Conseil Fédéral, 2009). As a result, individual insurance plays only a minor role. In 2010, 18% of all premiums paid for insurance contracts based on LAMal were for individual contracts (OFSP, 2012) and

an *ad hoc* survey among the major sickness insurers undertaken by the Federal Office of Public Health in 2007 suggests that individual insurance plays an even smaller role among LCA contracts (Conseil Fédéral, 2009).

Table 2.2. **The majority of collective agreements offer better conditions in case of sickness than required by law**

Collective labour agreements (private and public sector)[a] covering at least 1 500 employees with better conditions than the legal minimum in terms of continued wage payment and protection against dismissal in case of sickness, 2009

	Collective agreements		Employees covered		
	Number	% of total	Number[b]	% of employees covered by collective agreements	% of total number of employees in Switzerland
Total number of collective agreements[a]	98		1 390 900		
Continued wage payment[c]	66	67%	1 034 000	74%	25%
Depending on tenure	8	8%	338 900	24%	8%
Full wage for a limited time	26	27%	155 800	11%	4%
Partial or degressive wage for a limited time	27	28%	504 000	36%	12%
Other[d]	5	5%	35 300	3%	1%
Protection against dismissal in case of sickness	30	31%	294 000	21%	7%
For a limited time	3	3%	15 400	1%	0%
Depending on tenure	8	8%	83 000	6%	2%
Depending on the right of continued wage payment	4	4%	32 000	2%	1%
Depending on the right of insurance provisions	5	5%	82 400	6%	2%
Other[e]	10	10%	81 200	6%	2%

a. This is a selection of collective labour agreements (private and public) with prescriptive provisions covering at least 1 500 workers (representing 98 collective agreements and 1 390 900 workers). In 2009 there were a total of 602 normative collective agreements in Switzerland covering 1 533 100 employees. Not included in the data: collective agreements without substantive provisions (12 collective agreements and 166 200 workers) and the field of temporary work.

b. The provisions in the collective agreements may apply to all employees subject to the agreement or only to a particular group of employees. The statistics provided by Swiss Statistics do not permit such a distinction to be made.

c. The differences in conditions can either be in combination with a daily sickness allowance (obligatory, possible or recommended) or as an alternative to it for all or a particular group of employees.

d. Continued wage payment in collective labour agreements without provision for daily sickness allowance.

e. The additional protection depends on a combination of factors, such as the age or tenure of the employee and insurance provisions.

Source: OECD Secretariat calculations based on the Survey on Collective Labour Agreements in Switzerland in 2009 (Federal Statistical Office, OFS); number of employees from the Swiss Labour Force Survey.

StatLink http://dx.doi.org/10.1787/888932930461

Box 2.2. **Daily sickness allowance system in Switzerland**

Social sickness insurance includes compulsory health care insurance and optional daily allowance insurance. The latter is regulated by two legislations: the Federal Law on Sickness Insurance (LAMal) and the Federal Law on Insurance Contracts (LCA). Sickness insurance is mostly provided by private health insurers, who can offer either type of insurance.

Legislation

Daily allowance insurance based on LAMal is a social insurance and subject to a number of requirements: i) insurance companies cannot refuse to cover a person between 15 and 65 years interested in concluding a daily allowance insurance contract; ii) everybody should be treated in an equal way with respect to the premium, level and duration of sickness benefits; iii) the minimum duration of sickness benefits should be at least 720 days over a period of 900 days; iv) insurers may exclude pre-existing illnesses from coverage, but these reservations end after five years of coverage at the latest; and v) if a person has to change insurance companies because his or her labour contract ends, the new insurance company cannot impose new reservations. The law does not, however, impose a minimum benefit amount and in many cases the daily allowances are very modest (Conseil Fédéral, 2009).

Daily allowance insurances offered on the basis of LCA are private insurances and much more flexible as the conditions are to be negotiated with the insurance company. Providers have the right to deny applications and exclude certain illnesses without limitation in time, and premiums may vary depending on the age, sex, state of health and other criteria. Insurance companies also have the possibility to adjust their premiums according to the risk evolution. As LCA insurances are much more flexible and better targeted to the needs of employers than LAMal insurances, most daily allowance contracts are based on LCA, accounting for 92% of all sickness benefits in 2010 (OFSP, 2012).

Collective insurance contracts

Although daily allowance insurances are optional, an individual employment contract or a collective labour agreement may make the daily allowance insurance mandatory for employees. If the daily allowance insurance is mandatory for the employee, the Swiss Civil Code (Art. 324b) and jurisdiction impose that the employer pays at least 50% of the insurance premium (the rest is deducted from the employee's salary) and that the daily allowances are equal to at least 80% of the wage – after a maximum of three waiting days – for at least 720 days in a period of 900 days. The daily allowance insurance is then typically taken out as a collective insurance contract by the company with the same conditions for all employees (Conseil Fédéral, 2009).

Daily allowances in case of dismissal

While an individual insurance is independent of the employment status of a person, the coverage of a collective insurance usually ends with the end of the labour contract, although some alternative arrangements are possible. Under LAMal insurance contracts, employees have the option to switch to an individual insurance contract with the same conditions as long as they continue paying the insurance premium. With LCA contracts, this right of free passage does not exist, unless it is specified in the contract. Instead, if the employee is receiving daily sickness allowances at the moment of dismissal, the insurance company is obliged to continue paying benefits for the full period stated in the insurance contract. Nevertheless, the majority of LCA insurance contracts include a clause limiting the payment of daily allowances to 30 days after dismissal (Conseil Fédéral, 2009).

Box 2.2. **Daily sickness allowance system in Switzerland** *(cont.)*

Sickness allowance regulations in collective labour agreements

Collective labour agreements (private and public sector)[a] covering at least 1 500 employees, 2009

	Collective agreements		Employees covered		
	Number	% of total	Number[b]	% of employees covered by collective agreements	% of total number of employees in Switzerland
Total number of collective agreements[a]	98	100%	1 390 900	100%	34%
Collective agreements which oblige or recommend a collective daily allowance insurance	93	95%	1 355 600	97%	33%
Obligatory	80	82%	915 400	66%	22%
Recommended, possible	13	13%	440 200	32%	11%
Amount of daily allowances[c,d]					
Not defined	6	6%	107 400	8%	3%
Decreasing allowances	6	6%	117 500	8%	3%
100% of wage	7	7%	21 400	2%	1%
<100% of wage (fixed amount or minimum)	74	76%	1 109 200	80%	27%
Maximum duration of daily allowances[c,d]					
Not defined	8	8%	110 800	8%	3%
<= 720 days	57	58%	963 100	69%	24%
>720 days	28	29%	281 700	20%	7%
Cost sharing of insurance premium					
Not defined	13	13%	104 600	8%	3%
Not defined but at least 50% for employer	13	13%	345 500	25%	8%
>50% for employer	11	11%	120 700	9%	3%
Equal share for employer and employee	47	48%	620 500	45%	15%
Other[e]	9	9%	164 300	12%	4%

a) This is a selection of collective labour agreements (private and public) with prescriptive provisions covering at least 1 500 workers (representing 98 collective agreements and 1 390 900 workers). In 2009 there were a total of 602 normative collective agreements in Switzerland covering 1 533 100 employees. Not included in the data: collective agreements without substantive provisions (12 collective agreements and 166 200 workers) and the field of temporary work.

b) The provisions in the collective agreements may apply to all employees subject to the agreement or only to a particular group of employees. The statistics provided by the Federal Statistical Office do not permit such a distinction to be made.

c) Provisions (obligatory, possible or recommended) set in the collective agreements generally concerning workers with a contract of indefinite duration or more than three months after the trial period. The table does not include collective agreements fixing specific conditions for certain diseases or illnesses as defined for one or more groups and specific workers (fixed-term contracts or less than three months, auxiliary staff, during the trial period, etc.).

d) Contractual arrangements and the general conditions of insurance (reserves, insurance coverage, waiting periods, bonuses, etc.) are crucial for the establishment of the content of insurance contracts and the full definition of benefits (amount/duration). The table does not take into account such variations related to agreed (salary components) reference wage per diems, the reference periods for benefits (e.g. 900 consecutive days), and specific limits and conditions marking the beginning or the end of the insurance benefits, etc.

e) This category includes cost sharing in the form of a wage percentage or a possibility of reimbursement.

Source: OECD calculations based on the Survey on Collective Labour Agreements in Switzerland in 2009 (Federal Statistical Office, OFS); number of employees from the Swiss Labour Force Survey.

In sum, although the exact coverage of the daily sickness allowances system remains unclear due to a lack of data and the vast differences across companies and insurance contracts, the setup seems to imply that people with mental health problems are likely to be less protected in terms of sickness benefit entitlement and dismissal regulations in case of illness. People with a mental disorder have shorter tenure on average and are more likely to hold jobs with tenure of less than ten years (OECD, 2012), as they tend to have more difficulties in holding on to their job and are more likely to have frequent job changes (the latter especially among those with a moderate mental disorder). As such, both the period during which they are protected against dismissal and the duration of sickness benefit entitlements are shorter. This situation implies reduced responsibility for the employer as well as for the insurance provider, and therefore potentially a lower probability that such people are referred to the disability insurance at an early stage – unless they report their case themselves, which is not likely either, given the lack of self-awareness of mental ill-health.

In principle, large sickness absence costs would translate into higher premiums for the employer, thus in theory encouraging them to prevent long-term absenteeism and disabling health conditions among their employees.[8] Yet, anecdotal evidence suggests that the impact of these experience-rated premiums on prevention and intervention is limited, as companies can apparently easily switch insurance companies and renegotiate their premium rates due to fierce competition in the insurance market.

Conclusion

The Swiss labour law requires employers to take appropriate measures necessary to protect the health of employees, including their mental health. However, available data suggest that Swiss employers overall devote less attention to the management of psychosocial risks at work than on average in EU companies and pressure from the labour inspectorate in urging employers to do so is perceived as less important. In the past couple of years, awareness of mental health issues at the workplace has risen among labour inspectors, but it is rarely possible for them to prove inappropriate management practices or negligence by the employer, rendering inspection a rather powerless prevention tool.

Sickness monitoring and management is a critical phase in dealing with mental health issues promptly and usefully. Yet, the Swiss setup does not guarantee that sickness absences are monitored and well managed. Employers have no legal requirements in this regard and their financial responsibility over sick employees depends on the employee's individual

contract and, if any, collective agreement and insurance contract. Many insurance providers (including the disability insurance offices) offer prevention and reintegration services, but available supports and their take-up differ widely across enterprises. Importantly, since insurance coverage – including the benefit payment level and duration – is affected by tenure, workers with mental health problems face disadvantages as they tend to have more frequent job changes than the average worker.

Better address psychosocial risks at work

- *Raise awareness about mental health and work links.* Organise country-wide campaigns on the causes and consequences of mental ill-health at work and provide information and training for enterprises and managers to deal with mental ill-health among their employees.
- *Develop support tools for employers*. Develop easily accessible tools and guidelines for employers about what and how to assess and how to remove or alleviate identified psychosocial risks. Provide support of external experts if necessary, especially for small and medium-sized enterprises.
- *Monitor compliance with labour law*. Rather than monitoring inputs such as working conditions and resources to tackle psychosocial risk factors at work, the Swiss authorities could monitor outputs such as staff turnover and sickness absence rates. Making this information widely available to the public would create incentives for the firms to properly address problems in this field.
- *Consider changing the accident insurance law*. Currently mental illness is not recognised as an occupational disease. A discussion should be started about the partial recognition of work-associated mental health complaints that are worsened by work, as is, for example, already the case in Australia. A stronger responsibility of the accident insurers – who have valuable experience and strong tools (including, for example, case management) in helping people stay in their job or return very quickly – would be desirable.

Reinforce sickness absence management and monitoring

- *Encourage sickness monitoring.* Introduce regular controls of sickness absence certificates as well as mandatory notification for employers to the disability insurance of workers with long (of 30 days in a row) or regular absences. Failure to do so should

automatically translate into a sanction paid directly to the disability insurance.

- *Strengthen financial incentives.* Encourage greater adoption of experience-related premiums for daily sickness benefit insurance to strengthen the incentives for employers to actively engage in sickness management. Give insurers the right to make premiums conditional on compliance with monitoring and following the advice of the insurer with respect to sickness and return-to-work management.
- *Improve access for employers to professional help*. Employers should have access to professional advice to help employees with mental health issues to stay in work or return to work quickly if off work sick. Occupational health services should be expanded in general and especially within private sickness insurance schemes as well as the public disability insurance system.

Notes

1. See SECO (2011) for a detailed discussion of the legislation.
2. SUVA, the main (semi-)private accident insurer in Switzerland, also employs around 150 inspectors to control labour law infringements in enterprises with a high safety risk (accounting for about 6% of all firms in Switzerland), but they are typically not trained in psychosocial risks and their role in this area is marginal.
3. The six aspects of psychosocial risk management that were included are: 1) changes to the way work is organized; 2) confidential counselling for employees; 3) setup of a conflict resolution procedure; 4) changes to working-time arrangements; 5) a redesign of the work area; and 6) provision of training.
4. www.stressnostress.ch. (accessed 16 April 2013).
5. www.gesundheitsfoerderung.ch/pages/Betriebliche_Gesundheitsfoerderung/Tipps_Tools/label/unser_anliegen.php?lang=e (accessed 16 April 2013).
6. www.quint-essenz.ch/en (accessed 16 April 2013).
7. www.bsv.admin.ch/themen/iv/00023/03200/index.html?lang=fr (accessed 17 September 2013).

8. The variability of insurance premiums with a falling or declining number of sickness cases in a particular company – also referred to as experience-rating of premiums – is discussed in OECD (2006).

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Chapter 3

From payments to interventions: A decade of Swiss disability reforms

In the past decade, the Swiss disability benefit system has undergone a series of far-reaching reforms with a strong focus on mental health in order to tackle a steep and steady rise of beneficiaries with mental disorders. This chapter gives an overview of the nature of these reforms, such as the introduction of medical services within the disability insurance which can overrule the assessments of treating physicians and the new focus on early intervention and vocational reintegration of disability beneficiaries, and a preliminary assessment of their impact to date. Beyond the reforms, changes in the legislation and an intense public debate seem to have supported the awareness of all actors leading to a significant decline in new claimants into disability benefits. However, important challenges remain.

Until the 1990s, Switzerland had a relatively low rate of people receiving a disability benefit with few beneficiaries for mental health reasons. After 1990, the caseload of disability recipients steadily increased. In the past few years, the number of recipients has been falling again, but the number of recipients with a mental disorder continued to increase. The rise in disability benefits has led to a worrying deficit in the disability insurance fund. Since this fund was shared with the old-age pension fund, it threatened its future liquidity – especially against the demographical background of an aging population.

This has led to a number of political initiatives and several reforms of the Disability Insurance (IV) over the past decade, including a shift from an administration-based to an intervention-based philosophy. A set of financial and legal measures have been implemented, aiming at stabilising and reducing the financial deficits caused by the growth in disability beneficiaries. It remains an open question as to which measures were responsible, and to what extent, for the recent decrease in disability beneficiaries. There are some lessons other countries could learn from the Swiss reforms, such as the potential of insurance-based medical services or early intervention. However, mental health-related exclusion from the labour market has not been brought under control so far.

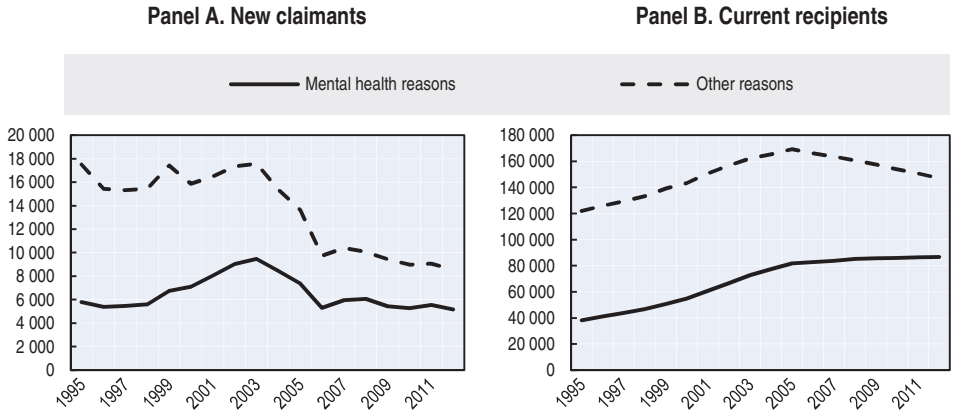
Mental disorders have been a key factor driving the rise in disability benefit claims

Switzerland has seen a steady increase in disability beneficiaries over the past two decades with a peak in 2005, primarily due to mental disorders. While the increase took place everywhere, it was especially high in some urban cantons as, e.g., Basel-City and Geneva. Since 2003, new claims with a mental disorder have decreased and subsequently stabilised at close to their level in 1995, whereas claims for other reasons have fallen well below that level (Figure 3.1). As a result, today around 40% of all disability beneficiaries receive a disability benefit for a mental disorder.[1]

Due to the steady increase in the beneficiary caseload, the financial situation of the disability insurance has deteriorated since the mid-1990s resulting in a cumulated deficit of CHF 15 billion within the old age pension fund in 2010. Several short and long-term measures have been implemented in the past ten years to balance the budget of the disability insurance and liberate the old age pension fund: i) the creation of a separate disability insurance fund, with a starting capital of CHF 5 billion from the old age pension fund ; ii) a temporary increase from 2011 to 2017 in the value added tax (VAT) from 7.6% to 8% to co-finance the new fund and to balance the yearly IV-deficit of around one billion Swiss Francs, and; iii) the implementation of three revisions of the disability insurance act.

Figure 3.1. **Disability benefit rolls are increasingly dominated by claimants with a mental disorder**

Number of new claimants and current recipients of disability benefits, mental health reasons versus other reasons, 1995-2012



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

StatLink http://dx.doi.org/10.1787/888932930005

Along with the discussions around these reforms and a referendum on the increase of the VAT, there has been an intense public debate about the disability benefit system in general and the increasing rates of mental disorder cases in particular. This seems to have affected all stakeholders and improved the awareness that the increasing exclusion of people with health problems from the labour market not only exacerbates their quality of life but also leads to tremendous costs in the long run (Modetta, 2006).

A shift from musculoskeletal to mental health problems

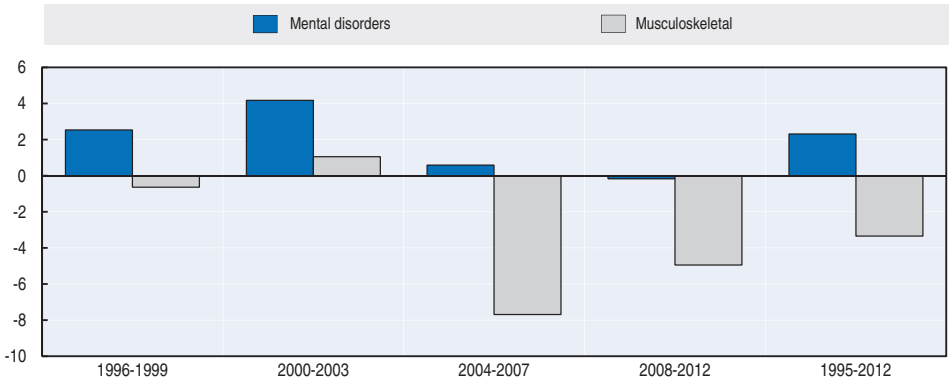
While new disability benefit claims caused by musculoskeletal disorders decreased strongly after 2003, new claims due to mental disorders increased until very recently. Over the whole period 1995-2012, musculoskeletal disorders decreased by 3.3%per year while mental disorders increased by 2.3% annually (Figure 3.2).

There are a range of possible explanations for these diverging trends. First, recent reforms of the disability benefit system may have had a strong effect on claimants with musculoskeletal disorders, but not yet an equally strong effect on those with mental disorders. Secondly, changes in the nature of work with a decline in manual and an increase in cognitively demanding work tasks may have let to changes in the frequency of different health

conditions. Thirdly, there may have been a shift from somatic (musculoskeletal) to psychiatric diagnoses related to the high co-morbidity of mental and physical ill health in the population; together with the increasing awareness of mental illnesses, this might have supported a new – and possibly more accurate – labelling of health problems by both claimants and their physicians.

Figure 3.2. **Disability benefit claims are confronted with a shift from musculoskeletal to mental health problems**

Average annual percentage change in new claims, mental health problems versus musculoskeletal health problems, 1995-2012



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

StatLink http://dx.doi.org/10.1787/888932930024

Not all mental disorders are equally involved in the escalation of disability benefits.[2] The increase has been mainly caused by the so-called "psychogenic and reactive" disorders, i.e. disorders which are supposedly caused by psychological mechanisms (i.e. not biologically caused reasons).[3] The number of disability beneficiaries due to a reactive mental disorder tripled between 1995 and 2012, and looking back to the mid-1980s, the number has multiplied tenfold from around 5 000 to 50 000. Since 1995, the large majority of all new claims for mental health reasons fall under this category.

Who are the "new" claimants?

Diagnostic characteristics

An in-depth analysis of the mixed category of beneficiaries with reactive disorders between 1993 and 2006 has shown that the predominant diagnostic reasons for the receipt of a disability pension are personality disorders,

recurrent depressive disorders and somatisation disorders (Baer et al., 2009). The latter two have risen disproportionally. Somatisation disorders are often combined with social problems, a heavy use of general medical services and a low use of psychological treatment – a big challenge for the disability benefit system. Due to their low average educational level and their focus on pain and recovery, these claimants have barely received any vocational rehabilitation measures, but were instead given an especially poor work-prognosis (much worse than with e.g. schizophrenic conditions) – in turn often resulting in a disability benefit award. The principle of the disability insurance that claimants without a vocational education do not qualify for re-education measures is counterproductive in this regard.

With respect to somatisation disorders, in 2004 the Federal Law Court ruled that pain disorders without a physical cause do not necessarily lead to work incapacity and, therefore, do not qualify a person for eligibility for a disability benefit. In 2011, the court expanded this decision to all medical conditions without a clear organic base, such as for example whiplash, chronic fatigue syndrome or fibromyalgia. This is in line with earlier exclusions of specific health conditions for qualifying for a disability benefit as was done with substance use disorders. The main idea behind these legal decisions lies in the concept that it is reasonable to expect that these specific health conditions can be overcome.

Personality disorders account for the single most important reason for the award of a disability benefit. Nevertheless, depressive disorders are the most common diagnosis among disability beneficiaries. This slightly confusing finding can be explained by the nature of the medical assessment process which is very intense, usually involving several physicians and resulting in several, and sometimes different, diagnoses (on average, five diagnoses per beneficiary). For instance, many claimants diagnosed with a physical disorder at the beginning of the process, were later given a psychiatric diagnosis. Therefore, the most prevalent diagnosis does not necessarily correspond to the diagnosis which determines the disability benefit award. Personality disorders account for about one-third of all current benefits (Baer et al., 2009). This matters because the traditional vocational rehabilitation measures of the disability insurance (education, re-education, vocational counselling) and rehabilitative services in general were designed for people who could no longer work in their job due to a physical health problem. These measures are often not effective for enduring personality disorders usually involving good work skills but poor social skills. In 2008, some specific measures for claimants with a mental disorder have been introduced (see below).

Poor work histories

Around 85% of current disability beneficiaries with a reactive mental disorder had worked over years or decades before applying for a disability benefit (on average at the age of 40). However, their annual income amounted to only around one-third of the average income of the working population (Baer et al., 2009). Usually claimants not only had low wages indicating their predominantly low education, but had also received social assistance and unemployment insurance benefits several times; hence, the typical disability benefit recipient with a mental disorder has never been fully integrated into the labour market.

Vulnerable social groups

There has been a strong increase between 1993 and 2006 of specific populations receiving a disability benefit out of reactive mental health reasons – low-educated immigrants, older workers and single mothers (Baer et al., 2009). None of these socio-demographic characteristics should be relevant for the decision whether to award a disability benefit, but in practice they obviously played an important role in the assessment process. It is well accepted that all stakeholders – employers, doctors, municipal social assistance services, law courts, etc. – considered it to be a good solution to refer people with significant health-related work problems or with negative employment perspectives to disability benefits – at least until around 2005. Accordingly, the rate of claimants having received a vocational rehabilitation measure before the award of a disability benefit was only about 13%, and in immigrant claimants the rate was even lower at 4%. This had effectively eroded the traditional "rehabilitation before disability benefit" – philosophy of the disability insurance, in force since 1960.

The share of immigrants in the disability beneficiary population due to reactive mental disorders increased from 28% in 1993 to 40% in 2006 while the share of people with foreign nationalities in the population has remained quite stable at around 20%. In 2008, the rate of new claimants from the former Yugoslavia (with a disability incidence rate of 0.7%) and Turkey (0.8%) was more than twice the rate of claimants with a Swiss nationality (0.3%) (Bolliger et al., 2010). Immigrants from high-income countries (e.g. Germany or Scandinavian countries) have significantly lower rates of new claimants.

Hence, the main factor is probably not the immigration status *per se* but the lack of education in a part of the immigrant population, and its consequences, e.g. low language skills, more physically-demanding manual work, poor labour market perspectives and lower wages – all this making the high benefit payment rates an attractive perspective (Bütler, 2009).

Moreover, contrary to social assistance benefits, disability benefits are usually independent of one's place of residence, i.e. payment does not stop when returning to the country of origin (with the exception of the Kosovo, as the Federal Court recently ruled) (Bolliger et al., 2010).

Two recent Swiss studies about immigrants in the disability benefit system (Bolliger et al., 2010; Guggisberg et al., 2010) conclude that self-reported health status – which is worse in the immigrant population – explains much of the higher risk for disability benefit recipiency. Whether the poorer self-reported health status corresponds to a higher "true" prevalence of objective health conditions remains open. Immigration from socially disadvantaged or poorer regions may be related to mental health vulnerabilities, but immigration requires a considerable effort and determination and therefore may be a sign of hardiness. Finally, there is evidence that the higher rate of disability benefit award is the consequence of a higher rate of applications, and not the result of a discriminating procedure of the disability benefit system (Bolliger et al., 2010).

In a nutshell, several factors contributed to the fast increase of "new" beneficiaries between the mid-1990s and 2006: i) a general acceptance to refer people with poor employment perspectives to the disability benefit system, however with huge differences between the cantonal disability insurance offices; ii) a passive attitude regarding the work abilities of people with common mental health problems; iii) an incomplete and unspecified vocational rehabilitation system offering no targeted measures for the majority of claimants with mental health problems, or offering no measures at all; iv) a lack of relevant financial incentives for low-income claimants to get on the disability benefit rolls; v) no financial incentives, insufficient support and financial security for current beneficiaries to seek employment; vi) inadequate reassessments of beneficiaries' remaining work capacities; vii) a focus on administrative, medical and legal requirements instead of rehabilitative issues, and; viii) a severe lack of early intervention measures in favour of reintegration measures.

Addressing the high number of new benefit claims

There are two principle possibilities for reducing the large number of disability beneficiaries: restricting the number of new benefit claims, including reducing the grade of the disability benefit of the new claimants; and increasing outflows from the system into employment or other systems.

The increase in disability claimants since the 1990s led to three revisions of the Disability Insurance Act (Boxes 3.1-3.4), with the 4th and 5th revisions targeted on new claims, and the 6th revision focusing

on the benefit caseload. All of these reforms have had a special focus on mental health problems.

The 4th revision of the Disability Insurance Act (which came into force in 2004) tackled the differing and rather permissive medical assessment of claimants, and was the first reform which tried explicitly to reduce the financial deficit by limiting new benefit claims. Moreover, it sought to standardise the huge differences between the cantonal disability benefit offices with respect to new claimants and caseloads of disability beneficiaries and strengthen rehabilitation. Finally, a new service of active job-search assistance was introduced for claimants with still existing work capacities which had formerly been the sole responsibility of the public employment system (Box 3.1).

Box 3.1. **The 4th revision of the Disability Insurance Act: Strengthening medical assessment and active job placement to reduce new claims**

As part of the 4th revision, ten regional medical services were introduced within the cantonal disability insurance offices in order to provide an adequate and comparable assessment of the functional capacities of claimants. If needed, the regional medical services can undertake their own examinations; this was previously not possible for the disability insurance.

Other important measures in the 4th reform include the introduction of job-placement services and of a three-quarter disability benefit for claimants with a 60-69% reduced earning capacity, resulting in four grades (one-quarter, half, three-quarter, and full disability benefit). Formerly, a reduced earning capacity of two-thirds qualified for a full benefit.

The supervision of the cantonal offices by the Federal Social Insurance Office was reinforced through the introduction of regular and more frequent audits and a new monitoring system. Finally, supplemental disability benefits for spouses of new disability claimants were abolished.

The 5th revision, in 2008, changed the strong disability benefit focus into a rehabilitative, work-ability focus – a process that had already started with the 4th revision. This reform focused on the insufficient vocational rehabilitation system and introduced a number of new early intervention measures. The implementation of new measures of early identification and early intervention for people at risk of claiming a disability benefit has led to a significant change in how the disability benefit system is being accessed (Box 3.2).

Box 3.2. **The 5th revision of the Disability Insurance Act: Generous rehabilitation measures and strict obligations to reduce new claims**

The 5th revision reinforced the emphasis on vocational rehabilitation, added a new focus on job retention, and generally implemented a paradigm shift in the disability insurance. It was the first reform to introduce a new vocational rehabilitation measure which was almost exclusively designed for claimants with mental health problems (the so-called "integration measures"). The reform also introduced a stricter regime with respect to disability benefit eligibility with an obligation for the claimants to co-operate. The main rehabilitation measures introduced in the reform were:

- Early identification of people at risk of becoming disabled, including a new form of low-threshold application to the disability insurance which – after 30 days of sickness absence or after several short-term absences – can be used by a variety of actors (claimants, employers, other social and private insurers, doctors, relatives or social welfare officers).
- A set of early intervention measures to secure job retention or to help in finding a new job, including: i) workplace adaptations; ii) educational courses; iii) active job placement; iv) vocational counseling; v) social-vocational rehabilitation; and vi) activation. These measures require an assessment and a binding rehabilitation plan. They are under the control of the cantonal offices, time-limited and cost-limited (with a maximum of CHF 20 000 and an expected average of CHF 5 000 per person). During the early intervention period, an assessment ("Triage") about the principal direction of further measures is executed within 180 days. When this basic decision has been taken (this can be further rehabilitative measures, assessment of the eligibility for a disability benefit, or no eligibility at all), the early intervention period ends. This rather quick basic decision, compared to the situation before the reform, should enable both the insurance and the claimant to focus on a return-to-work instead of strengthening their disability benefit perspective and paralysing the rehabilitation process. Related to this, the claimant should be supported by an employment-focused case manager, who has some freedom in offering rehabilitative measures to the claimant (instead of the former administrative process which primarily assessed the eligibility of the claimant).
- Substantial wage subsidies for employers hiring a claimant: Subsidies can be paid for half a year and can amount to 100% of the salary in case the claimant has not regained full work-capacity. Moreover, for new sickness absences of a hired claimant, the potential increase in the employer premium to the daily allowance insurance is reimbursed. Finally, if integration measures take place in an enterprise (instead of a sheltered workshop), the employer receives a (maximum) subsidy of CHF 100 per working day during a year.

Additional measures were taken to reduce the negative work incentives for claimants and more generally to reduce the deficit of the disability insurance. Financial measures include: i) abolition of supplemental disability benefits for spouses of all current recipients; ii) abolition of medical rehabilitation of adult claimants (this is not financed by the disability insurance anymore but by the health and accident insurance); iii) abolition of the (fictitious) career supplement for claimants under age 45 (beneficiaries, who have become disabled before the age of 20, still receive an extraordinary pension which amounts to 133% of the minimum pension); iv) abolition of daily allowances for claimants not working before applying to the disability insurance; v) increasing the minimum contribution period to the disability insurance in order to become eligible for a disability benefit from one to three years, and; vi) financial sanctions in the case a person has not applied to the disability insurance after early identification although requested to do so.

The shift in paradigm has implied that interventions: i) occur more quickly instead of waiting first for medical documents, administrative calculations or eligibility decisions which took months or years before; ii) are more personal, i.e. meetings are held with claimants instead of exclusively working with the case files; and iii) are more work-oriented instead of benefit-oriented.

Early identification is a powerful tool and should be enhanced

Between 2008 and 2010, one in four first contacts with the disability insurance were through less formal "early registration" instead of the traditional formal registration which obliges the insurance to start the full assessment procedure (Bolliger et al., 2012). The number of early registrations has remained very stable since their introduction, with 11 300 registrations in 2009 and 11 200 in 2012. The composition of the registering authorities has not changed either: 25% of the early registrations have been made by the insured person or relatives, 30% by the employer, 10% by a physician, 25% by private insurances (e.g. daily allowances insurances) and 5% each by the accident insurance and social welfare offices. Altogether, the share still employed is higher among people accessing the benefit system by an early registration (77%) than by a formal registration (65%) (Bolliger et al., 2012).

The high employment rate at registration is encouraging and suggests that acting quickly has enormous potential. There is usually a substantial time lag in contacts with the disability insurance authorities by the social welfare or the unemployment insurance office. Especially employers, but also daily allowance insurers, however, might get in contact with the disability insurance at a very early stage. Initial contacts made by employers normally mean that potential claimants still have a job (Table 3.1). It is a success that employers report in almost 30% of all cases but this number should be increased further. Explanations for the still too low number of early registrations by employers include that this measure is not known well enough (Bolliger et al., 2012) and that many employers do not have enough confidence in the effectiveness of supports by the disability insurance (Baer et al., 2011).

Table 3.1. **Most people registered early to the disability insurance are still employed, especially if registered by the employer**

Employment situation of claimants in early registration, by informing authority

Informing authority	% of all early registrations (2009)	% employed claimants (2008-10)
Employer	27%	89%
Daily allowances insurance	13%	80%
Private insurance	13%	79%
Accident insurance	6%	74%
Claimant, relative	25%	73%
Physician	9%	69%
Unemployment insurance, etc.	4%	39%
Social assistance	4%	28%
Total	100%	77%

Source: Bolliger, C. et al. (2012), "Eingliederung vor Rente", BSV; Invalidity Statistics 2009, Federal Social Insurance Office.

StatLink http://dx.doi.org/10.1787/888932930480

Early intervention should be expanded for reactive mental disorders

Parallel to the implementation of early reporting procedures, a set of intervention measures have been installed to offer quick support. The main aim of these measures is to ensure job retention. Employees with a mental health problem have been identified as a main target group for these types of interventions. Accordingly, the share of claimants with mental disorders in vocational rehabilitation participating in early intervention measures has increased from around 5% in 2008 to around 25% in 2012 (Figure 3.3, Panel A). However, in claimants with reactive mental disorders who are more likely to be in employment than claimants with a psychotic disorder, the share was not as high. Moreover, although these measures were especially designed for people with a mental disorder, claimants with musculoskeletal disorders have profited most (Bolliger et al., 2012). Around 70% of all early intervention measures were accounted for by claimants with a physical disorder and only 30% for the mentally-ill who account for 40% of all new disability benefit claims and probably an even higher share of early registrations.

Nevertheless, the number of early intervention measures in people with mental disorders has strongly increased since their implementation

(Figure 3.3, Panel B). Social-vocational rehabilitation is the most frequent measure used by claimants with mental health conditions (Figure 3.3, Panel C: Rehabilitation). This measure was developed specifically for people with mental disorders reflecting their frequent need for combined psychological and vocational measures, and aim at re-establishing a basic working ability in people who are not yet stable enough to function in a normal working environment.[4]

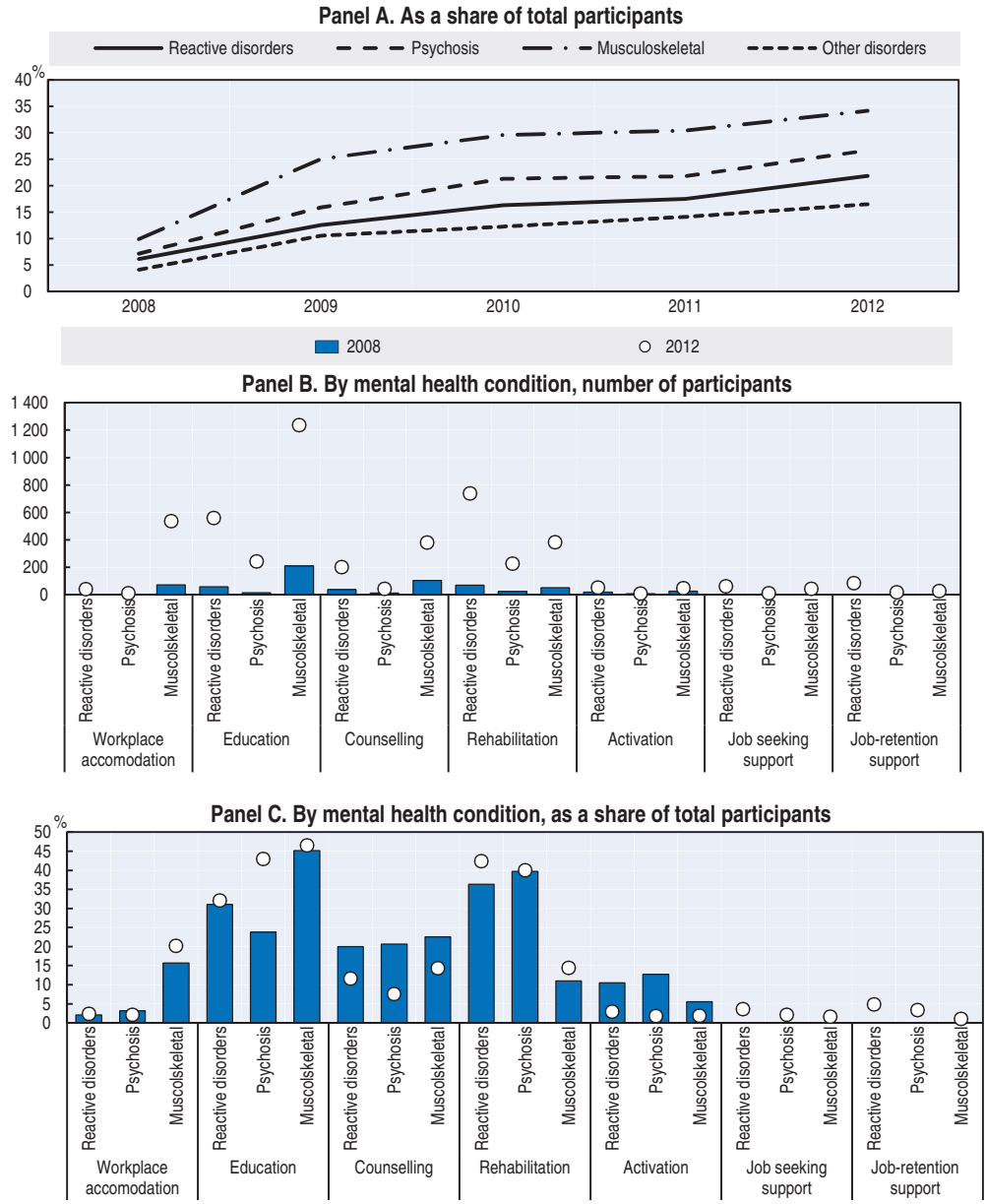
In terms of the type of early intervention measures, educational courses, social-vocational rehabilitation and, less so, counselling are the most used measures. Workplace adaptation, as well as job-seeking and job-retention support (i.e. counselling of both the employee and the employer etc.), are rarely used in the framework of early intervention (Figure 3.3, Panels B and C). Workplace adaptation has traditionally been and apparently still is a support for workers with physical health problems. Job-seeking and job-retention supports have hardly been used by anyone – partly reflecting their rather recent introduction. Finally, it is unclear why the use of counselling measures has declined.

The integration-oriented 5th revision of the disability benefit system has generally led to an increase in the use of vocational measures, including education, re-education, vocational counselling and job-seeking supports (Figure 3.4). In 2008, there were still more new benefit claims than users of vocational measures, except for musculoskeletal problems. Only three years later, the picture was very different: in psychotic disorders, there were as many people in rehabilitation as new claimants, and for reactive disorders, there were two persons in rehabilitative measures for every new claimant.

The higher prevalence of vocational rehabilitation measures is important because cantonal disability offices which grant more vocational rehabilitation measures – i.e. those which have a stronger work-orientation in their approach – were shown to be more successful with reintegration (Bolliger et al., 2012).

Figure 3.3. **Most early intervention measures are predominantly used by people with physical health problems**

Use of early intervention measures as a share of all vocational rehabilitation measures, by health condition, 2008-12

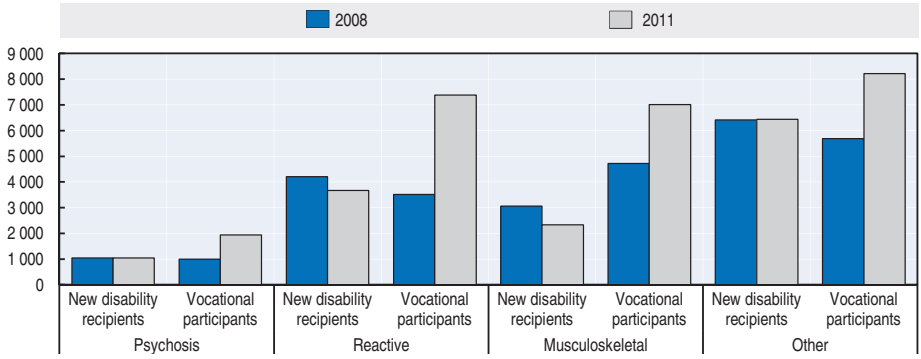


Source: OECD calculations based on data from the Federal Social Insurance Office.

StatLink *http://dx.doi.org/10.1787/888932930043*

Figure 3.4. **The use of vocational measures had increased among all groups**

New disability recipients and participants of vocational measures by main mental health reason



Note: Vocational measures include early intervention, rehabilitation and professional measures.

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

StatLink http://dx.doi.org/10.1787/888932930062

Reaching working people with problems is crucial for success

A recent evaluation of the effects of the new early intervention measures shows that before the reform 40% of all claimants were in employment roughly 18 months after initial contact with the cantonal disability office. After the reform, this rate has increased slightly to 44% (Bolliger et al., 2012). While there may be different factors contributing to this increase (e.g. changes in the business cycle), the results show that claimants who were employed at the first contact with the cantonal disability office had a much higher employment rate 18 months afterwards than unemployed claimants (Figure 3.5, Panel A), both before and after the reform. Of those employed at uptake, 55% were employed 18 months later compared to 30% of initially unemployed claimants. For the latter, vocational measures make a big difference: initially unemployed claimants with a vocational measure have a higher employment rate than those without – though this effect became smaller after the reform.

The weaker effect of vocational measures after the reform is perhaps partly explained by the higher number of beneficiaries awarded with a vocational rehabilitation measure (Figure 3.5, Panel B). The selection of beneficiaries for vocational measures has probably not been as strict as it was before the reform, e.g. regarding health status or education). This applies to all claimants, independent of their initial employment status. The general progress in the employment status (from 40% to 44%) of claimants 18 months after initial

contact with the cantonal disability offices has predominantly been caused by a higher number of employed claimants at uptake, who remained employed without a vocational measure – and not by a higher effectiveness of the vocational measures. It has to be seen whether early intervention will deliver a more significant improvement of the employment outcome in the future (this evaluation came at a rather early stage). From a cost-effectiveness perspective, early intervention measures are low-cost measures with average costs of around CHF 5 000, compared to, for example, re-education measures which cost a multiple and often do not result in employment.

Characteristics of the new integration measures

The so-called "integration measures" combine psychological aspects (social skills and cognitive training, strengthening of motivation to work, etc.), social aspects (offering a more structured day, etc.) and vocational aspects (accustoming the person to work life, etc.) which should help claimants with a mental disorder to stabilise their health condition and prepare for more demanding vocational rehabilitation measures. The basic idea behind this new measure has been to offer vocational support with a low threshold in order to prevent chronicity and give patients a work perspective at an early stage.

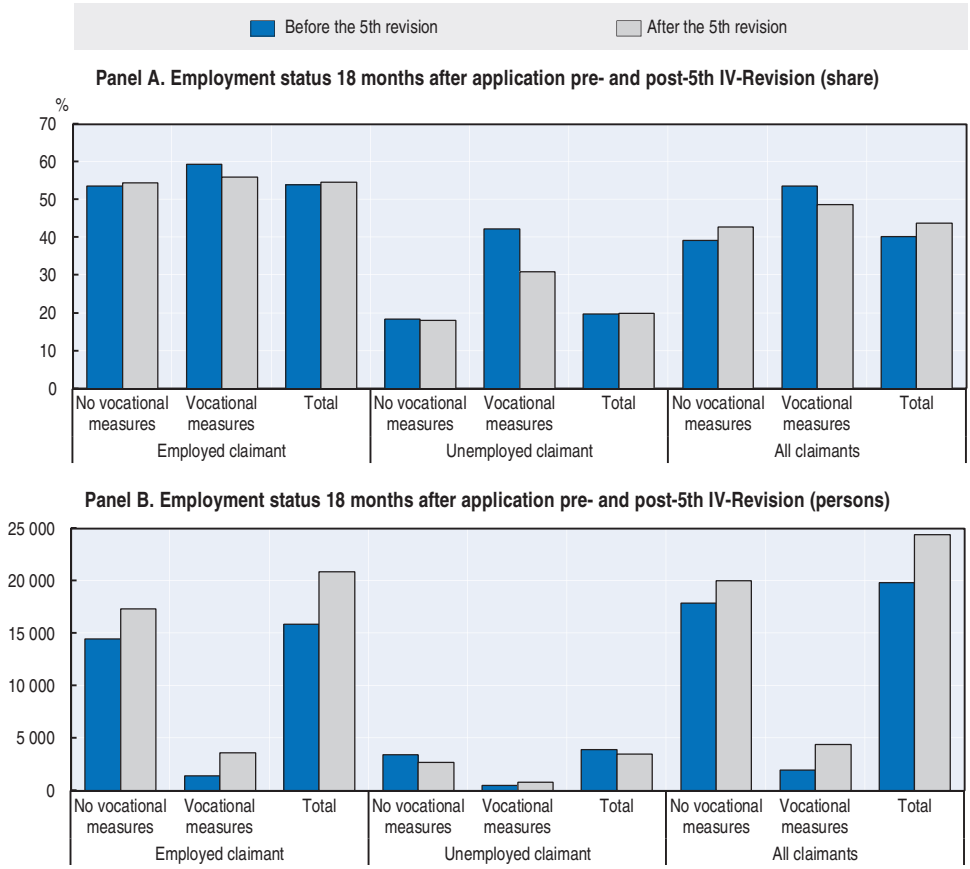
Integration measures aim to narrow the gap to more intensive traditional vocational measures. Social-vocational rehabilitation aims at building up working capacity to 50% which is the minimum required to be eligible for more intense vocational counselling, education or re-education. The combination of social and vocational elements takes into account the need of people with mental disorders for psychological support to strengthen their work capacity. While the implementation of these integration measures can be seen as an important step, scientific evidence on supported employment programmes has consistently shown that unlimited support is crucial for success due to the often recurrent nature of mental health problems. The new integration measures are still time-limited for one year (in total over the lifetime). It was foreseen to expand this period with the second part of the 6th reform which was rejected by parliament in June 2013.

The integration measures involve two steps: i) resilience training with a minimum workplace presence of two hours per day during four work days a week, and ii) advanced training with a minimum workplace presence of four hours per day during four work days a week. These new measures were designed as a specific support tool considering the typical characteristics of many claimants with mental disorders, e.g. high vulnerability to stressful situations, low energy or cognitive impairments after a crisis or a relapse. Integration measures can take place in a specialised enterprise (sheltered workshop, etc.) or in a "normal" enterprise, be it the previous enterprise where the claimant had

formerly worked or in a new enterprise. The disability insurance can grant the enterprise up to CHF 100 per day in the case such an integration measure is arranged.

Figure 3.5. **The new measures have had a slightly positive effect on employment outcomes 18 months later groups**

Employment status of early intervention clients 18 months after application, by employment status at application and type of vocational measure



Note: "Employed claimant" refers to the situation at application, i.e. just before the first contact with the disability insurance.

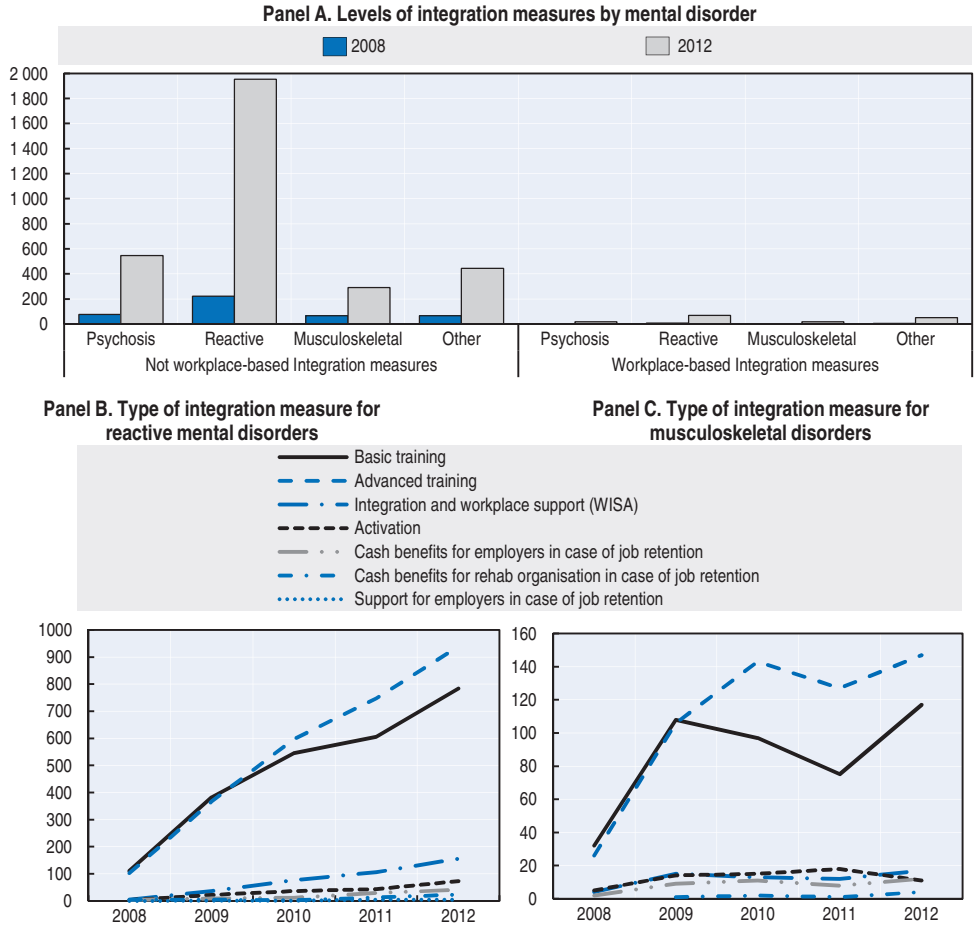
Source: OECD calculations based on data from Bolliger, C. et al. (2012), "Eingliederung vor Rente", BSV.

StatLink http://dx.doi.org/10.1787/888932930081

Since their introduction, the use of integration measures by claimants with a mental disorder has increased from around 300 in 2008 to 2 500 in 2012 (Figure 3.6, Panel A). The legal possibility and financial incentive to take up these measures within regular firms has not been exploited so far. The number of integration measures in the previous or a new enterprise is almost zero, although the vast majority of claimants in such measures have been people with reactive mental disorders, who generally do not need protection in a sheltered environment but a quick return to a "normal" job including support from a job-coach.

Figure 3.6. **Integration measures – for whom, where and how are they executed?**

Participants in integration measures, by health condition and type of integration measure, 2008-12



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

StatLink http://dx.doi.org/10.1787/888932930100

The composition of integration measures used is similar for claimants with reactive disorders (Panel B) and musculoskeletal disorders (Panel C). Only basic training and advanced training have been granted frequently (in practice, these measures are often granted consecutively). There has been little use so far of integration and workplace supports ("WISA"), which should take place "near" to the open labour market, and even less or no use of all other measures – including cash benefits and support to employers in the case of job retention. Thus, the current situation is still characterised by i) a pervasive sheltered-training philosophy and a lack of workplace-based supports or employer incentives; and ii) a focus on severe mental illness (e.g. schizophrenia and severe depression) and a lack of "WISA" measures for common mental disorders. Such workplace-based supports are generally not as expensive as traditional vocational rehabilitation measures, and should be even less expensive in common mental health conditions with a usually better working ability. Possibly, the potential of integration measures has not been fully exploited yet due to a lack of clarification on who should be granted what type of measure. Also, the idea that employers may receive a cash benefit in the case of job retention, and that rehabilitative organisations receive a cash benefit when a clients' job is secured, has yet to be put into action.

Active job placement services

Another important measure of the 4th revision was the introduction of active job placement services, including the engagement of 200 placement officers between 2004 and 2006. Today, around one-third of all rehabilitation professionals in the cantonal disability insurance offices are placement specialists. It has been shown that the more resources the cantonal offices put into vocational integration personnel, the more effective they are (Guggisberg et al., 2008, reconfirmed in Bolliger et al., 2012). Active job placement services might be especially important for claimants with a mental disorder, because many of them do not actively seek a job themselves due to fears and avoidant behaviour.

Assessment of claimants

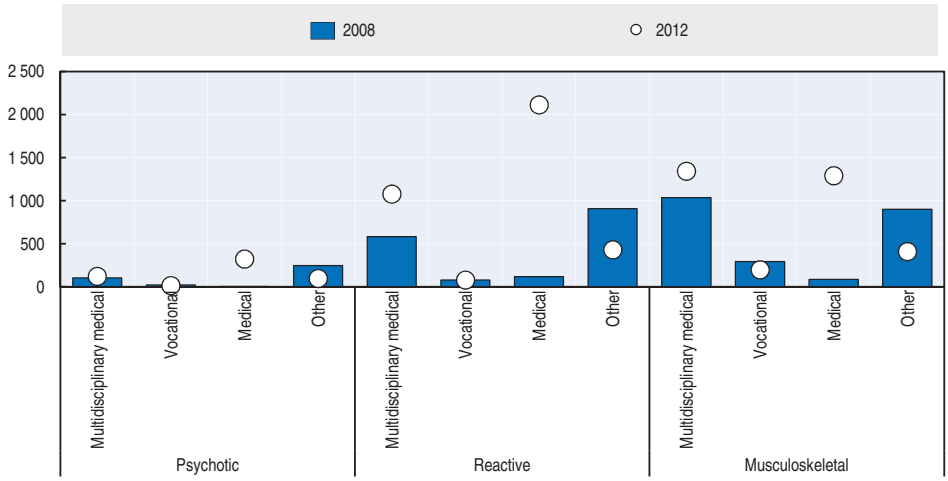
With the 5th revision of the disability insurance a quicker assessment procedure was implemented. Today some 75% of all early intervention measures are started within six months after registration – though with large differences between cantons (Bolliger et al., 2012). Despite improvements, often still considerable time is lost before interventions begin. A clear analysis of the health condition and its impact on work functioning remains crucial – not only for assessing the degree of the

work incapacity, but also for assessing the rehabilitation needs and identifying the adequate rehabilitation measure.

Altogether, the number of medical assessments and reports of claimants (at every stage of the process) has increased very strongly since 2008 (Figure 3.7). In reactive mental disorders, medical and multidisciplinary medical reports have increased from 700 in 2008 to more than 3 100 in 2012 – whereas the number of vocational assessments has remained unchanged. Medical reports are full accounts of a claimants medical, personal and vocational situation and are quite time- and cost-consuming (with an average cost per claimant of CHF 10 000). The reasons for this sharp increase may relate in part to court rulings demanding additional medical assessment. However, these medical reports have most likely been commissioned to obtain a decision concerning the award of a disability benefit at the end of the process, rather than to provide a sound medical base for rehabilitation planning.

Figure 3.7. **Medical and multidisciplinary medical assessments and reports are much more frequent than a few years ago**

Assessments by type of assessment/report and by health condition, 2008-12



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

StatLink http://dx.doi.org/10.1787/888932930119

Medical assessments have traditionally been extensive, with around five physicians assessing each disability benefit claimant with a reactive mental disorder between 1993 and 2006, but without providing a clear description

of the health-related functional incapacities (Baer et al., 2009). The intensity of medical examinations has increased further, in part related to the rise in appeals against decisions regarding the award of a disability benefit from 2 200 to 5 400 between 2004 and 2009, with a slight decrease afterwards. The stricter assessment of work capacity by the regional medical services, especially regarding unclear pain disorders, and the increasing number of claimants with reactive mental disorders have contributed to the rising number of medical assessments.

There are currently about 300 physicians working in the regional medical services including around 50 psychiatrists – compared to only 30 physicians prior to reform. The share of psychiatrists (around one-sixth) does not mirror the diagnostic composition of claimants and also shows large variation across the country, with shares of 5-25%. The precise impact of the regional medical services on new disability benefit claims is unknown. The services have probably led to a stricter assessment culture and contributed to the decrease in new claims. This has to be seen against the background of stronger obligations. Firstly, the definition of work incapacity or disability has been narrowed to a functional deficit (not an illness) which is objectively insurmountable. Secondly, the obligation to participate in vocational integration measures has been strengthened. All measures which potentially support integration and do not adversely affect the claimant's health condition are considered to be reasonable and must be followed actively. Otherwise, benefits may be reduced or withdrawn.

In practice, there are two kinds of assessments, an internal one aiming at identifying the integration potential and an external one which is done in complex cases where the employment perspective is rather poor. Nevertheless, the majority of the assessments executed by both the regional medical services and the medical examination institutions are still carried out for court cases, not for rehabilitation planning. The use of medical assessments for rehabilitative purposes has generally not increased over the past decade (Ebner et al., 2012). In a representative analysis of 800 psychiatric reports from 2008-09, only two-thirds of the reports described and deduced the functional deficits and work incapacities, or described the working potential (resources) of the claimants. Moreover, only 30% of the reports described the personality of the claimant, although 70% of all disability benefit recipients with reactive mental disorders have personality issues or a diagnosed personality disorder, according to the assessing physicians (Baer et al., 2009). Generally, psychiatric reports of disability benefit claimants neglect psychosocial issues in favour of medical questions, show a substantial variation between cantons, and do not use standardised

instruments to describe the work capacity (Ebner et al., 2012). This equally applies to reports from the regional medical services.

These unsatisfying findings initiated the development of formal guidelines for psychiatric examinations of disability benefit claimants in conjunction with the FSIO and the Swiss Association for Psychiatry and Psychotherapy (Colomb et al., 2012). It was recommended to use the framework of the International Classification of Functioning (ICF) to rate incapacities of people with mental disorders (Linden et al., 2009). The potential of these recommendations remains to be seen, even more as they are not binding.

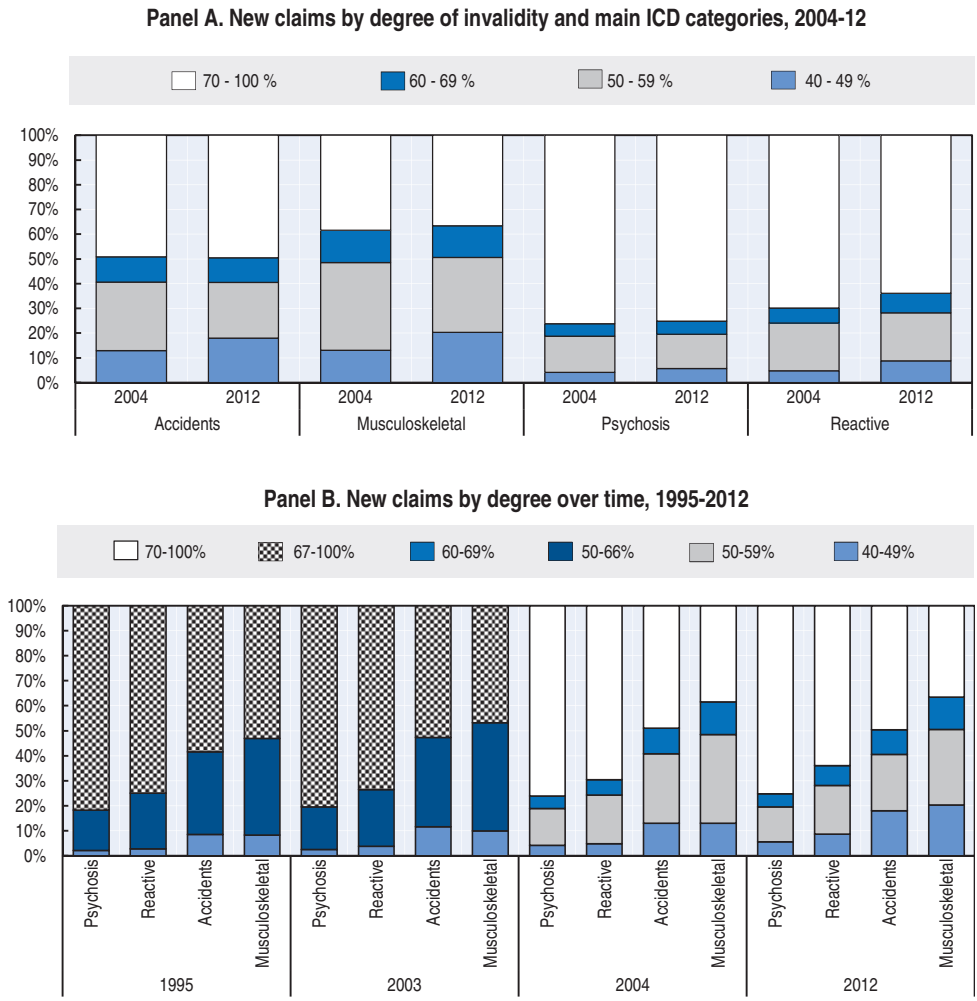
A high-quality medical assessment is crucial, because the disability benefit process stipulates that a sound assessment of the medical, vocational and personal situation is carried out in order to evaluate the working capacity of the claimant. This assessment should involve a multidisciplinary team of the cantonal disability office with vocational rehabilitation specialists, job-placement specialists, the regional medical service and other (external) specialists if needed. However, while it was planned with the 6th revision to oblige cantonal disability offices to execute multidisciplinary assessments, this element was withdrawn because it would have narrowed the latitude of the disability offices (Aiello, 2011). Without a precise knowledge of the health-related working deficits and of the necessary steps to overcome them, it is not possible to develop a sound rehabilitation plan. To establish a valid problem-analysis, the treating physician, as well as the employer, should be consulted systematically. In this respect, the new measures of early registration and intervention are promising: during early registration, one-third of the treating physicians and employers had been contacted, and during early intervention even as many as 80% (Bolliger et al., 2012).

Benefit adequacy and work incentives

The development of full and partial disability benefits

The 4th revision of the Disability Insurance Act in 2004 also changed the benefit structure from a three-level system to a four-level system. As Figure 3.8 (Panel A) shows, the disability benefit degrees have been quite stable since then for all health conditions, including different mental disorders.

Figure 3.8. **The introduction of a three-quarter benefit has had little effect**



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

StatLink http://dx.doi.org/10.1787/888932930138

Looking at the situation prior to 2004 (Panel B), there has generally been a drop in the award of full benefits after 2003: while in 2003 74% of all benefits were full benefits, the share dropped to 70% and 64% in 2004 and 2005, respectively. A further reduction of the share of full benefits in mental disorders might be possible on condition that the necessary support measures were provided.

The issue of partial work capacity is also important because, for new claimants, the second part of the 6th revision of the disability insurance foresaw to remove the existing benefit degrees using a linear model without steps in order to improve work incentives (see Box 3.3). The linear benefit model could have improved incentives to work because any additional income would lead to a real increase in total income – provided the work capacity is adequately evaluated and the remaining work capacity is translated into employment (see below).

Income situation before and after a disability benefit award

There is evidence that disability benefit recipients for mental disorders have a much lower income than those with physical disabilities. A survey of tax registers (Wanner et Pecoraro, 2012a) showed that 45% of single disability benefit recipients with a mental disorder have an income below 60% of the median income. Single beneficiaries with congenital disabilities (25%), physical disabilities (33%) or injuries after an accident (20%) less often have such a low income. Moreover, single recipients with a mental disorder work less frequently (30%) than recipients with a congenital disability (55%) or a physical disorder (40%). The analysis shows that – apart from the diagnosis – an early commencement of the health problem, a partial disability benefit and lack of contributions to second-pillar entitlements contribute to low income, above all if there is no additional income from employment. All these factors, due to the early onset of mental illness, usually apply to beneficiaries with mental disorders.

The share of single mentally-ill benefit recipients having an income from the second or third pillar is as low as 28% for men and 32% for women, compared to 49% and 46% for physical conditions. This is relevant because the median amount of the second and third pillar in disability benefit recipients is between CHF 10 000 and CHF 18 000 per year, depending on the household structure.

For the average person, the financial situation (including income from employment and the benefit system) remains about the same when single, male claimants with a mental disorder are awarded a disability benefit (CHF 35 000 per year). Due to the relatively lower income of women, their yearly income improves by almost CHF 10 000 after the disability benefit award.[5] However, the result strongly depends on previous earnings: for single claimants with earnings of less than CHF 30 000, the median income increases from around CHF 20 000 to CHF 28 000 after becoming a beneficiary. In claimants with earnings higher than CHF 30 000, the transition to the disability benefit system results in a loss of income: 15% in men and 3% in women up to earnings below CHF 80 000, and 20% in men and 8% in women who had earned more than CHF 80 000.

Mentally-ill claimants often received a low income already long before registering with the disability benefit system. Recipients with a reactive mental disorder had an average annual income of CHF 20 000 between 1993 and 2006 (Baer et al., 2009). Single claimants with mental disorders in the last year before transition to the disability benefit system had an average income of CHF 32 000 (Wanner and Pecoraro, 2012b). Therefore, the award of a disability benefit often signifies an improvement in the financial situation of mentally-ill claimants, although almost half of them remain on a level near to poverty (i.e. live with an income below 60% of the median income of the working population). This negative work incentive for the group of low-educated, mentally-ill workers with a broken work history should be addressed, because low-skilled workers and people with a low income in general have a higher risk of receiving a disability benefit. A key priority should be to prevent that workers live in a financially precarious situation without employment perspectives for years, thereby making the perspective of a secure benefit income attractive. Thus, early recognition and intervention are crucial.

Box 3.3. **The 6th revision (second part – rejected by parliament in June 2013)**

The second part of the 6th revision would have enabled the disability insurance to pay back the debts to the old age pension fund until 2025. The main measure of the reform was the introduction of a linear benefit system or payment schedule. Other planned measures focused on reinforcing early intervention-type vocational rehabilitation measures in line with the 5th revision, and on financial measures.

- With respect to early intervention and rehabilitation, early registration would have been extended to workers without sickness absences; time limits of integration measures (explicitly for claimants with mental disorders), currently limited to one year, would have been eliminated; and counseling and support services to employers independently of an application to the cantonal disability office would have been introduced.
- The cantonal disability offices would have had to implement multi-professional assessments for new claimants, and to secure a holistic evaluation of both the medical and the rehabilitative situation.
- Financial measures would have included the reduction of children benefits (currently 40% of the disability benefit of the parents) to 30%. Current children benefits would not have come into force until three years after a benefit was awarded. And the travelling expenses of claimants in vocational rehabilitation measures would have been more strictly limited to indispensable disability-related costs.

Currently, taking up employment or increasing the hours of paid work may lead to an over-proportional reduction in disability benefits. Accordingly, practical evidence has shown that benefit recipients always want to know how much they may earn without losing their benefits. Gysin and Bieri (2011) calculated the effects of a linear benefit model: a single person earning CHF 90 000 before a full disability benefit award receives CHF 35 000 from the disability insurance as long as any additional income does not exceed CHF 25 000. If the person's additional income increases to CHF 30 000, a fall in total income will occur from CHF 60 000 to CHF 47 000, because the full disability benefit will be replaced by a three-quarter benefit. This person would have to triple the amount of work income (to CHF 70 000) in order to reach the same net income as when his or her earned income was CHF 25 000. The problem is reinforced when the benefit recipient has children. Within the linear benefit system recipients would have a monetary incentive to take up a job – down to a disability degree of 40%, the minimum threshold, which would remain a threshold with negative work incentives.[6]

Recently, the pilot-project "start-capital" (Bütler et al., 2011), financed by the FSIO, evaluated whether financial incentives would increase the number of disability beneficiaries taking up a job or increasing their work effort – and reduce their invalidity degree by at least 25%. To evaluate the effect of a direct payment, two intervention groups with a starting capital of CHF 9 000 and CHF 18 000 respectively were created; the control group was not offered any cash benefit. Due to lack of participation, the planned four-year project had to be discontinued after two years.[7] Apparently the cash payment offered was far too low to compensate for a "secure" disability benefit income. There have been similar experiences with incentives programmes in other countries, for example, by offering simplified processes to combine disability benefits with work-incomes or time-unlimited protection for working beneficiaries to return to the disability benefit without a reassessment. Generally these schemes suffer from very low take-up (OECD, 2010). For example, in the Unites States Ticket-to-work programme the take-up rate was 1-3% of the caseload despite high investments and guarantees for financial security as well as a range of support measures. One factor for the low participation probably is that beneficiaries had been on benefits for too long a time resulting in avoidant behaviour regarding a change of the situation out of fears to fail and to become de-stabilised again.

Addressing the high benefit caseload

The first part of the 6th revision, implemented in 2012, focused mainly on the caseload of existing benefit recipients (Box 3.4). Between 2012 and 2017, the disability insurance, according to the target of the Swiss Federal Council in 2011, aims to reduce the disability benefit caseload by 12 500 full-time equivalents or 17 000 beneficiaries, amounting to 8% of all beneficiaries in 2011 (or 18% of all current recipients with a mental disorder in the case mental disorders would be the only target group).

An exceptional case concerns current recipients with a medically unclear pain disorder (without an organic cause), who no longer qualify for a disability benefit. Beneficiaries with such conditions will be reassessed and, in the case of existing work ability, will lose their disability benefit (or a part of it) retroactively. They will be offered vocational rehabilitation for a maximum duration of two years. During these two years the disability benefit will continue to be paid, if the claimant participates in vocational rehabilitation measures. The Federal Court has taken several decisions in the past decade, narrowing the eligibility criteria for the award of a disability benefit. Since 2011, all medically unexplained health conditions (e.g. fibromyalgia, neurasthenia, chronic fatigue syndrome, whiplash) no longer qualify for a disability benefit. With the 6th revision current claimants with such disorders will be reassessed within three years. They will fully or partly lose their benefit in the case of a medically assessed work capacity, unless they were older than 55 in 2012 or have had a disability benefit for more than 15 years when reassessed. It is estimated that 4 000 of the 17 000 beneficiaries who should be reintegrated are benefit recipients with pain disorders. More generally, current disability benefit recipients with a mental disorder (including the group of somatisation disorders) are the main target group for reintegration.

While it is too early to take full stock of these reforms, some elements regarding the reassessment of current recipients and the instruments and incentives for reintegration are worthy of discussion.

Box 3.4. **The 6th revision (first part): Support to current beneficiaries and incentives to employers to increase outflows from disability benefit**

The 6th revision in general aimed at sustaining vocational rehabilitation, further reducing the deficit of the disability insurance and increasing incentives to work. The reform was divided in two parts (6a and 6b). The revision 6a came into force in 2012, the second part – planned to be implemented in 2015 – was eventually rejected by parliament.

With respect to mental disorders, the first part of the 6th revision focuses mainly on an increased reassessment and reintegration of current disability recipients. The reform seeks to replace administrative routine reassessments of disability beneficiaries by a personal contact between the case manager of the disability insurance office and the disability recipient in order to explore the integration potential in-depth.

To enable and support this process, several measures have been introduced which should compensate the fears of claimants to take up employment and the fears of employers to hire people with mental health conditions:

- Re-integration: Disability beneficiaries who try to gain competitive employment are supported during the re-integration process and continue to receive their disability benefit. The work trial is a new measure which is regulated for both employers and benefit recipients. It is restricted to six months.
- After re-integration: During the first three years after getting off the disability rolls, former beneficiaries who work or seek competitive employment are eligible for counselling. In case of integration failure, e.g. due to a relapse, the disability insurance should quickly assess the eligibility of a renewed disability benefit entitlement. In case of a renewed work incapacity, the disability insurance pays a temporary benefit at the level of the earlier disability benefit.
- During the first three years, the employer is not required to announce possible sick leaves of the employed beneficiary to his daily allowances insurance, therefore eliminating the fear of a possible increase in premiums. Moreover, employers are not obliged to integrate the new employee in their second pillar scheme as the claimants stay with their own scheme.

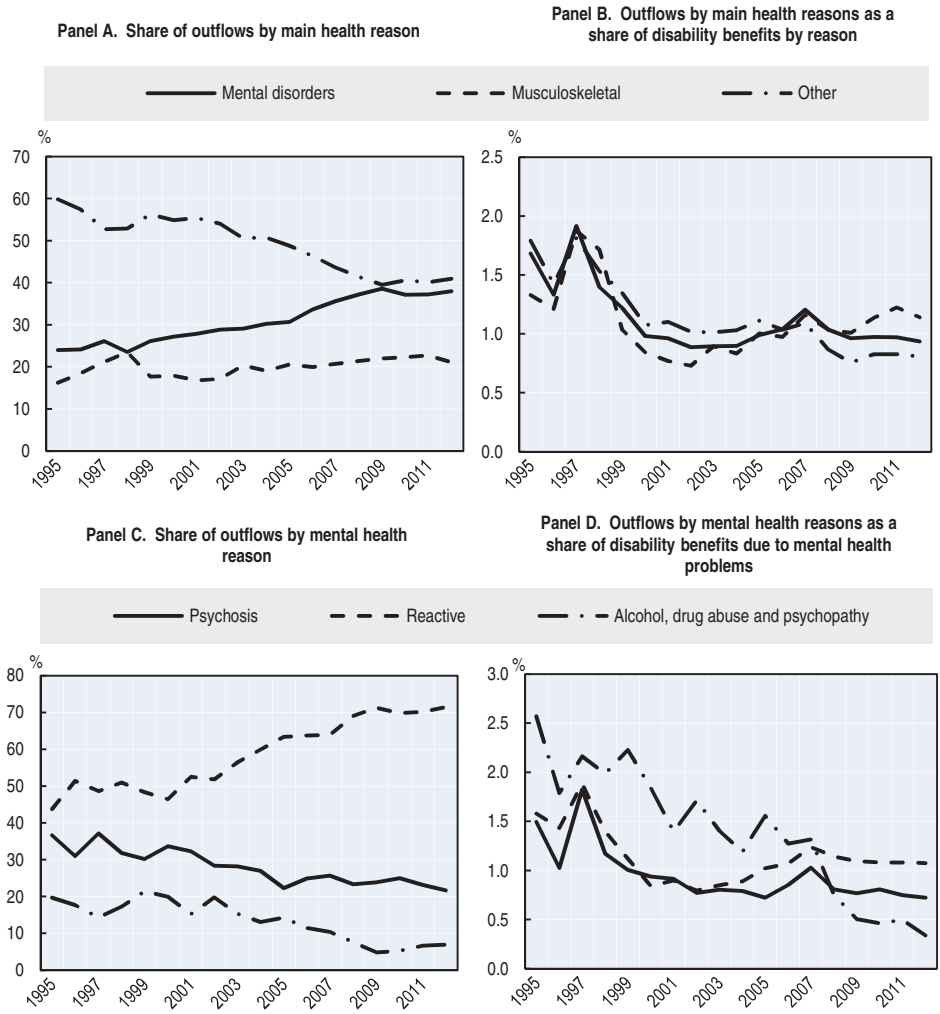
A new reassessment culture is needed

After the award of a disability benefit, recipients are periodically reassessed. However, these reassessments do not usually lead to an outflow from disability benefits into employment (Figure 3.9).

Since 1995, the share of mental health conditions in outflows from disability benefits (excluding deaths and transition to old-age pension) has increased from 24% to 38% (Panel A). This was below the corresponding increase in the caseload of recipients for mental health reasons. Relative to the corresponding caseload, the outflow of beneficiaries with mental disorders has not increased (Panel B); the outflow was slightly under 1% of the caseload which is the same as for other health categories and less than

over the period 1995-99. Looking at specific mental health conditions leads to the same conclusion (Panels C and D). Currently, around 815 recipients with a mental disorder leave the disability benefit rolls every year.

Figure 3.9. **Outflows into employment are the exception, irrespective of the health condition**



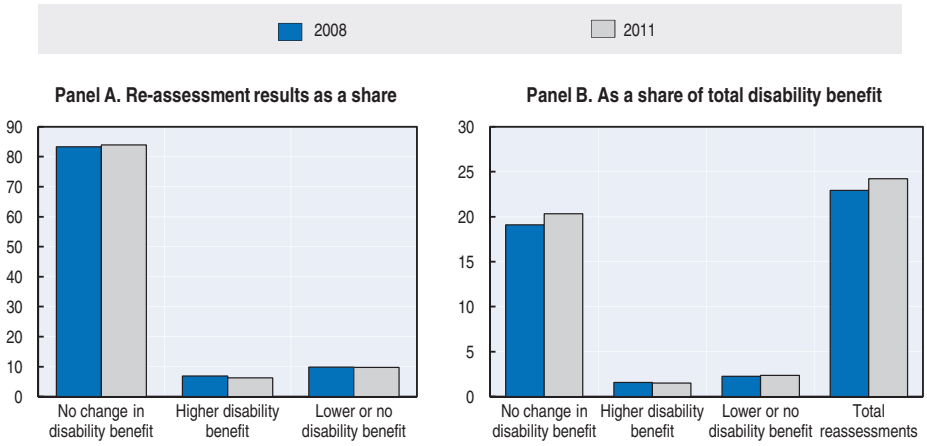
Source: OECD calculations based on data from the Federal Social Insurance Office.

StatLink http://dx.doi.org/10.1787/888932930157

This magnitude has to be seen against the aim of the first part of the 6th revision to reintegrate 17 000 current benefit recipients – mainly recipients with a mental disorder in general and recipients with a reactive mental disorder especially – into the labour market within six years. In order to reach this target, the disability insurance has introduced a range of new measures (see Box 3.4). It was crucial to change the reassessment method because it failed to identify recipients with integration potential. During an average year almost 50 000 current claimants were reassessed before the 6th revision, i.e. 20% of the caseload (Figure 3.10, Panel B).

Figure 3.10. **Benefit reassessments are frequent but rarely lead to a change in entitlement**

Results of reassessments of current disability claimants, 2008 and 2011



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

StatLink http://dx.doi.org/10.1787/88932930176

Previously, these reassessments were based on a self-assessment of the beneficiary and an evaluation of the treating physician – together with a subsequent (mostly administrative case file-based) evaluation by the cantonal disability office. The result is that in more than 80% of the reassessed cases the degree of the work capacity remains unchanged – with no change between 2008 and 2011 (Figure 3.10, Panel A). In half of the remaining cases, the evaluation of the work capacity resulted in either a higher or a lower degree of benefit. Thus, reassessments resulting in a lower or terminated benefit amount to only about 2% of all disability benefits (Panel B).

With the 6th revision, a new reassessment procedure was implemented, although the current practices vary a lot between the cantons: i) current claimants are met for an interview, and there may be a contact with the treating physician and an assessment by the regional medical service; ii) in the case of an assumed reintegration potential, or in the case of an unclear pain disorder, further interviews with the claimant can follow as well as discussions with the treating physicians and other involved parties; iii) a rehabilitation plan is elaborated and actions are taken, or the eligibility for a new disability benefit is reassessed; and iv) the result is evaluated. Interviews instead of administrative file-case evaluations are new to this process. Greater emphasis is placed on developing a trusting relationship with the claimant (Schär et al., 2011).

In order to help shift people from benefits to employment, a good relationship between the professionals of the cantonal disability insurance offices and the treating physicians (often psychiatrists) is crucial. This includes a shared analysis of the work problem, a shared rehabilitation plan and a common understanding of the mutual obligations. However, there is evidence that friction remains between the disability offices and treating physicians (Romann, 2012). Treating physicians may feel ignored because their reports and assessments are overruled by a physician from the regional medical service who hardly knows the patient, or because they have been considered by the disability offices to underestimate work capacity, or because the regional medical service has intervened in their medical treatment, e.g. by imposing requirements regarding medication. The regional medical service has a main role with respect to the new reassessment of current benefit recipients. Treating physicians' knowledge and co-operation are also crucial for both rehabilitation planning and integration success, because treating doctors are the claimant's confidants. In turn, vocational rehabilitation measures will be ineffective if treating physicians repeatedly issue sickness absence certificates or act against progression of the patients' work capacity.

Developing evidence-based criteria and interventions

More personalised reassessments may have significant potential, especially in claimants with a mental disorder who often have work-related fears, poor self-confidence and low self-esteem. In order to successfully implement such a strategy, some factors seem crucial. First, criteria (on diagnosis, severity, duration and course of the illness, working biography, etc.) for the identification of current benefit recipients with a reintegration potential would support efficiency and minimise frustrations. So far, it is within the scope of each cantonal disability office, or of each professional, to identify claimants. Second, guidelines on a range of issues should be

elaborated, e.g. how to build up a trusting relationship, how to counsel beneficiaries with different mental disorders, how to counsel employers, how to create a sustainable relation with the treating physician, or how to design an effective rehabilitation plan. Such guidelines would support the professionals of the disability offices.

The lack of professional evidence-based criteria and concepts, when and how to intervene depending on different situations (e.g. job retention versus reintegration) and psychiatric disabilities, is striking against the background of the high investments in the integration of claimants with mental health conditions by the reforms of the past decade. The legal definition of the new vocational measures does not spell out the description of effective interventions. The FSIO might support the cantonal disability offices by fulfilling its supervision role and initiating the elaboration of guidelines together with the treating physicians, rehabilitation professionals and other actors.

Balancing work incentives, support and obligations

When disability benefit recipients engage in a reintegration process, they face the risk of replacing a secure benefit income by an unsecure income from work. Accordingly, the disability insurance has implemented "security" measures, e.g. former beneficiaries can receive a temporary benefit in case their work capacity is reduced again by at least 50% during 30 days within the first three years after reintegration. This temporary benefit corresponds to the amount the beneficiary received previously. In this case, the disability office reassesses work capacity. This financial security is likely to be especially important for vulnerable people with fluctuating mental disorders.

The lack of confidence in one's work capacity is deep-rooted, reducing the effects of incentives for people on disability benefits. Moreover, the longer people are on benefits the less likely they are to engage in reintegration trials. In the Netherlands, there has been a successful experience of a similar reintegration programme focusing on new beneficiaries (OECD, 2010). But it is unlikely that a fully voluntary programme can effectively reach a large number of people on disability benefits. This may be especially true in Switzerland which has very high payment rates for people with low income. Moreover, people with low education, who would face unskilled jobs in possibly difficult environments, may perceive employment as a burden and prefer not to work (Bütler et al., 2011).

However, there is broad evidence that people with a mental disorder often want to work but do not actively seek employment because they fear

to fail, to have a relapse or to face conflicts in the workplace (Baer and Fasel, 2009). People with mental health conditions often show reduced assertiveness, passivity or an inadequate illness perception, and may develop fear-avoidance behaviour (Oyeflaten et al., 2008; Muijzer et al., 2012). This has to be seen against the background that most disability benefit recipients with a mental disorder have not functioned well in the labour market before contacting the disability insurance (Baer et al., 2009) – a fact that increases their reluctance to try reintegration. Thus, in order to support a return-to-work, it is crucial to find a balance between financial incentives, a trusting relationship and effective rehabilitative support, as well as obligations to co-operate actively in reintegration measures, including consequences if this is not the case.

Allaying the fears of employers

Employers are reluctant to hire applicants with a known (former) mental health condition. A Swiss experimental survey of 750 small and medium-sized companies showed that if employers had the choice between nine applicants – a healthy but unreliable and lazy applicant, five applicants with a former physical disease and three reliable and committed applicants with a former mental disorder – they would usually hire the unreliable but healthy applicant 50%), followed by applicants with a former physical disorder (47%). Applicants with a former mental disorder – depression, schizophrenia and alcohol dependency – would almost never be hired (3%), although their health condition is stable and their work capacity is 100% (Baer and Fasel, 2009).

Prejudices against applicants with a mental health condition do not fully explain employers' reluctance to hire them. Most employers have already had negative experiences with employees with mental health problems and are afraid to hire workers with such conditions. However, in the same survey, employers indicated that the following measures would substantially increase their willingness to hire people with health problems: work trials; wage subsidies; information about the disability and how to handle the worker's disability; and on-going support by a professional (OECD, 2013).

The FSIO has incorporated the fears and needs of the employers with the 6th revision by integrating the new "work trial" into the professional measures. During up to six months of the work trial, the employer does not have to hire or to take the person into the second pillar scheme. Moreover, the possibilities to pay wage subsidies to employers have been expanded. Already since the 5th revision, the disability insurance can provide job-coaching, primarily to support the claimant, and if needed, the employer. With these promising measures, employers are largely protected against financial risks.

Additional potential may be identified in two respects: first, time-limited job-coaching does not reflect the nature of mental disorders. Practical evidence shows that problems often arise with a time-lag and they often recur, even years later. Employers do not usually contact the cantonal disability office in due course in such cases. Therefore, finding a solution to provide a low-cost but unlimited support would be crucial to ensure job-retention. Secondly, job-coaching today relies on the claimant's and not on the employer's needs. This underestimates the importance of the manager's interventions. Sound information and support to the employer at the beginning, and on-going and active (but less intensive) support afterwards, would be crucial. For employees with a mental disorder, a "good" manager (who feels secure, gives clear directions and is responsive) is the most important support. The second part of the 6th revision had foreseen an intensified counselling of employers.

How much effect can be expected from vocational rehabilitation measures?

The development of a continuous research programme on disability ("FoP-IV") and a new possibility (since 2008) for the disability insurance to fund pilot projects to prevent disability and support reintegration, has significantly improved the evidence base. Research and pilot projects have supported the aim of the 5th revision to bring a more rehabilitative culture into the disability insurance.

However, scientific evidence on the effectiveness of vocational rehabilitation measures of the disability insurance is scarce, and the majority of the initiated pilot projects are still running. These projects address three issues: reintegration incentives, inter-institutional collaboration and vocational rehabilitation. The project "XtraJobs" aims at compensating the fears of employers to hire people with disabilities using a temporary staffing model, i.e. clients are temporarily hired by specialised personnel employment agencies and delegated to enterprises. The evaluation showed that within two years only 143 clients took up the programme. Eighty-seven were delegated to enterprises, and out of these, 29 were hired (Bieri et al., 2010). Thus in total only 20% have found employment and it is unknown how sustainable these jobs have been. However, at CHF 33 000 for each of the 143 cases and even CHF 167 000 for every placement, the costs were high. The reasons for the low take-up were that the project was not well known to employers and not sufficiently implemented in the cantonal disability offices. This was changed in a follow-up project.

Such a 20% success rate was also found in a representative analysis of disability claimants with a reactive mental disorder who were offered

traditional vocational measures by the disability insurance and no full disability benefit two years afterwards (Baer et al., 2009). While the success rate after a vocational measure of the disability insurance is on average 72% for all health conditions, it is only 58% for claimants with a mental disorder. The file-case analysis of the current working situation of successfully integrated claimants with a mental disorder, however, showed that in reality only about a third of those 58% were in full- or part-time employment, i.e. around 20%. The new measures of the disability insurance have the potential to improve outcomes but a *sustainable* reintegration remains difficult.

Preventing longer absences and job loss

A very promising measure of the second and rejected part of the 6th revision of the Disability Insurance Act was the new possibility to counsel employers at an early stage of a problem. Currently, employers can report an employee to the cantonal disability offices after 30 days of sickness absence, or after several shorter absences, respectively. This is problematic for two reasons: first, intervening at the earliest six weeks later might be too late already; and secondly, the majority of workers with a mental health problem do not take sick leave. In a survey of Swiss employers on how they intervene with *particularly difficult* employees with mental health problems, 60% of the concerned employees have not taken any longer sickness absence spell but were present at the workplace (Baer et al., 2011). The employers identified mental health problems in employees very early but usually intervened much later. They tried in vain to solve problems for a period of three years on average, before the employment contract was terminated in many cases. Sickness absence is usually not the beginning of a problematic work situation but the preliminary end of it. Accordingly, it is crucial to intervene much earlier, at a stage when the job of a mentally challenged worker is still secure and when work colleagues and managers are still ready to retain and support the person. To achieve this, managers and human resource-professionals should seek external support much earlier, i.e. as soon as the usual good leadership behaviour (such as discussing the problematic behaviour or the lacking performance with the employee, setting clear targets, offering support etc.) fails to improve the situation.

Early counselling of employers could strengthen their ability to deal with employees with a mental disorder in the workplace. If the cantonal disability offices would broadly implement this measure in the future, this could bring a new perspective into the disability benefit system, because the current focus on support and training of people with a disability would be complemented with a focus on enabling employers to deal with vulnerable employees.

Conclusion

Since the 1990s, Switzerland has seen a constant rise in the disability benefit system of new claimants with a mental disorder. Due to the lack of outflow from disability benefits back to employment, the caseload of such beneficiaries has steadily increased. This development has led to a disastrous financial situation of the disability benefit system which threatened the solvency of the pension fund. The increase of benefit claimants for a mental health reason has been partly related to a frequent transition of people on social assistance to the disability benefit system, and to the increasing labour market exclusion of older workers, low-educated immigrants and single mothers – predominantly with either depression or pain disorders. Until 2006, very few claimants received a vocational rehabilitation measure before they were awarded a disability benefit.

The Federal Social Insurance Office has reacted with several reforms of the Disability Insurance Act between 2004 and 2012 with the aim of first reducing new claims into disability benefits, and later on increasing the outflow of current recipients into employment. The disability benefit reforms brought a far-reaching change of the system focusing more on remaining work abilities and work-oriented support measures, instead of administrative or pure medical questions of disability benefit eligibility. Moreover, more accessible measures to intervene early were implemented at the expense of highly selected, cost-intensive and often ineffective vocational reintegration measures. At the same time, obligations for claimants to co-operate in vocational measures and to seek medical treatment, and the legal and medical thresholds for disability benefit eligibility have steadily risen.

This combination of reforms has been successful: Since 2005, the number of all new claimants has decreased by 45% leading to a stabilisation in the caseload of beneficiaries. However, the number of new claimants for a mental disorder still increased, although at a significantly reduced pace. Within a decade, the disability benefit system has achieved a transformation from a benefit administration to a rehabilitation agency, also providing more adequate vocational measures for claimants with a mental disorder. Nevertheless, this process is not yet completed and the effects of the reforms are, so far, widely unknown. In order to reach the aims of the reforms and to continue the change, some remaining challenges have to be addressed and new opportunities should be fully used.

Increase the system's orientation towards employers

- *Further push early registration*. Since employment outcomes of vocational measures are much better for claimants who still have a job, early registration should be promoted and become the main pathway to the disability benefit system. Action should be taken so that employers use the possibility of reporting employees to the disability office.

- *Raise the take-up of early intervention measures by people with a mental illness*. The new early intervention measures are currently provided mainly for claimants with a physical disorder. These measures should be expanded to people with a mental disorder, especially also to those with a common mental disorder, who are still in employment.

- *Expand workplace-oriented interventions*. Early intervention measures include a broad range of services but only educational courses and social-vocational rehabilitation are used widely. Therefore, the potential of early intervention is not yet fully used. Early intervention measures which are workplace-based should be significantly expanded, including counselling and job coaching to ensure job retention.

- *Promote integration measures in regular workplaces.* The new integration measures have also been used only partly: basic and advanced training to increase the work capacity were used widely – although mostly in sheltered enterprises. Support measures in regular workplaces and supports for employers to foster job retention were used rarely. To the contrary, integration measures should whenever possible be provided in non-sheltered workplaces.

- *Develop counselling for employers*. Early counselling of employers with respect to effective interventions towards employees with a mental health problem (recently rejected by parliament) would have considerable potential as a preventive measure to reduce new claims for disability benefits and to strengthen the position of the disability offices with the employers. Such measure should be implemented, and the disability offices should build up knowledge on how to effectively intervene in the workplace.

Further improve assessments and reassessments

- *Strengthen the shift to a workability focus in the assessment.* Medical assessments have strongly increased in numbers in the past five years whereas specialised vocational assessments remained irrelevant for claimants with a mental disorder. This makes intervention planning difficult. There is still a need for a profound change: whenever necessary, assessments should be multidisciplinary and involve employment specialists, and be done earlier to assure adequate reintegration planning.
- *Further improve the quality of medical assessment.* The continued poor quality of medical assessments for claimants with a mental disorder has been recognised, and formal recommendations have been elaborated for psychiatric medical examinations. These recommendations should be implemented rigorously, supplemented by disability-specific professional reintegration guidelines to be developed by physicians in multidisciplinary co-operation with employment specialists.
- *Improve the quality of reassessments*. (Medical) reassessments of current benefit recipients do not result in a substantial change in their assessed work capacity, thus probably wasting a lot of potential in beneficiaries. The administrative reassessment should be replaced swiftly by dialogue and personal contact with the treating physician, as currently foreseen. Moreover, reassessments should be done systematically. In cases of diverging opinions (between the treating doctor and the regional medical services), both medical parties should be obliged to discuss the case and find an agreement.
- *Improve the collaboration with treating physicians*. Finally, the collaboration between the cantonal disability insurance offices, the treating physicians and the medical associations should be improved substantially by close collaboration in planning and executing the reintegration process, including agreements on how to handle potentially difficult situations and sickness certifications.

Make working more attractive for current recipients

- *Promote the use of partial benefits.* New claimants with a mental disorder still have a high rate of full benefits (higher than claimants with a musculoskeletal disorder, for example). Remaining work potential of this group could be better exploited when receiving a partial benefit.

- *Introduce a linear benefit payment schedule.* A linear benefit payment model would give current beneficiaries (especially those with low education and, thus, low earnings potential) better incentives to increase their employment efforts. Currently, it often does not pay to work more because of very significant thresholds effects. The proposed linear benefit model (rejected by parliament in June 2013) should be implemented.
- *Remove work disincentives*. Disability benefits in Switzerland are still comparatively generous for certain groups, e.g. young people without a labour market record and people of any age with family responsibilities. The payment structure should be reviewed to assure a balance between benefit adequacy and work incentives.

Notes

1 . In line with the definition of mental disorder in this report – excluding organic mental disorders and mental retardation (OECD, 2012) – there are around 87 000 people on disability benefits for a mental health reason. Together with these excluded disorders, the share of mental health-related disability benefits is 43% in 2012.

2 . The classification of health-related impairments of the disability insurance comprises nine outdated categories of mental disorders which are not compatible at all with the International Classification of Diseases (ICD-10): schizophrenia, bipolar disorders, organic psychosis, other psychosis, psychopathies, reactive disorders, alcohol dependence, other substance dependencies, and mental retardation. The use of this classification may be continued for statistical reasons, but should be complemented by ICD-diagnosis. This would allow for better analysis and international comparisons.

3 . The distinction of mental disorders by their supposed cause (i.e. the etiology of mental illness) has been abandoned with the ICD-10. The so-called "psychogenic and reactive disorders" (Code 646 of the disease-classification of the disability insurance) comprise very different mental health conditions as, for example, depression, personality disorders, psychosomatic disorders, etc.

4 . Social-vocational rehabilitation (called "integration measure" in practice) is not generally used as an early intervention measure in the case of a still existing job. It is rather a low-threshold measure to initiate an enduring rehabilitation process for the severely-ill (e.g. starting with working in a sheltered workshop for two hours a day after a discharge from the psychiatric clinic).

5. Social assistance benefits and complementary cantonal benefits before the award of the disability benefit were not included in the analysis, thus there is some underestimation of the income before disability benefit award.

6. There was some discussion on whether the maximum level of the linear benefit should accrue at 70% work incapacity or only at 80%. A change to the latter would have meant savings of around CHF 70-150 million per year because the disability degree would have fallen for 14% of current recipients (it would have remained the same in 77% and increased for the remaining 9%).

7. The cantonal disability offices informed 4 000 disability benefit recipients about the project and invited them to participate. Only 145 claimants answered within six months (4% of all contacted persons), and only 49 persons were interested in participating. Out of these 49 persons, 17 were classified as having a relevant integration potential and not needing too high of a support resource. Eventually, three persons began with reintegration measures.

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Chapter 4

Swiss co-operation efforts to tackle long-term unemployment and inactivity

This chapter looks at the ability of the unemployment benefit scheme and the social welfare system in Switzerland to deal with the high prevalence of mental illness among their clients. It discusses awareness of the issue as well as means to identify mental health problems and help people with such problems to re-enter the labour market. The chapter's main focus is on the current status, role, impact and future potential of inter-institutional co-operation which was introduced more than a decade ago and has been under constant development since.

The disability benefit system plays a key role in Switzerland's mental health and work policy in terms of raising awareness of the challenges around mental ill-health and influencing people's patterns of labour market exit and return to work. However, it is not the only critical player. People with mental ill-health who lost their job or never had a decent job are often receiving other benefits too, especially unemployment benefit and social assistance. Hence, cantonal employment agencies and municipal welfare offices are also important actors. In view of frequent transitions across benefit systems and the appearance of claimants in different schemes at different moments in time, Switzerland has put more and more focus over the past decade on the co-operation between different systems and actors, commonly known as "inter-institutional co-operation" (IIZ). This has changed procedures in many cases but there is still a long way to go to achieve improved outcomes.

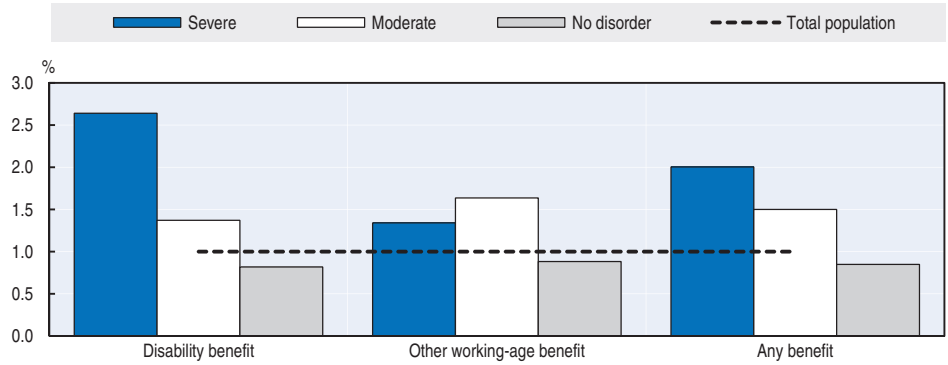
The relevance of different benefit schemes

Measured over a three-year period (2004-06), close to 20% of the working-age population in Switzerland received one of the three main income-replacement benefits for at least two months (Fluder et al., 2009).[1] This reflects the great importance of the income protection systems during periods of unemployment and inactivity. Of those who did receive a benefit, about half received an unemployment benefit and one quarter each either a disability benefit or a social assistance payment.[2] The payment duration varies greatly across different types of benefits: while the average unemployment benefit spell has been fluctuating around 100 days,[3] the majority of disability benefits are permanent payments (Chapter 3), and, of those receiving social assistance, roughly one-third depend on such payment on a more or less permanent basis (Aeppli and Ragni, 2009).

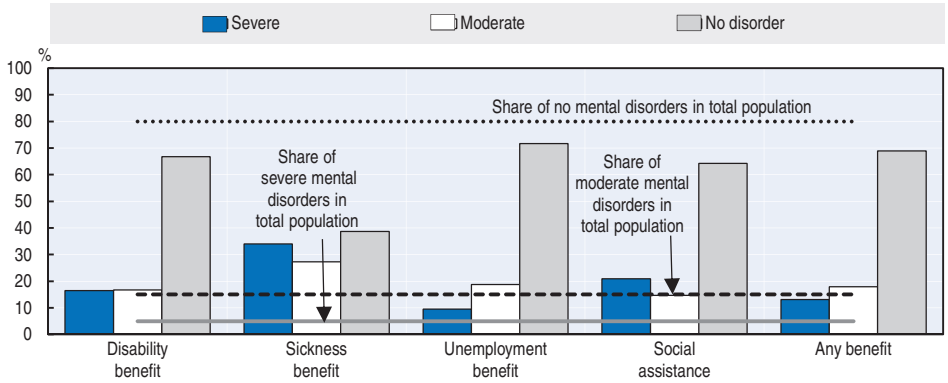
As in other OECD countries, the proportions relying on benefits are much higher among people with a mental disorder (OECD, 2012). Unfortunately, this cannot be shown using Switzerland's administrative data as only its disability benefit data record the claimant's health status. The only helpful source linking benefit receipt and the person's mental health status is the Swiss Health Survey, even though at a total rate of 12% of the working-age population this survey underestimates benefit use.[4] The latest available data referring to 2007 (2012 data were not yet available in 2013 at the time of preparing this report) suggest that for people with a moderate mental disorder benefit recipiency rates are 50% higher than for the total population, and they are even twice as high for those with a severe mental disorder. Of those on benefits in the severe group, two-thirds receive a disability benefit and one-third another benefit, while in the moderate group less than half of those on benefits receive a disability benefit (Figure 4.1, Panel A).

Figure 4.1. **Benefit receipt is much higher for people with poor mental health**

Panel A. Proportion of people who receive a working-age benefit, by mental health status (relative to the total population; total population=1.0)



Panel B. Proportion with a mental disorder among beneficiaries of different types of working-age benefits



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

StatLink *http://dx.doi.org/10.1787/888932930195*

Put differently, a very large share of people in Switzerland receiving income-replacement benefits suffer from a mental illness. The same 2007 survey data suggest that 33% of those receiving a disability benefit have a mental disorder (either severe or moderate), which is broadly in line with what is known from administrative data. This share is equally high or even higher on other benefits: 60% of those on sickness benefit, 35% of those on social assistance and almost 30% of those on unemployment benefit have a mental disorder (Figure 4.1, Panel B). This implies that policies and reforms

which aim to improve labour market inclusion of people with a mental illness need to extend to all benefit schemes.

Frequent transitions from one benefit to another

Since the beginning of the 1990s, the caseload of beneficiaries of various benefits has increased considerably. Unemployment only arose as an issue in the early 1990s (since then fluctuating with the business cycle); the number of people receiving disability benefit almost doubled from 1990 to the mid-2000s; and later social assistance caseloads also increased sharply. A number of separate reforms within each benefit system have tried to address this issue, often with implications for other systems. The latest increase in social assistance claimants in the past years, for example, is partly the result of more restrictive access to unemployment and disability benefits.[5]

This development has raised concerns about transitions across benefit schemes, especially affecting people with unclear and more complex needs – presumably including many people with a mental disorder. The potential problem being that these people are being pushed from one system to the next, also referred to as the "revolving door" effect, with no single benefit administration taking full responsibility for the person in question; in turn implying they will never get the support they need. .

For the first time, Fluder et al. (2009) quantified transitions between benefit schemes for the working-age population. They conclude that the revolving-door effect is limited to a relatively small group of beneficiaries, smaller than was perhaps assumed. Merging various administrative data sources, their main findings included the following:

- Around only 8% of all those receiving a benefit during the observation period (2004-06) experienced a transition from one benefit to another, and around 1% have had at least two such transitions.
- Another roughly 10% received two benefits at the same time (typically a social assistance top-up to another benefit).
- The most frequent transition was from unemployment benefit to social assistance (upon loss of unemployment benefit eligibility) – this group accounted for over one-third of all new social assistance claims.6
- Transitions from social assistance to disability benefit (upon deterioration of work capacity) or to unemployment benefit (when availability for work improves) were also common – they

accounted for one in five new disability benefit claims and one in 20 new unemployment benefit claims.

- Flows out of the social protection system are much larger: almost 90% of all unemployment exits and two-thirds of all social assistance exits are flows out of the benefit system.
- Finally, among rejected disability benefit claimants, receipt of another payment is very frequent: every second rejected claimant has received another benefit before, during or after the rejection decision.

Hence, back-and-forth referrals across different benefits are relatively rare in numbers but transitions into a main benefit through another benefit are frequent. Policy therefore has to tackle three aspects: first, the large numbers of clients with a mental disorder in all benefit schemes; secondly, the frequent flow into social assistance of long-term unemployed exhausting their benefit entitlement; and thirdly, the frequent flow into disability benefit via a period of social assistance dependency. Such benefit transitions are likely to be especially frequent for people who oscillate between health and ill-health; among them people with mental ill-health will be overrepresented.

Switzerland should be commended for having put in place a tool to monitor benefit flows and the interaction between different social security systems, based on a range of policy-relevant indicators (called SHIVALV or AS-AI-AC,[7] see Box 4.1). Findings from the monitoring tool confirm the results above which seem rather robust over time, except for fluctuations in unemployment and long-term unemployment stemming from the business cycle. The data show, for example, that over 90% of all those receiving a disability benefit are still on that benefit in the following year. The corresponding share is about 70% for social assistance payments and currently 60% – up from 50% before the recent downturn – for unemployment benefit (Kolly, 2011; and BSV, 2012).

The recent data also confirm the robustness of transition patterns between benefits, and the low numbers of transitions out of the disability benefit system. On the contrary, many of those leaving social assistance remain in the benefit system by moving to either unemployment or disability benefit (about one in three exits are within the benefit system). The largest of all transitions – with more than 10 000 persons annually – is from unemployment to social assistance upon exhaustion of unemployment benefit entitlement (Table 4.1).

Table 4.1. **People on social assistance frequently transfer to other benefits**

Benefit caseloads in 2009 and transitions from 2009 to 2010 between disability benefit, unemployment benefit and social assistance

From (in 2009):	To (in 2010):			Caseload	Share of exits…	
	Disability benefit	Unemployment benefit	Social assistance	In 2009	…within the benefit system	…over the total caseload
Disability benefit	242 700	170	290	260 900	3%	7%
Unemployment benefit	2 590	181 700	11 100	300 200	12%	39%
Social assistance	6 200	8 400	106 500	149 700	34%	29%

Source: OECD secretariat compilation based on SHIVALV basic indicators 2005-10.

StatLink http://dx.doi.org/10.1787/888932930499

Box 4.1. **A system to monitor social security system interactions**

The monitoring tool builds on a personal identification code which is available fully for social insurance data (disability benefits and unemployment benefits) and partly also for social assistance data. The latter implies that social assistance data have to be weighted and extrapolated to match the social insurance data. The tool provides a set of indicators in four different areas, updated annually (data for 2011 were made available in February 2013):

1) *Benefit caseloads*: Number of persons receiving unemployment benefit, social assistance or disability benefit (monthly and yearly figures).

2) *Benefit flows*: Number of persons who within a calendar year move onto a benefit, move out of a benefit (irrespective of the destination), or remain on a benefit (by duration).

3) *Combined benefit receipt*: Concurrent receipt of two or more benefits (e.g. social assistance and disability benefit) within a year and within a month. [*Note*: Combined benefit receipt can possibly indicate a transfer from one benefit to another; see next item.]

4) *Transfers across benefits*: Number of transfers between unemployment and social assistance, social assistance and disability, and unemployment and disability (including the duration of benefit receipt before the transfer and the frequency of transfers).

The potential of the monitoring tool as a policy instrument is, however, not fully exploited. So far information is collected by gender, age, nationality, region and marital status. Educational attainment, living arrangements, income, and health and mental health status would be important variables worth exploring to identify groups for which policy does not fully deliver.

No identification of unemployed with mental health problems

The unemployment benefit system is often the first benefit system that people have contact with. This is also true for many people with a common mental disorder which in a majority of cases will not be diagnosed and which may even be unknown to the person involved. The new early-intervention focus of the disability insurance scheme will reach only a small number of those struggling with a mental illness because it is geared towards people at a very high risk of becoming eligible for a disability benefit eventually – i.e. generally people with a diagnosed, comparatively more severe health problem. Therefore, the ability of the unemployment scheme to measure the mental health status of claimants and identify those who face significant labour market barriers because of a mental health problem is critical.

The Public Employment Service (PES) is a cantonal affair, with each canton having an agreement with the Swiss federation to ensure that labour market reintegration is swift and sustainable through the use of services and benefits and an activation regime with possible benefit sanctions. In international comparison, the unemployment benefit system is quite accessible but also demanding for the client in terms of job search (see Box 4.2).

What does this regulatory framework mean for the large proportion of the unemployed with mental health problems? The relatively strict monitoring regime provides an opportunity for caseworkers to identify employment and job-search barriers of all types, including diagnosed and undiagnosed mental illness that impacts on the person's job-search behaviour. The same holds in principle for the first interview at intake, which is held within 1-2 weeks and therefore relatively early, in international comparison. This meeting serves to identify abilities and skills as well as barriers, including potentially health problems, and to develop a strategy for a swift return to work between the PES counsellor and the client.

The strict focus on people ready and able to work and the 44-day rule could imply that people with a mental illness lose their unemployment benefit entitlement relatively quickly. This could push people even with only a mild or moderate mental illness away from the labour market. The role of benefit sanctions for claimants with a mental illness is unknown, but the effects of sanctions are mixed in general; using Swiss register data, Arni et al. (2009) found that enforced sanctions increase the job-finding rate but can reduce subsequent employment stability and post-unemployment income.[8]

Box 4.2. **The Swiss unemployment benefit system: generous but quite rigid**

The maximum payment period of unemployment benefit is normally one year but up to two years for people over age 55, people with maintenance obligations, and people with a partial disability. The maximum payment period now requires a contribution record of at least the same length, e.g. a one-year benefit payment requires a one-year contribution record. The system provides a relatively high initial benefit level with a net replacement rate (at average earnings) of around 85-90% of previous earnings, depending on family size (OECD, 2013a). At the same time, the system is comparatively strict in terms of job-search and availability requirements and, equally so, job-search monitoring. In terms of benefit sanctions i.e. temporary reductions in benefit payments as punishment for noncompliance with eligibility requirements, Switzerland is in an intermediary position when compared to other OECD countries (Venn, 2012).

All benefit recipients, including those participating in labour market measures, are required to search for work unless they are specifically exempted. The unemployed have to provide proof of job search to the regional PES office once a month, with job-search requirements depending on the person's individual circumstances. Normally, some 4-10 actions have to be reported each month (OECD, 2007) but this requirement can vary from canton to canton; in the canton of Zurich, for example, 10-12 serious job-search actions are typically required (Duell et al., 2010).

Job offers can be refused if they are not considered suitable for the state of health of the unemployed. An unemployed person must be ready and able to work. When certified sick, the person is not considered unemployed and job-search requirements can be waived for a maximum of 44 days within the unemployment benefit entitlement period of up to two years maximum; be it for one or several illness cases. Given that the jobseeker meets the PES caseworker once a month, short-term sicknesses of, for example, one week would usually not be reported. After 44 days of sickness-related waiving of job-search obligations, unemployment benefit eligibility would end and the person would have to lodge a claim for a disability benefit or, more probably, social assistance.

The awareness of mental health as a critical issue for the PES is very low in Switzerland – despite the large share of clients with mental illness, especially among the long-term unemployed (throughout the past decade, some 50% of all claimants remain unemployed for over six months, and almost one-third for over a year). Common mental illness is not a priority for the PES; the four main target groups currently are the young, the old, migrants and the unskilled. The cantonal employment agencies according to law have no explicit responsibility to identify mental illness and support those people in their job search. Employment counsellors are not trained to help this group and they have no screening instrument at hand to identify mental health challenges. They can refer a client to the cantonal disability insurance, or suggest consulting a doctor and help in organising an appointment with a doctor. This could include a referral to a specialist service in case of addiction problems, for example, with the client's

approval. Only if an unemployed person refuses a job offer for health-related reasons could they request a medical certificate. In so far, the best indirect identification of undisclosed common mental health barriers is by offering a wider array of jobs and the feedback from employers received thereof.

The job of a PES employment counsellor is to bring clients back into work. Psychological expertise is not available at the PES, which is unfortunate in view of very good experiences with successful job placements for unemployed people with common mental disorders by psychologically-trained caseworkers in Denmark (OECD, 2013b). Easy-to-use screening instruments have also been shown to identify common mental disorders in various sub-groups of the population with high validity (e.g. Søgaard and Blech, 2010). Systematic use of such tools could speed up the identification of mental health-induced employment barriers provided there is quick access to medical services. Otherwise non-disclosed mental health issues could and would remain undiscovered and, hence, unaddressed, for a very long time.

Another problem in Switzerland related to the strong focus on job-ready clients is a relatively large caseload of around 125 clients per counsellor on average (although this figure varies across and within cantons). This is too large a number to achieve good outcomes for unemployed with additional barriers, even if the actual active caseload may be lower (typically one-third of the total caseload will need very little counsellor time). In order to get around this, difficult-to-place clients are outsourced to specialist providers, like for example *Profil*, a provider specialised in placing people with chronic health problems or disability in the first labour market. These providers can work with much larger resources over a given period, typically for six months. Funding levels allow for caseloads of around 25 clients or even less per caseworker. This is helpful for clients with severe and diagnosed mental illness but the much larger number of unemployed with common mental disorders are treated as mainstream clients without extra resources. For these clients, the standard procedure aimed at rapid placement is adopted. They may be offered training that allows the identification of "inappropriate behaviour" in regard to employment, which could be a sign of a mental health problem. But there is a risk that they end up as long-term unemployed and exhaust their unemployment benefit entitlement. Tools such as post-placement job-coaching could help these clients in finding sustainable employment.

Better awareness of mental health problems in welfare offices

When unemployment benefit eligibility ends, people can apply for social assistance (or in some cantons unemployment assistance). This can be after either the exhaustion of the maximum unemployment payment period ("disqualified unemployed") or the 44-day limit for being sick while unemployed and on benefits and therefore not being available for the labour market. More than one-third of all new social assistance claimants have received unemployment benefit prior to their claim.

Attention to the high prevalence of mental disorders in their clients is much higher in municipal social welfare offices than in PES offices. Social workers and counsellors in social welfare offices are generally dealing with people with complex problems and lower employment chances many of whom also suffer from a mental illness. Workers in the welfare office of Zurich city, for example, say that virtually every one of their clients has mental limitations, not least because of the long and frustrating process before turning to their office, but limitations are often at a level below the clinical threshold for a mental disorder. Staff in in other welfare offices, e.g. in Vevey, suspect that about half of their clients have a mental illness.

The higher awareness of mental health issue does not, however, imply that social welfare offices necessarily have any tools available or make systematic efforts to identify mental health problems of their clients. There are enormous differences across and within cantons in the way welfare services are operated. Wealthier cities – especially Zurich, Bern and Basel – generally have much higher resources, more professional staff and better tools available for their clients. They are also likely to deal with more clients with mental health problems. The processes will therefore differ considerably across the country.

The city of Zurich stands out as one of the most active in this regard. The process at the social welfare office starts with an initial assessment which includes a payment eligibility assessment and the preparation of an assessment report. Some mental health issues might surface during this intake phase. Some 30-50% of all cases are resolved at an early phase – either the client is referred to the disability insurance, provided with payments to bridge a no-income period or returns to the labour market. After about 3-6 months, a person (or family) is considered a long-term client and casework can be initiated. The welfare office in Zurich city has a range of tools at hand which, although not necessarily developed for this purpose, can help identify mental health problems (see Box 4.3 for more details). It also has an on-going co-operation with a psychiatric-psychological service which visits the welfare office twice a week. Such systematic co-operation is not widespread elsewhere.

Not every community will be able to follow the comprehensive approach of the city of Zurich, even though many welfare offices have special competence measurement tools and reinsertion programmes (reinsertion into work or training), including special programmes for adolescents. Many of the smaller communities (there are 2 596 communities in Switzerland with an average population size of about 3 000 people) will lack the resources to build its own comprehensive service. Services at a regional level could provide specialist tasks (such as professional assessments) that can be accessed by smaller communities.

Box 4.3. **A promising approach of the welfare office in the city of Zurich**

Zurich is the biggest city of Switzerland, confronted with large inequalities and a substantial number of people in need of help, and it also has a very large immigrant population (30% of the population and 50% of the welfare clients). The municipality invests substantially in tools aimed at maximizing its inhabitants' level of inclusion and improving their labour market potential. The following initiatives and measures are noteworthy:

- Every person applying for social assistance and potentially able to work has to take training called "Basisbeschäftigung" (basic activity). During four weeks people have to undertake manual work for six hours per day and five days per week. This is mandatory and helps to identify a claimant's work capacity and develop a return-to-work plan. However, it is also a good way to identify undiagnosed mental health issues.
- The welfare office has a vocational training centre ("Fachstelle BTZ") providing work integration services for people with a disability, referred to and financed by the disability insurance office. While this has existed for twenty years, the clientele of this centre is now predominantly people with a mental disorder. The centre has its own psychological service which is available during the assessment and training phase to help identify mental health problems and avoid drop-out from training.
- Under the authority of the social welfare office, each primary and (lower) secondary school in Zurich has a social worker, based in the school. These social workers can reach out to students at risk and provide support to teachers, students and parents. Mental health issues (also of parents) are among the most frequent problems that arise.

The focus of welfare offices is broader than that of employment offices, including social integration (especially housing), financial integration (debt relief) and work integration. The latter will only be realistically possible for a fraction of the clients. In Zurich, work integration is the goal for about 25% of all new clients – noting that some of their clients have a job already. Little is known about the re-employment rates of welfare clients. Based on around 1 500 telephone interviews in five Swiss cities with new clients in 2005 and 2006 who were followed until late 2008 Aeppli and Ragni (2009) conclude that i) one-quarter held a long-term job with an unlimited work

contract; ii) one-quarter had found unstable short-term employment; and iii) another quarter did not find employment and was fully dependent on social assistance. Of the remainder, half were working poor (having a job, topped up by social assistance) and the other half were without a job and without any benefits. Results were best in cities with the lowest caseloads.

There is no evidence available on the work-integration success rates for social assistance clients with a mental disorder but since they tend to be more disadvantaged and further away from the labour market, they are likely to be below the average. For example, return-to-work rates were lower for people who first went through an external integration measure compared with those who did not need such a measure. Otherwise, a poor level of education, low work motivation, a lack of labour market skills and more generally a higher age are key factors which reduced the job-finding rate (Aeppli and Ragni, 2009).

Improved co-operation between cantonal and local key actors

In recognition of the need for greater co-ordination between the different benefit systems, the country's initiative for inter-institutional co-peration (IIZ) was launched in the early 2000s (e.g. Luisier, 1999). IIZ started with high ambitions and has evolved considerably and involved more and more partners since (see Box 4.4 for more details). The main goals, however, remained unchanged: to improve labour market integration of people with complex barriers, often involving mental health problems, and to avoid carousel effects (i.e. people being shifted around between different systems), service gaps and service duplication – i.e. to make the social protection system both more efficient and more effective.

In early 2004, the federal government published a handbook for inter-institutional co-operation which summarised very clearly what challenges the country is facing in regard to the interface between social assistance, unemployment insurance and disability insurance, and – as a fourth but much smaller partner – the system of vocational guidance (SECO, 2004). The handbook also gives guidance to the partners on how the IIZ co-operation process could be organised and what tools and solutions could be used or developed.

Among the biggest challenges identified at the outset were the lack of knowledge by each partner about the aims and working methods of the other partners; the lack of agreed assessments of the client's challenges and abilities; the lack of joined-up services; a lack of information transfer when a client switches partners; long waiting times for various decisions (e.g. on disability benefit eligibility); and more generally poor incentives for all actors to do the utmost for a client with complex needs. For example, the

PES tended to refer clients with complex social and health problems to either the disability office or the social welfare office, which in turn returned those clients to the PES who were deemed to have too much work capacity to qualify for their services.

Box 4.4. **Evolving forms of inter-institutional co-operation in Switzerland**

IIZ is the German short form for "inter-institutional co-operation" between three main systems initially: the cantonal PES (i.e. unemployment insurance), the cantonal disability office (i.e. disability insurance) and the municipal welfare offices (social assistance). Later vocational training and migrant integration became additional partners. The philosophy of the new form of co-operation is to encourage individual actors to co-ordinate their activities, to make their own actions more transparent and to share information with other institutions. While the federal government provides some support for the IIZ, e.g by having prepared an IIZ handbook and by providing a secretary as a platform for cross-cantonal exchange, it has largely been developed and implemented at the cantonal and local level.

IIZ PLUS was a first extension of IIZ to include those private insurers typically involved at an early stage, i.e. the sickness benefit insurers, the accident insurers and the pension funds offering occupational disability benefits. These are private insurers which are not structured regionally but closely linked to the employer, thus creating additional challenges for co-operation. Such co-operation is crucial for early identification of problems and support needs (especially of people on sick leave), such as job counselling and placement or other reintegration measures – aspects that subsequently became a key objective of the fifth revision of the Swiss Disability Insurance Act.

IIZ MAMAC was a special project launched in 2006 extending the IIZ approach by a medical-vocational assessment with case management (MAMAC). It aimed at making IIZ work better through i) a joint assessment of a person's work capacity that is binding for all institutions; ii) reintegration measures jointly agreed by all IIZ partners; and iii) making one institution responsible for managing a particular case throughout the entire process. The target group for this project was people with complex problems concerning at least three institutions, who suffer from health problems and face social difficulties but have been enrolled for less than six months and have a reintegration potential. By 2007, IIZ MAMAC projects had been started in 16 cantons. The project was evaluated in 2009 and formally discontinued afterwards although some cantons continued the approach by broadening the target group.

Today, IIZ is understood to include any purposeful co-operation between two or more institutions of the unemployment insurance, the disability insurance, social assistance, vocational training and migrant integration, including structural as well as case-based forms of co-operation and also both formalised and more informal ways of co-operating.

Accordingly, IIZ objectives include bringing clients with complex needs to the right institution faster; increasing co-operation across institutions to increase reintegration chances; clarifying funding responsibilities for

complex cases; and also identifying and addressing health – especially mental health – problems which hinder a fast labour market reintegration.

Two aspects are critical. First, IIZ is a highly decentralised initiative, with most forms of co-operation developing on a regional and often local level. This implies considerable creativity and flexibility but also variability and inequality across communities and cantons in the forms, occurrences and successes of co-operation. Consequently, even a simple stocktaking exercise is a difficult task and a scientifically rigorous evaluation near to impossible.

Secondly, IIZ is an on-going process which is under constant development and expansion. For example, more focus has been given recently in some cantons to better co-operation between education and labour market authorities. The goals in this case include making labour market services more accessible to young people who need help in entering the labour market and providing parallel employment and education services for those who broke up education. This has considerable potential for early school leavers with a mental health problem.

What is known about the effectiveness of IIZ?

How well has the IIZ process which started more than 12 years ago delivered on its objectives? This question is difficult to answer in view of the large range of rather different IIZ models developed across Switzerland. Certainly it has created and continues to create a lot of innovation and information exchange at the local level. Whether this has improved services and outcomes is another question.

The only real evaluation concerned IIZ MAMAC and the findings were quite disappointing. The project was well received and adopted by a majority of cantons in a rather comparable way, which initially gave rise to a very positive assessment of its potential success (Champion, 2008). However, while clients experienced the process positively, the project has on average not led to an increase in labour market integration; it has had little impact on the overall costs of the social insurance system; and the period from the first contact with the social system to the IIZ MAMAC referral was still as long as eight months (Egger et al., 2010). On the positive end MAMAC has helped to establish IIZ structures and set up a network of partners in most cantons, and to consolidate bilateral co-operation between partners on a non-formal level.

One key issue with IIZ MAMAC was the rather narrow definition of the target group, i.e. “people with multiple barriers and reasonable integration potential”. It is not surprising that from its start in mid-2007 until

March 2010 in total only about 1 300 cases were referred to the new process. This number was only a very small fraction of all newly unemployed, social assistance claimants and recipients of integration measures of the disability insurance (Egger et al., 2010) – and, therefore, only a fraction of those who would potentially benefit from strengthened co-operation between different institutions.

Clients of just two institutions, say, a client of the employment office and the social welfare office, were not considered for the IIZ MAMAC process also because sometimes bilateral agreements exist with relatively clear definitions of what to do by whom. Initially this was true for most IIZ initiatives with the typical IIZ client being a client of three or more authorities, with multifaceted problems including in most cases health problems. For example, almost all IIZ MAMAC clients have had health problems, predominantly a mental illness, often coupled with financial problems. For these clients, round tables involving all institutions in question and guidance through the system by case management are needed.

Following the IIZ MAMAC evaluation in 2010, the type of co-operation developed under the IIZ label is expanding further, including initiatives that date back to the late 1990s and in some cantons not even using the IIZ label. On-going stocktaking of existing IIZ initiatives (publication forthcoming in early 2014) has identified four major types of co-operation in place across Switzerland today:

- Multilateral forms of co-operation concentrated on the integration of youths and young adults, including variants of VET case management.
- Multilateral co-operation for people with complex problems, generally involving case management and often building on the MAMAC experiences and structures.
- Bilateral co-operation of two institutions, most frequently between the unemployment insurance and local social welfare.
- Structural forms of co-operation, including for example integration planning and training jointly provided by two or more institutions.

The organisational form of the IIZ process takes very different shapes in different cantons and communities. One example is the labour market gateway ("Pforte Arbeitsmarkt"), a three-year pilot project in ten communities of the canton Aargau, designed as a one-stop vocational reintegration centre run jointly by all three institutions (the employment service, the disability office and the social welfare office) with the objective of achieving a sustainable reintegration into the open labour market through

fast intervention and strong co-operation with employers. In other regions or cantons, co-operation of the three institutions builds on existing structures without a new dedicated co-operation entity, sharing clients and holding joint meetings as necessary and, typically, transferring the main responsibility ultimately to one of the institutions. Intermediate organisational forms also exist. Most cantons have a dedicated IIZ co-ordinator based in one of the three main institutions. Without evaluation, it is impossible to assess which organisational structure could deliver the best outcomes or if structure matters. In their assessment, Egger et al. (2010) conclude that the cantons should not treat IIZ MAMAC as a stand-alone instrument outside the cantonal IIZ concept (as was the case in many cantons) – a plea for a more holistic and integrated thinking which could be achieved in different ways.

Irrespective of the organisational form chosen by a region or canton, the IIZ process has a range of structural weaknesses that still have to be addressed. The most critical is financial incentives for all players to become engaged. The main aim of each institution continues to be to reduce its own spending. Hence, everyone is inclined to refer own clients they cannot handle themselves – hoping that others can help – but they withdraw from the process at the moment the client leaves their caseload. For example, the PES would typically pull out as soon as unemployment benefit eligibility ends. This is partly due to the impact goals and indicators used to assess PES performance, which measure the speed of reintegration success and the ability to avoid repeat, long-term and very long-term unemployment – but do not take into account the effectiveness of the PES in helping jobseekers who are not (or no longer) entitled to unemployment benefit. This is critical because in order to achieve optimal outcomes and draw on existing supports from all different institutions, all actors would need to stay actively engaged. Along the same line, a person not entitled to unemployment benefit or disability benefit or social assistance will not get into the IIZ process ever, even with multiple work, health and social problems (Nadai et al., 2010).

A second key weakness is the voluntary nature of IIZ; every partner can choose whether to co-operate or not. Eventually hundreds of agreements have been or are being signed to strengthen the binding character of co-operation, but obligations end when partners question the usefulness of co-operating. In practice, IIZ always starts at one of the involved institutions, with a caseworker realising that a client suffering from multiple problems could benefit from the IIZ process, and/or that his institution could benefit from bringing the client into the co-operation framework. In the case of IIZ MAMAC, for example, the bulk of referrals came from the regional PES (55%) and another 30% from municipal welfare offices; with only about 10% of all cases being referred from the disability insurance (Egger

et al., 2010). The qualitative study by Nadai et al. (2010) suggests there are large regional differences for IIZ more broadly in terms of referral. IIZ tends to be initiated by the PES in some parts of the country but more by social welfare offices in others. This dominance of one institution indicates problems in the balance of involvement between the institutions, partly reflecting the extent to which key actors (like the heads of regional or local offices) "believe" in the IIZ approach and the gains to be made by co-operation. Differences of this type are likely to have an impact on the effectiveness of the IIZ approach in so far as the duration from job loss to becoming an IIZ client is much longer on average if the referral is through the social welfare office. Hence, it is particularly important to get the unemployment system involved to assure that jobseekers with complex needs and mental health problems have a chance to benefit from more intense co-operation of different institutions – via IIZ – at an earlier stage.

Insufficient incentives to engage and the voluntary nature of the IIZ explain to a considerable degree why the whole process of implementation was very slow. The first few years after its launch were characterised by testing and learning but also by a lack of awareness and involvement. Only with IIZ MAMAC did the process gain momentum and individual institutions start to implement an IIZ policy – typically by nominating an IIZ contact responsible for selecting cases for the shared process and sharing information with the contacts or case teams in other organisations.

The large difference across cantons and localities in how IIZ is being run and implemented potentially presents an opportunity to identify the most practical and most effective way forward. However, for this to be the case, the structural weaknesses will have to be addressed. As long as the disability offices, employment services and social welfare agencies look through their own lenses and work towards their own measurement criteria, effective solutions involving all partners simultaneously remain difficult to achieve.

A thorough evaluation will be needed to demonstrate the strengths and weaknesses of IIZ. Anecdotal evidence suggests that it takes maybe half a year on average for a client to be referred to the joint IIZ team; that people then typically stay some 1-1.5 years in the co-operation during which their employability is gradually increased; and that maybe between one-third and up to one-half of the clients eventually find a job, which however might not be sustained. Critically, IIZ projects typically lack a stronger and systematic involvement of the health sector which would allow a real integration of treatment and employment services.

In conclusion it appears that IIZ is generating knowledge on the obstacles to, and success factors for, co-operation and thus could have great

potential for people with mental ill-health who often face complex challenges. However, IIZ still reaches too few people and comes too late in most cases thereby reducing its impact very significantly; and the focus of all institutions involved continues to be on cost containment for their own institution rather than on service efficiency and effectiveness for society as a whole.

IIZ in its current arrangement is an institutional attempt to sort out budgets and responsibilities. This will help IIZ clients in accessing available services of the involved institutions faster. However, it will not generate services that are lacking. For instance, for jobseekers with mental health problems integrated delivery of health and employment services would be more effective than better co-ordinated services from the unemployment, disability and social welfare system. As examples from other countries like the United Kingdom show, integrated services can be provided within one institution without the costly and burdensome process of co-ordination (OECD, forthcoming).

Making services effective for clients with mental ill-health

The practical aim of IIZ is to stimulate the various authorities in working together to assure that clients have quick(er) access to appropriate services, and not necessarily only those services available at the institution from which the client receives a benefit payment. This raises the broader question as to whether any of the institutions in question has any services at hand that have shown to be effective for clients with more complex problems which include mental ill-health.

The range of vocational and social reintegration measures available in Switzerland is vast.[9] Unfortunately, however, measures are rarely ever evaluated. Ragni (2007), summarising a series of labour market policy evaluations in the first half of the 2000s, concludes that active labour market programmes and policies in Switzerland have not been all that successful: some programmes successfully "push" people back to work (e.g. employment programmes) but largely because of the threat effect, i.e. jobseekers increase their search efforts to avoid the measure. Most measures, however, have negative net employment effects because negative indirect effects – lock-in effects especially for training programmes, substitution effects especially for wage subsidies, and deadweight effects more generally because some people would have found a job without the help of a programme – outweigh any positive direct programme effects (see also Lalive et al., 2006).

Little to nothing is known about the extent to which measures are taken up by clients with a mental illness and whether they are effective for these

clients (even putting undesirable indirect effects aside). Somewhat more is known in this regard about measures offered by the disability insurance but the results are modest (see Chapter 3). Lacking any measurement of a person's mental health status in both the unemployment and the social welfare schemes little is known about the impact of the interventions under these schemes for different client groups.

The wealth of labour market services available in Switzerland is considerable. Employability measures, employment and reintegration services, career counselling and job coaching are offered by various largely private service providers (non-profit and for-profit) and funded by a range of authorities, especially the PES, the welfare authorities and the disability offices but also the private sector (private insurers and partly employers). In this regard, there is substantial overlap and doubling-up of services and many providers will have contracts with several authorities and stakeholders. Most providers will deal with a multitude of clients and only few are specialised in clients with a mental illness only. Similarly, particular measures may be used by people with mental illness predominantly but most will not have been designed for this group only. Some providers are specialised in people with complex problems and may have caseloads in the order of 25 clients per caseworker. There are plenty of providers operating in only one or just a few cantons, and only some covering the entire country. Accordingly, the range and quality of services can vary greatly across the country (Duell et al., 2010).

The regulations of the different authorities also differ but two characteristics seem general: First, the systems foresee stepwise interventions with a rather rigid timeframe. For example, a client from the disability insurance can be in integration measures for up to twelve months, followed by up to six months in a professional measure (depending on the measure) and another three to six months of job coaching. Second, providers are compensated through a fixed amount per client per time unit and contracts are negotiated individually, not through a tender. As a consequence, the system seems to be driven partly by the needs of the provider, not those of the client. Clients will typically be in measures for as long as funding is available, and there are limited incentives for "established" providers to move clients on and achieve good employment outcomes.

This very rich but somewhat dysfunctional service market could be improved, and employment outcomes increased, with a partial and gradual shift to employment outcome-based funding – i.e. paying providers for employment outcomes rather than service output. Outcome-based funding of employment services is increasingly becoming common across the OECD, especially in Australia, the Netherlands and the United Kingdom

(OECD, 2013c). Such a funding framework would require a professional tendering process and a good quality-assurance framework. It would allow funding to be linked to sustainable employment and non-employment (e.g. education) outcomes and to vary the level of funding with the level of disadvantage of the client. Were mental health problems to become a key element in determining funding levels, the situation could improve very quickly for this group of clients. Moving to an outcome-based funding framework should be comparatively easier in Switzerland given the general trust in, and reliance on, the private sector in both service provision and the social and health insurance sector more generally.

Conclusion

With the gradual development of an activation stance in the Swiss unemployment insurance in the early 1990s, at the same time as unemployment started to become a more important issue, the focus of the PES shifted more and more towards people ready and available for work. This has potentially led to a situation whereby more difficult jobseekers with more complex labour market problems were not considered as central PES clients any longer. One consequence of this development was that people in this group were increasingly shifted to other benefit schemes, initially the disability system and more recently the social welfare scheme – with both systems in parallel becoming systems of last resort. The lack of awareness within many PES offices about the high share of unemployed with significant mental illness is also a consequence of this development.

In response to this evolution, inter-institutional co-operation (IIZ) arose as a critical topic, because there was increasing discussion about people with complex needs being shifted back and forth between different parts of the rather compartmental benefit system. While the data subsequently produced to examine this issue suggested that in fact this phenomenon concerns only a small number of people, IIZ efforts were strengthened considerably and significant resources were invested – although with large differences across the country – to develop cantonal and regional co-operation tools and mechanisms. However, in practice, so far only a small number of people benefitted from the new approaches. Furthermore, in the absence of any evaluations, it is not known whether outcomes have improved for them.

More importantly, the bundling of efforts and resources towards IIZ has masked other and maybe more critical problems, including the significant mental health problems that many of the regular clients (who are not referred to the IIZ process) have. This is especially relevant for the PES as both the disability insurance and the social welfare offices are more aware of the high prevalence of mental disorders among their clients. Partly as a

result, while Switzerland has one of the lowest unemployment rates in the OECD, the share of long-term unemployment – measured as more than six months or more than one year of unemployment – is higher than the OECD average (OECD, 2013c).

Also, although only few people experience repeat transitions between different benefit schemes, transitioning into a benefit through another payment is quite frequent; most importantly, many people exhausting their unemployment benefit entitlement move onto social assistance, and many of those on social assistance apply for a disability benefit at some stage. Hence, co-ordination of these systems and their measures and approaches and the interface between the systems is a relevant matter, and the IIZ process is a step in the right direction.

However, further efforts are required. In particular, the IIZ process suffers from its institutional focus and the lack of and/or sometimes conflicting incentives to co-operate better of the institutions involved. Overcoming this problem by getting the incentives right is one way to go but a difficult one. Instead or in addition, each institution should give more focus to its own clients with complex problems, and with mental health problems in particular. Providing extra services – e.g. health or workplace services – quickly within one institution in addition to the services currently available in this institution, will often be the better strategy than handing the difficult-to-place client over to a long and costly process.

Seek to identify mental health problems of clients and address them promptly in both the unemployment and the social welfare system

- *Screen for mental health issues when indicated.* PES and social welfare officers have no tools at hand to identify clients with a mental health issue. Employment outcomes would be better were these issues also addressed early on. Hence, whenever problems are suspected, validated instruments should be used to screen for mental ill-health in the client population. This could be done at the intake phase or whenever considered necessary – not to screen people out at an early stage but to be able to address mental health barriers quickly and avoid long-term unemployment.
- *Build mental health knowledge.* The adequate use of such tools requires corresponding knowledge about mental illness among counsellors of the PES and social workers in social welfare offices. They need training in how to identify mental health issues and how and when to use screening tools. Psychological expertise in caseworkers is a major success factor in improving work reintegration rates of jobseekers with a mental disorder.

- *Act quickly*. If a significant mental health issue is discovered, the health sector should get involved very quickly. This can be done by referring people to the health sector and promoting treatment (which requires a strong link with the health sector), or by offering some forms of treatment in-house (e.g. some behavioural therapy). Screening could also be used to refer a client with complex needs to the IIZ process earlier than is now the case. The earlier the process starts, the better the likely rates of success. People with identified mental health risk should be referred very quickly to an intense measure aiming at health improvement, condition management and capacity building.

Modify the PES framework to better help jobseekers with mental illness

- *Broaden performance assessment indicators*. The impact indicators used to assess PES performance look at returning jobseekers to the workforce quickly and avoiding repeat, long-term and very long-term unemployment (measured in terms of benefit off-flow). These criteria should be broadened to encourage individual PES offices to help difficult-to-place clients (such as those with additional mental health problems) as well as non-beneficiaries find sustainable jobs. Such broadening of performance goals will also be helpful for the IIZ process.

- *Develop a strategy for the sick unemployed*. Sick unemployed people are freed from job-search requirements. However, after 44 days of sickness they lose their unemployment benefit entitlement. This will often concern people with a mental illness. A suitable strategy should be developed to maintain contact with this group – many of whom may still have a significant capacity to work – and to continue to provide help and encouragement to find a job.

- *Develop a strategy for benefit exhaustees*. Similarly, more attention should be given to people at risk of exhausting their unemployment benefit entitlement – among whom those with a mental illness are over-represented. This group will need more intensive help early enough (because after one year of unemployed reintegration chances are rather slim). When unemployment benefits are exhausted, people should continue to benefit from activation measures and active labour market programmes.

Strengthen the capacity of the social welfare sector to deal with clients with mental illness

- *Develop tools addressing mental ill-health.* With the high prevalence of mental illness in social welfare clients, social services need better tools to prevent the progression of mental illness. The approach of Zurich – which includes assessment tools, a vocational training centre, social workers in schools, and the regular presence of a psychiatric service – could be taken as a benchmark. This will be important for bigger and middle-sized cities.
- *Cantonal and regional services for smaller communities*. Smaller welfare offices lack the capacity to develop and implement a full range of tools and services geared towards mental ill-health. For those offices, facilities could be put in place at a regional level (e.g. in one welfare office in a larger region), or even at a cantonal level if it is a smaller canton. These facilities should be easily accessible by the local community. This will require some resource reallocation.
- *Address disincentives to work*. More generally, similar to the disability benefit system, interventions by social welfare officers are restricted by low work incentives of clients (especially if they have dependants). This issue should be addressed, for example by the use of income disregards or tax credits to assure that additional hours of work always pay.

Address the structural weaknesses of the IIZ approach

- *Strengthen incentives for co-operation*. Inadequate and conflicting financial incentives are probably the single most critical factor limiting the success of IIZ. This issue could be addressed, for example by introducing mutual co-funding arrangements. Easing some restrictive practices would also help in generating a better incentives structure, for example, by maintaining full access to PES services when unemployment benefits are exhausted; or extending eligibility for training granted by the disability offices also to unskilled workers.
- *Involve the health system.* Almost every relevant actor is involved in IIZ except for the health system (which is indirectly involved when the disability insurance is involved but not in most bilateral co-operations). Since IIZ is all about (mental) health and social barriers to employment, the (mental) health system should be an

equal IIZ partner – both as provider of medical expertise in the assessment phase and with respect to developing a treatment strategy.

- *Improve co-operation with employers.* The second group of actors not sufficiently involved in IIZ are employers. People with mental health problems in particular often confront workplace issues which should be addressed in the course of the IIZ process. Ways should be sought to build better networks between IIZ case teams and employers.
- *Complement co-operation with service integration.* Co-operation has its limits. A full-blown integration of services – especially employment and health services – is often easier within just one institution. Therefore, the PES and the social welfare offices should consider increasing their health expertise in order to provide certain treatments instantly.

Improve the funding and outcomes of employment services

- *Consider moving to an outcome-based funding framework.* Funding services with fixed payments per client unit is administratively easier but not ideal to assure sustainable outcomes. Paying service providers for durable employment (and non-employment) outcomes, as is increasingly done in other countries, could improve outcomes. Matching funding levels with the assessed level of disadvantage of the client, identified through better profiling and assessment tools and with mental health as an explicit component, could boost outcomes for this as well as other disadvantaged groups.
- *Start experimenting with such a funding framework.* Moving to an entirely new funding framework is not straightforward. Building a competitive market through (in Switzerland probably canton-specific) service tendering requires careful preparation, building on the rich experience now available from other countries, and a strong case for change. The Swiss authorities should start exploring the steps necessary to develop the system in this direction. This requires better knowledge on the outcomes currently achieved by private providers for different client groups, and on the gains that could be achieved relative to the current situation by giving PES offices better profiling and assessment tools and installing a broader performance framework.

Notes

1. Loos et al. (2009) come up with a similar share of around 19% of the Swiss working-age population receiving a benefit, when measured at any moment in time and including sickness, work injury and early retirement payments.

2. Those who receive an unemployment benefit have strict job-search obligations, with the support of cantonal employment agencies, while requirements are much more lenient for those who receive a disability benefit or social assistance.

3. Federal Social Insurance Office (2013).

4. The Swiss Health Survey is a quinquennial survey covering the population 15 years and over living in private households (the institutional population is excluded). The survey consists of a telephone interview and a written questionnaire.

5. For example, some 5-15% of the new social assistance cases in 2011 (varying by region) are estimated to be a result of the latest unemployment benefit reform through which the payment duration was linked more closely to the claimant's contribution record (Salzgeber, 2011).

6. Data discussed in Baur (2003) suggest that about half of those exhausting their unemployment benefit entitlement found a job within two years (often with lower pay and lesser security). Two years after benefit exhaustion, some 10% each were drawing either a disability benefit, a social assistance benefit or encountering a new unemployment benefit spell.

7. SHIVALV and AS-AI-AC are the German and French acronyms for "social assistance – disability insurance – unemployment insurance".

8. In 2008, about a quarter of all benefit claimants received a sanction, with an average of 2.5 weeks of benefit suspension (Duell et al., 2010).

9. See for example the brochures of the canton Wallis (Kantonale IV-Stelle Wallis, 2012) which summarise, in both French and German, all the measures available from either the unemployment insurance or the disability insurance or the social welfare office.

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Chapter 5

Making more of the potential of the Swiss mental health care system

This chapter assesses the performance of the mental health care system in Switzerland in providing adequate treatment to persons with mental disorders. While very comprehensive, there is potential to reach even more of those needing treatment. Therefore, the chapter looks at the role and collaboration of different mental health care providers and the potential for further improvements. The contributions of psychiatric services and physicians in private practice to facilitate job retention and re-integration are assessed, and barriers as well as possibilities to engage more actively in health-related work problems are discussed.

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.

Although most mental illnesses have a good potential for improvement over time if treated quickly and effectively, these illnesses usually begin very early in the life course and can be persistent or subject to frequent relapses. Moreover, mental ill-health often has a negative impact on social skills, personality and work-related anxiety, and leads to stigma both inside and outside of the workplace. Job retention and re-integration of workers with mental health problems may only be solved by integrated interventions addressing the medical condition and adequately intervening in emotionally complex situations in the workplace. Adequate treatment is, therefore, necessary in any policy strategy aiming to raise the labour market participation of people with a mental disorder, but, as discussed in Chapter 2, it must also be connected to workplace interventions.

While there are many generalist and specialist mental health care providers in Switzerland, and while the Swiss health care system ranks highly regarding the satisfaction of users, there are challenges around linking general and specialist health care with employment issues and with rehabilitation and employment services. The large resources available in the Swiss health care system enable differentiated and good medical and psychological services but the diversity of these services also involves the risk of fragmented activities and concepts. These challenges are addressed below.

Characteristics of the mental health care system

Some structural characteristics of a mental health care system may have consequences not only on illness recovery but also on the employment situation of the patient, including for example whether the treatment facility is close to the patient's place of residence, facilitating contacts between employers and mental health care, or whether services are offered in a non-stigmatised environment (e.g. in general hospitals), facilitating access to treatment, or whether outpatient services and interdisciplinary day clinics are available, facilitating the return-to-work process.

Switzerland, generally, has a well-performing health system with a broad range of accessible services, universal health insurance coverage, and high levels of patient satisfaction (OECD, 2011; Sturny and Camenzind, 2011). At the same time, health expenditures in Switzerland in 2009 ranked among the highest within OECD countries both as a percentage of GDP (11.4%) and on a per capita basis (5 000 USD PPP; OECD, 2011).

In 2010 total costs for health care services covered by mandatory health insurance amounted to CHF 32 billion (EUR 28 billion). CHF 21 billion were contributed by health insurance and CHF 11 billion by the confederation, the cantons and the municipalities. CHF 30 billion (94%)

went into somatic health care and only CHF 2 billion (6%) into specialised mental health care. Of the latter, 56% went into inpatient psychiatric care, 14% into ambulatory and day care services, and 30% into private practices.

A large array of mental health services

First, in 2010 around 6 000 general practitioners (GPs) treated some five million patients. An estimated one-quarter to one-third of these patients had a (co-morbid) mental disorder (e.g. WHO/Wonca, 2008; Goldberg and Lecrubier, 1995). The same magnitude (around 35%) was found in a survey of 2 330 GP patients in the canton of Bern (Amsler et al., 2010). Generally, nearly 80% of the Swiss population sees a doctor (a GP or a specialist) at least once during a year. This rate rises to more than 90% in people suffering from an enduring mental health problem (Sturny and Schuler, 2011). The more people feel stressed, the more they seek medical treatment (Schuler and Burla, 2012). However, in most cases, people with a mental disorder do not seek treatment for their mental health problem but for a physical health condition, and mostly their mental health problem remains undetected and/or untreated. Nevertheless, 36% of all psychiatric diagnoses are done by GPs and another 2.5% by specialised somatic physicians in private practice. All other mental psychiatric diagnoses are done by psychiatrists.

Second, also in 2010 around 2 900 psychiatrists in private practice treated 330 000 patients (Schuler and Burla, 2012). Their caseload (115 patients per psychiatrist on average) is much lower than the caseload of the average GP (830 patients). While the number of treated patients in GP practices has increased by around 4% between 2006 and 2010, the increase in psychiatric practices was much higher at more than 18%. Compared with GPs, psychiatrists treat especially often patients with schizophrenic, neurotic and personality disorders. Psychiatrists can be accessed directly by patients within the mandatory health insurance, without GP referral. Some psychiatrists work together with psychotherapists, to whom they can delegate patients – enabling patients to be reimbursed for the costs by their health insurance (generally, the compulsory health insurance only covers the costs of psychotherapy provided by psychiatrists). Altogether, in 2010 around 4 000 psychotherapists provided treatment to clients with mental health problems; around one-third of the psychotherapies are paid out of pocket by patients.

Third, there are many outpatient psychiatric institutions in Switzerland (ambulatory care, day hospitals). According to Moreau-Gruet and Lavignasse (2009), there are around 500 units in 60 institutions with each unit treating between 11 and 65 patients per 1 000 population, depending on the canton. Altogether, an estimated number of around 175 000 cases are

treated by outpatient psychiatric services (Schuler and Burla, 2012; Moreau-Gruet and Lavignasse, 2009). The most treated mental health conditions in these services are neurotic, affective and substance abuse disorders.

Fourth, around 60 000 patients (around 80 000 cases) in 2009 were in inpatient treatment, around three-quarters of them in a psychiatric clinic and one-quarter in a general hospital. While the rate of hospitalised patients has not increased between 2002 and 2009 the *case rate* has, i.e. the same patients were re-hospitalised more often (Kuhl and Herdt, 2007). The main diagnoses in inpatient treatment are substance use disorders (in men), affective disorders (in women) and neurotic disorders. Treatment can take place in a psychiatric clinic or a specialised unit in a general hospital. There are also a lot of hospitalisations of patients with co-morbid mental and physical disorders in general hospitals. A somatic hospitalisation may provide the occasion to identify co-morbid mental disorders. Hospital doctors often perceive mental health problems in their patients. In a survey of patients of medical clinics of two general hospitals, doctors reported "relevant" mental disorders (which need treatment) in around 25% of the patients (Cahn and Baer, 2003). However, this early identification seldom leads to a referral to a specialist after discharge from the hospital.

GPs recognise mental disorders but treatment and referrals are scarce

The gap between the high rate of patients with a mental disorder and the low treatment rate in GP practices is not only due to a low recognition rate. In a Swiss survey of GPs about patients with depressive disorders, GPs reported 3.2 treated cases of depression per 1 000 patients. However, GPs estimated that around one in three of their patients have a depression, when including milder forms (Schuler and Burla, 2012). Because milder forms of depression can translate into more severe ones if untreated, there would be a potential if GPs intervened more often. A main problem still is that only 5-10% of people with a mental disorder discloses their illness to their GP and asks for treatment (Linden et al., 1996). Most substance use disorders on the contrary are treated by GPs, who are responsible for nearly 60% of all diagnoses for alcohol abuse disorders and for 70% of all other substance abuse diagnoses.

Only a minority of patients diagnosed with a mental disorder in a private practice is referred to a psychiatrist. For example, this occurs for only 20% of patients with a depressive disorder (Schuler and Burla, 2012). Referral from GPs to psychiatrists is influenced by different factors, e.g. patient preferences, whether GPs perceive treatment as their own duty and whether they see themselves as competent, whether there is good collaboration with psychiatrists at the local level, whether they are accessible without

excessively long waiting times, and whether the GP can expect the patient to be referred back to him or her (Spiessl and Cording, 2000).

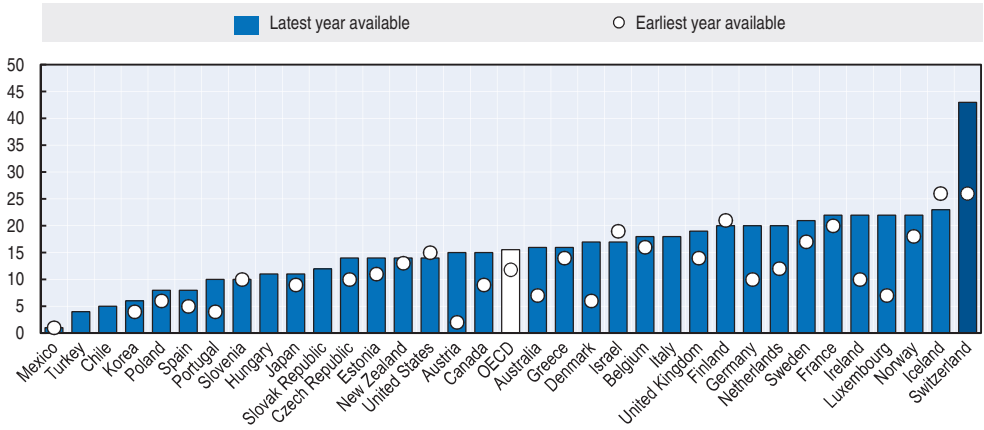
In a Swiss survey of around 550 patients in private practice (Cahn and Baer, 2003), GPs reported that 19% of their patients have a mental disorder which should be treated, and another 9% have a minor mental health problem. According to the GPs, only in the case of 15% of patients with a need for psychiatric treatment was a specialist involved, which equals 3% of the total number of patients in general practices. This very low number may indicate that there are some problems with the referral to psychiatrists.

High density of psychiatrists and psychotherapists in practice

An outstanding characteristic and potential of the Swiss mental health care system is the large number of psychiatrists in private practice (Figure 5.1). With almost 45 psychiatrists in private practice per 100 000 population Switzerland has three times more specialists than the OECD average. The high rate of psychiatrists per population suggests that psychiatrists in private practice are partly functioning as a first-line primary care service for people with a mental disorder.

Figure 5.1. **Extremely high rate of psychiatrists in Switzerland**

Density of psychiatrists per 100 000 population in OECD countries, earliest and latest years available



Note: The OECD average is an unweighted average.

Source: OECD Health Care Quality Indicators Data 2011, http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_REAC.

StatLink *http://dx.doi.org/10.1787/888932930214*

Despite a large supply, however, access to psychiatric services remains an issue. A recent Swiss study simulating clinical symptoms of an acute

depression and an acute psychotic disorder concluded that making an appointment with a psychiatrist is difficult, far more so than making an appointment with a GP (Bridler et al., 2012). Establishing a personal contact with a GP was possible in 95% of all cases, but only in around 50% of cases with psychiatrists. On average, seven phone calls were necessary to make an appointment with a psychiatrist, which was only possible with 30% of all of the contacted psychiatrists. The other psychiatrists were not reachable or not accepting new patients. The average waiting time for an appointment with a psychiatrist for an acute problem was around six days.

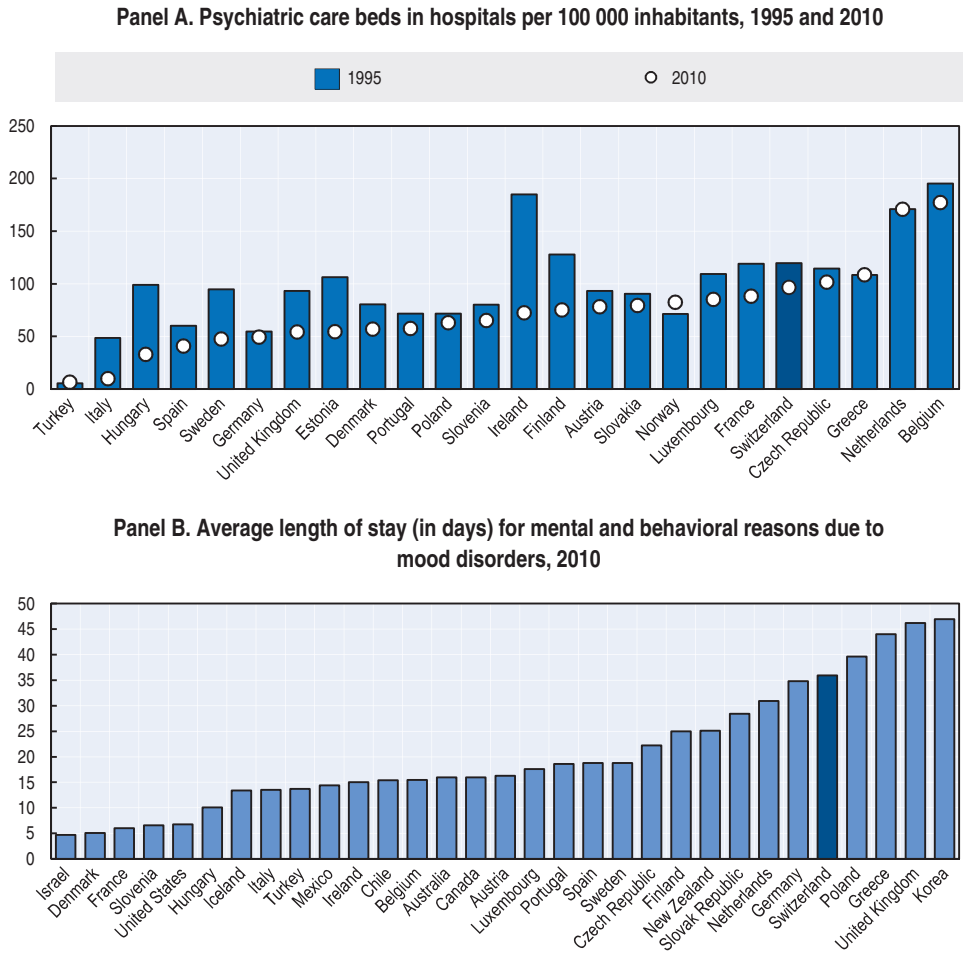
Another bottleneck for accessing psychiatric services is the long treatment duration in psychiatrist practices. A survey of psychiatrists in the canton of Bern (Amsler et al., 2010) showed that the treatment duration is around 60 months (i.e. the duration of the already realised treatment combined with the expected future treatment duration). Long treatment durations reduce access for new patients.

Switzerland also has a large number of psychotherapists, some 4000 across the country. Data about the number of psychotherapies provided, however, are not available and the overall contribution of psychotherapists to mental health care is therefore not measurable. Psychotherapists are currently not on an equal footing with psychiatrists regarding their health insurance status, i.e. the services they offer are not a part of the catalogue of services covered by mandatory health insurance. Only if a psychiatrist delegates a psychotherapy treatment to a psychotherapist is it remunerated by mandatory health insurance. A law about psychological professions has been put into force in 2013 which not only regulates the criteria and conditions to work as a psychologist in different areas but also clarifies the possibility of psychotherapists providing treatment at the expense of mandatory health insurance.

High inpatient resources make the system costly

Despite the high number of psychiatrists in private practice, Switzerland has the fifth highest rate of psychiatric beds and the fourth longest inpatient stay in the OECD in 2010. There are around 100 psychiatric inpatient beds per 100 000 population (Figure 5.2, Panel A) providing treatment over a relatively long duration, around 30 days on average over all mental illnesses and 35 days for mood disorders (Figure 5.2, Panel B). In contrast to many other countries, the bed rate per population has only moderately fallen since 1995. Longer hospitalisation does not necessarily improve outcomes; on the contrary, there is some evidence that shorter inpatient stays relate to better rehabilitative outcomes (e.g. with respect to independent living; Nordentoft et al., 2010).

Figure 5.2. **Very high inpatient mental health resources in Switzerland**



Source: For Panel A, New Cronos, Eurostat, http://epp.eurostat.ec.europa.eu. Panel B, OECD Health Care Quality Indicators Data 2011, http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_PROC.

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Switzerland is also different from many other OECD countries in that inpatient psychiatric treatment is usually detached from general hospitals and concentrated in separated public or private psychiatric clinics, often far away from the patients' workplaces. This may hinder people to seek treatment due to the fear of stigmatisation. It is easier to seek treatment in a general hospital in town than in a psychiatric clinic outside of the city, and

to disclose a stay in a general hospital than in a psychiatric clinic. Moreover, mental disorders are often co-morbid with physical disorders, suggesting that specialised treatment in general hospitals also providing somatic treatment would be more efficient.

Large differences between cantons in the use of inpatient care

Hospitalisation rates for mental disorders in Switzerland are in the range of one to four admissions per 1 000 of the population. Rates are high and increasing for substance-use and affective disorders, which are responsible for every second inpatient admission (Figure 5.3, Panel A). Rates for schizophrenia and neurotic disorders have remained stable.

The overall hospitalisation rates for mental disorders vary considerably across cantons, from around 20 admissions per 1 000 population in the cantons of Geneva and Basel-City to seven admissions in the rural cantons of Nidwalden or Schwyz in 2010 (Figure 5.3, Panel B). It is highly unlikely that these differences are fully explained by differences in illness incidence between cantons. It is more probable that differences are supply-driven and relate to different mental health care traditions, different quality of outpatient mental health care and rehabilitative care, and differences in access to care. In the past decade, hospitalisation rates have increased in 19 of 26 cantons. The average duration of hospitalisation also varies across cantons (Figure 5.3, Panel C).

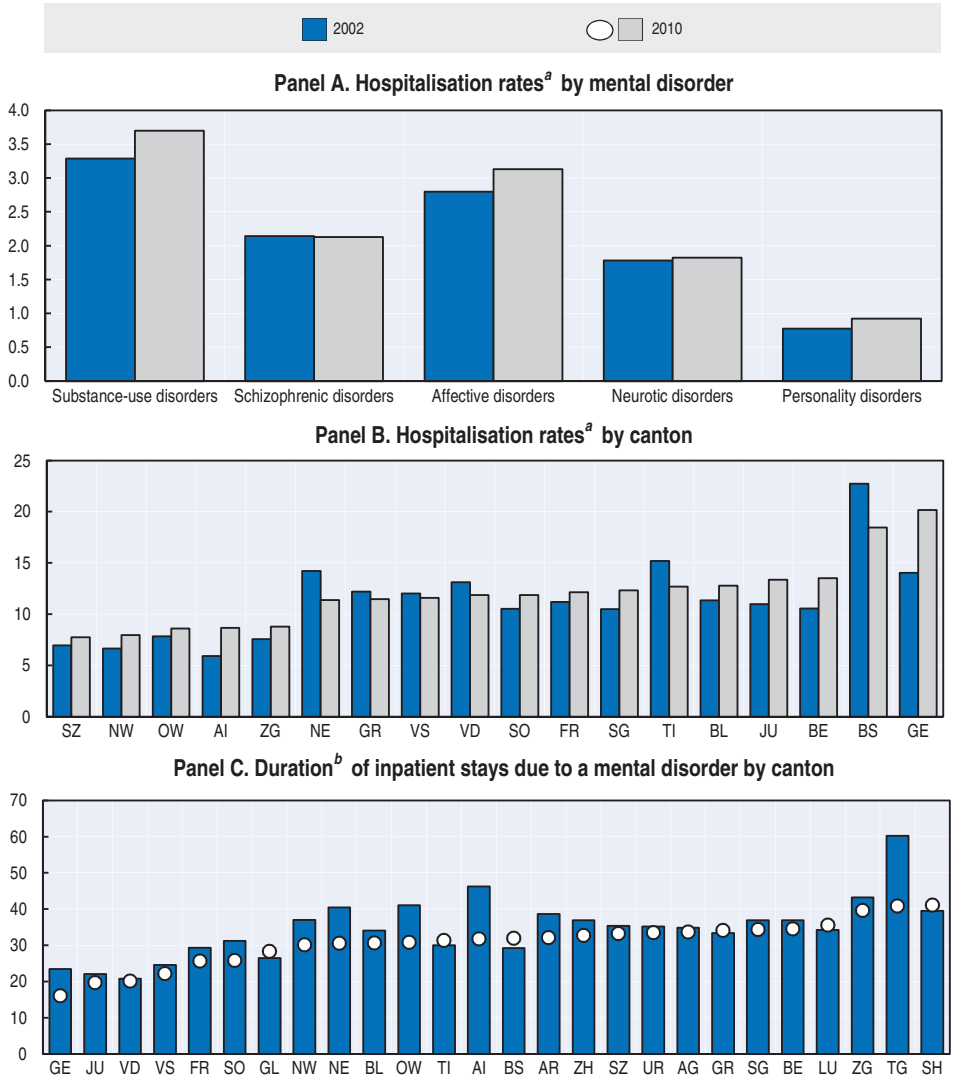
Readmissions in turn are relatively rare

Long treatment duration does not necessarily lead to significantly better improvement of symptoms. Lauber et al. (2006) analysed Swiss inpatient data and showed that the optimum inpatient length of stay for mood disorders is between 15 and 30 days. After this period symptoms do not improve any more but stay stable. The average length of inpatient stays for mood disorders in Switzerland of 35 days (Figure 5.3) suggests that a substantial proportion of patients with mood disorders stay in a psychiatric clinic for too long.

The long duration of inpatient treatments in Switzerland may have additional negative consequences on the employment situation of those undergoing treatment, first, because there is a long absence from the workplace among those who are still employed, and, second, because long inpatient treatments may increase avoidant behaviour (i.e. avoiding to return to the workplace out of fears of failure or conflict, etc.).

Figure 5.3. **Hospitalisation rates for mental disorders are generally rising but rates and durations vary considerably between cantons**

Rates per 1 000 population, persons aged 15-64



a. Hospitalisation rates are defined as the rate of hospitalisations in a psychiatric clinic or in a psychiatric unit of a general hospital within a year, per 1 000 population in a canton.

b. The duration refers to the average length of stay in a hospital in each canton.

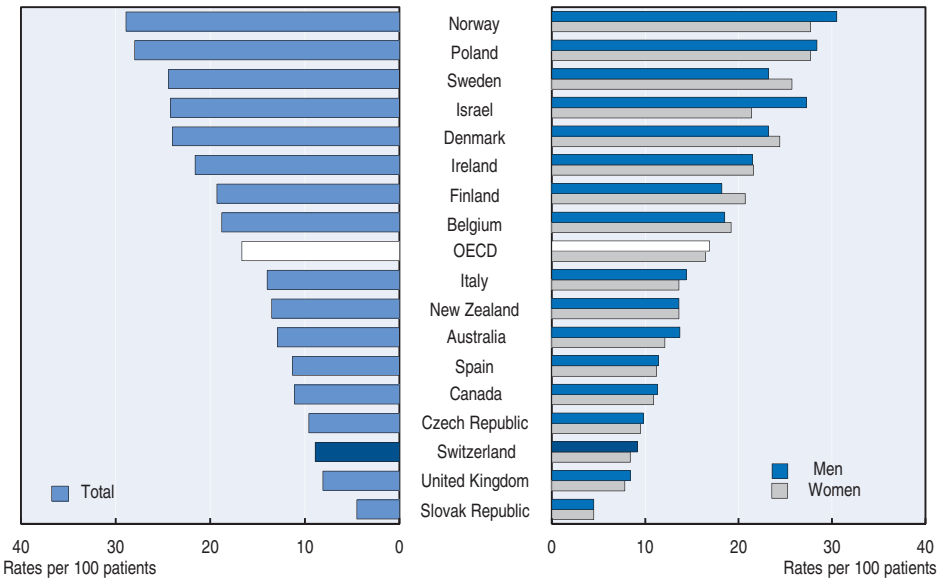
Source: Medical Statistics of the Hospitals 2010, Swiss Health Observatory, Obsan, Federal Office of Statistics.

StatLink http://dx.doi.org/10.1787/888932930252

On the other hand, readmissions of discharged psychiatric inpatients are rare in Switzerland, thereby supporting job retention among such patients. Less than 10% of schizophrenic inpatients are re-admitted within 30 days (Figure 5.4). This is around one-third of the rate in countries such as Norway, Sweden or Denmark, for example, which have a much shorter length of stay, and about the same as in the United Kingdom where inpatient stays are even longer than in Switzerland. However, there is evidence that length of inpatient stay and readmission are not necessarily related (see e.g. Hodgson et al., 2001), suggesting that it may be possible to reduce the duration of hospitalisation without risking to increase readmission rates.

Figure 5.4. **Few inpatient re-admissions in Switzerland**

Schizophrenia re-admissions to the same hospital, 2009 (or nearest year)



Source: OECD Health Care Quality Indicators, 2011, http://dotstat.oecd.org/Index.aspx?DataSetCode=HCQI_STAND.

StatLink http://dx.doi.org/10.1787/888932930271

An important factor for readmission is the quality of after-care in the community (Zhang et al., 2011). Thus, readmissions rates have to be valued against the background of the whole mental health care system. In Switzerland, the low readmission rate might be related to a well-functioning system of after-care in the community, including the high rate of psychiatrists in private practice.

While around 18% of patients are admitted to a psychiatric clinic due to their own or their relatives' initiative, and around 75% are admitted by GPs, after-care is mostly provided by private psychiatrists (around 40%) or an outpatient psychiatric institution (around 22%). The share of GPs treating patients discharged from a psychiatric clinic is around 13%. This implies that psychiatric clinics often initiate treatment or re-allocate patients from general to specialised care (i.e. from GPs to psychiatrist). But, in the other direction, psychiatrists do not refer substantial numbers of their patients to psychiatric clinics. This suggests that psychiatric outpatient treatment is effective in the sense that it prevents inpatient hospitalisations and that there might be further potential to scale back in-patient care by providing accessible specialist care without necessarily reducing the quality of care.

However, treatment availability in private psychiatrist practices also varies considerably across cantons with a high concentration of practices in a few urban cantons, e.g. more than one psychiatrist per 1 000 population in Basel-City and 0.67 per 1 000 in Geneva, and a much lower density in rural areas, as e.g. the canton of Uri with one psychiatrist per 30 000 population. In the latter regions, mental health care is therefore provided by GPs to a much larger degree.

The potential of day care is not fully used

Day hospitals for patients with acute mental health conditions, who are often still in employment, have a high rehabilitative potential (BAG, 2004; Cahn and Baer, 2003). Usually, personnel working in day clinics are interdisciplinary involving psychiatrists, psychologists, social workers, nurses and social pedagogues, and the needs of the patients are mostly at the interface between illness recovery and social or vocational re-integration. Furthermore, treatment duration in day hospitals is often around 3-6 months, allowing for a sound assessment of working problems and support needs, for executing training elements, and for preparing vocational re-integration, for example by initiating work trials or supporting job-seeking. Moreover, psychiatric day clinics cause significantly lower costs than full inpatient care (between one-third to one-half) while treatment outcomes are comparable, or, with respect to quality of life and social outcomes, probably better (Marshall et al., 2011).

However, unlike some well-researched day care facilities in the United States which have been transformed successfully into supported employment services (Becker et al., 2001), day care facilities in Switzerland do not target vocational integration. The programmes of day clinics in Switzerland mainly consist of therapeutic treatment and there are no employment specialists working in such day clinics. Hence, where available,

Swiss day clinics may be a good alternative to full inpatient care, but they do not use their potential with respect to social integration and employment.

Funding mechanisms favour inpatient care

The main reason for the high number of inpatient facilities in Switzerland – despite widely accepted guidelines by the Conference of the Cantonal Health Directors (GDK) to strengthen ambulatory and day care – lies in funding mechanisms favouring inpatient care (GDK, 2008). While outpatient mental health care, including day hospitals, is exclusively financed by health insurance (on a fee-for-service basis), around 50% of the costs of inpatient care are financed by the cantons, provided a hospital is on the cantonal hospital list. This considerable co-financing gives inpatient care much more financial freedom, and it provides strong incentives for health insurance to finance inpatient care. The cantons should have an interest in scaling down inpatient care but political barriers seem to blockade this.

High inpatient spending makes the system unnecessarily expensive. Moreover, from an employment perspective, these financial incentives and funding arrangements run counter to the more employment-friendly approach of outpatient services which: first, treat a clientele more often still in employment; second, usually treat patients with a better rehabilitative prognosis; and, third, are potentially more effective in supporting people to stay at work than more remote inpatient care.

Employed people prefer outpatient treatment

There is some evidence that patients still employed prefer outpatient crisis services over inpatient services. In a comparison of patients in need of crisis intervention, the degree of social integration in general and the employment situation of the patient in particular were shown to be critical for the choice of treatment (Krowatschek et al., 2012). Employment status and marital status are the most important factors differentiating inpatient from outpatient treatment – independent of the degree of functional impairment.

While inpatient care is effective in terms of symptom reduction, with comparatively low readmission rates in Switzerland, it is questionable whether inpatient hospitalisation serves the treated population well with respect to employment: around one-third of the inpatients partly employed at admission to the psychiatric clinic are unemployed when discharged (Baer and Cahn, 2008). Although this figure has to be interpreted with caution, it suggests that inpatient psychiatry is not the best approach to secure jobs.

Under-treatment is substantial – despite enormous resources

Despite large resources in specialised mental health care as well as in health care more generally, under-treatment remains considerable and is an important concern in Switzerland, as in other countries (Schuler and Burla, 2012). According to the Health Survey 2007, 5.3% of the population was in professional treatment due to a mental health problem in the past 12 months – mostly treatment by a psychiatrist (39%), a psychotherapist (34%) or a GP (21%). The treatment rate in 2007 was around one percentage point higher than in the first Health Survey in 1997 but still very low compared to the prevalence of mental disorders in the population, even if only every second person concerned would be in need of treatment. Rüesch et al. (2013) come to a similar conclusion. Around 480 000 people aged 14 and over are treated by specialised mental health care per year (data mainly from 2009); this corresponds to 7% of the population. Probably, the rate of treated persons who register for the disability insurance is significantly higher. However, the question remains how adequately these claimants have been treated. The generally moderate treatment prevalence also applies to employed people suffering from depressive symptoms (Baer et al., 2013). According to the Health Survey, only 9% of workers with mild depressive symptoms and 27% of those with moderate to severe depressive symptoms were in medical depression treatment in 2007 (mostly with a psychiatrist). In view of the prognostic importance of early treatment in order to stay in employment (see e.g. van der Feltz-Cornelis, 2010) the magnitude of under-treatment of both mild and severe depressive conditions in workers is worrying.

With respect to the screening of a Major Depressive Disorder (MDD) fulfilling the diagnostic criteria of DSM-IV, the same data show that 65-70% of those with at least one MDD episode in the past 12 months were not in treatment during this period (Schuler and Burla, 2012; Rüesch et al., 2013). Along with the discussion above, this suggests that, on the one hand, people who seek psychiatric or psychological care receive intensive and enduring treatment, while, on the other hand, the majority of the population with treatment needs is not reached by the mental health care system. This raises the question whether more collaborative models with psychiatrists consulting GPs might not only improve patients' functioning (van der Feltz-Cornelis, 2010) but also treatment take-up in patients with mental health problems.

Organisation and responsibilities of mental health care

Overall, a stronger employment focus is needed in treatment concepts of mental health care, including the development of employment-related quality indicators of care and bringing employment issues into the further

education of psychiatrists. However, the question arises at which political layer this should be done. In Switzerland, the confederation, the cantons and the municipalities are involved in legislation and provision of (mental) health care (OECD, 2011). The confederation has a legislative and supervisory role but it has no direct influence on mental health care structures or concepts. This results in a lack of a coherent steering competence. However, the authorities for medical education would be able to implement a more employment-oriented approach.

Rather weak steering at the national level

Recently, the parliament decided not to implement a proposed law on prevention and health promotion which would have given the confederation, i.e. the Federal Office of Public Health (FOPH), more means to intervene in health care. Employment-related issues of people with mental health problems are entirely left to the social insurance system, as reflected in the revisions of the disability insurance (IV) over the past nine years.

In 2013, the government decided on 12 priorities in health policy to be put in place in the coming seven years ("Health 2020" report). In order to tackle the expected increase in chronic non-communicable diseases due to changes in population structure, health behaviour and working life (e.g. higher expectations on workers) and the rise in related costs for health provision and social security, health policy should strengthen its focus on early identification of health-related problems in the workplace. A main focus should be given to people with mental disorders. The report criticises the health system for being too focused on acute inpatient care, neglecting prevention and early intervention, and for not being well co-ordinated.

In order to compensate for the lack of mechanisms to steer mental health care, the Federal Offices of Public Health, Economic Affairs and Social Insurances, together with the Conference of the Cantonal Health Directors (GDK) and the Swiss Foundation for Health Promotion, established a network for mental health. This network should function as an information platform for knowledge transfer and bring the different stakeholders from different government layers as well as different professional fields (mental health, primary care, prevention, health promotion) together. However, this network has no executive power for direct action. The network is also a consequence of earlier initiatives to establish a shared and coherent health policy, e.g. the "project for a national health policy" which started around ten years ago, but which has never been fully implemented. Within that project, recommendations for a national mental health policy and for mental health care were elaborated which initiated similar activities by the GDK, e.g. guidelines for cantonal mental health care planning (GDK, 2008). The

new network is a new attempt to bring different actors together but an information platform cannot compensate the lack of steering in a field which involves several actors with differing interests.

The FOPH also supported the implementation of the so-called "Alliances against depression" in ten cantons in the past ten years. These alliances aim to: educate GPs in identification and treatment of depressive disorders; raise the awareness of the population; educate other key persons (teachers, nurses, police officers, journalists etc.); and support people with depression and their relatives. While the alliances had some effect on public awareness, there is no evidence so far that the education objective has been achieved.

While the FOPH has no direct influence on health care provision, it is responsible for education, licensing and further education of mental health professionals. This responsibility might be a starting point for seeking to improve the mental health care system in terms of making it more responsive to the link to work problems and job retention of patients. By developing the evidence base of mental health problems at work, including evidence-based support concepts, and by integrating this evidence into the curriculum of physician training and further education of psychiatrists, the FOPH could have a considerable impact.

The cantons plan and provide mental health care

A very important layer in health care are the cantons which provide – and partly finance – inpatient health care services as well as services for people with disabilities, and are responsible for health care provision (inpatient and outpatient), prevention and health promotion. This results in Switzerland having 26 different mental health care systems, giving the GDK substantial importance in the planning of the future mental health care system.

The GDK has initiated the development of guidelines for psychiatric service planning (GDK, 2008), however, the guidelines do not consider employment issues or rehabilitative support needs at all. Nevertheless, the GDK has stated that mental health care is oriented too much on inpatient care and that the duration of hospitalisations should be reduced. According to the GDK, inpatient care takes up too large resources which might be used in a more effective way by expanding outpatient care.

Definitions and criteria vary across sectors

The interface between mental health care, rehabilitation services and social insurance is highly fragmented. An example of the fragmentation is the assessment for disability benefit eligibility by the cantonal IV offices

and the assessment of service needs of people with disability, a responsibility of the cantonal departments of education. In case someone is awarded a disability benefit and wants to work afterwards, the canton's education department is responsible for assessing the health-related needs for assistance, e.g. a place in a sheltered workshop, a supported housing facility, etc.

Due to a recent shift in the financial responsibility for people with disability from the confederation to the cantons, all cantons had to develop a concept for the care of this group. Most cantons are in the process of changing their funding system from object-financing (of rehabilitative institutions) to subject-financing (of people with disability). Consequently, the cantons have been elaborating new instruments over the past few years to assess the support needs of people with a disability.

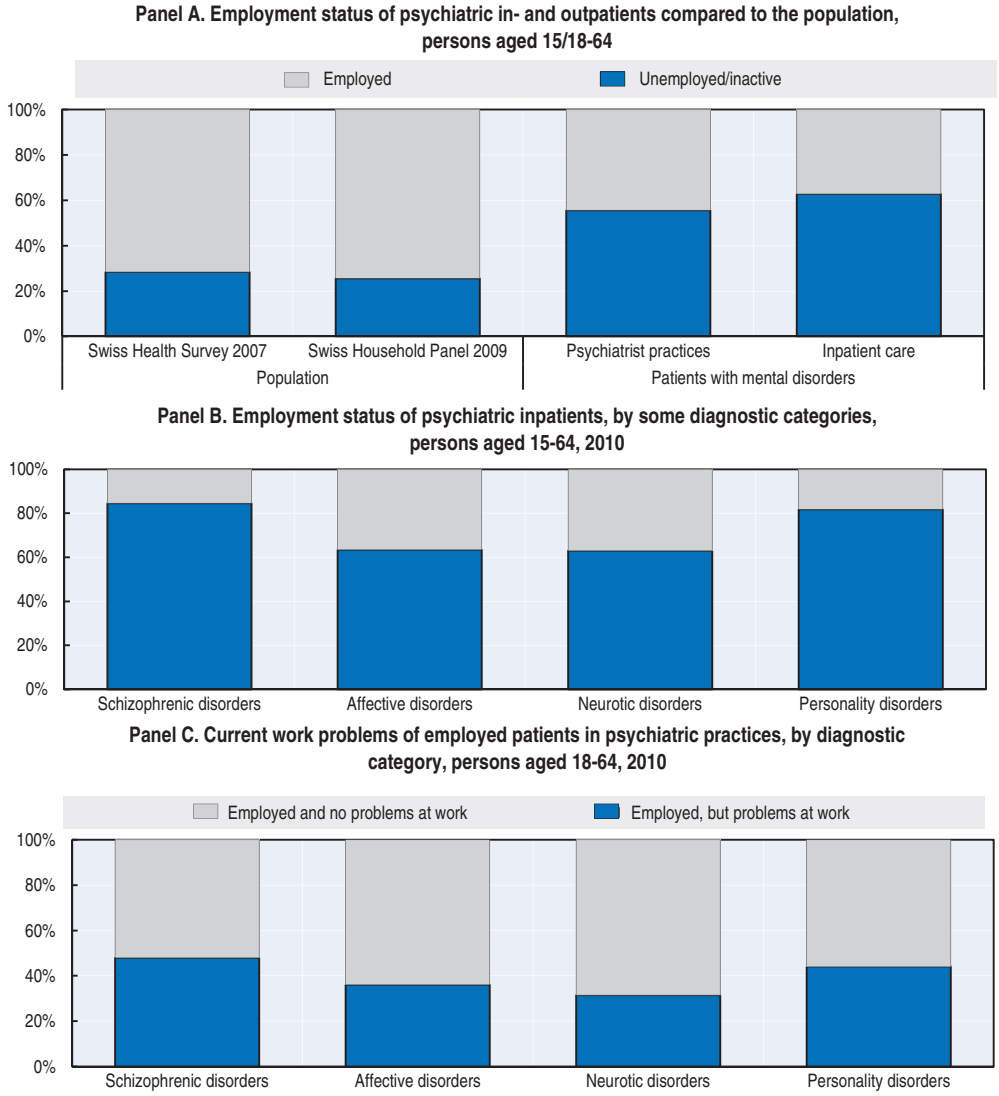
These new cantonal assessment instruments have been developed without co-ordination with the IV-offices, which – due to their responsibility for the assessment of a disability benefit entitlement – are well aware of the degree of impairment of a beneficiary, and, moreover, without any involvement of physicians or psychiatrists. The medical situation is given not much importance for the assessment of the rehabilitative needs of the person with disability.

Employment has a large impact on treatment outcomes

The employment situation of a patient is one of the most important determinants for the probability, the length and the outcome of inpatient admission (Kuhl and Herdt, 2007; Baer et al., 2013). Figure 5.5 (Panel A) shows that patients in psychiatrist practices and in clinics are seldom employed (around 40%), and those with schizophrenic or personality disorders are especially disadvantaged (Panel B). Both of the latter disorders usually have an early onset in childhood or young adulthood and may be very disabling due to cognitive deficits (schizophrenia) or interpersonal problems (personality disorders). For outpatients who are still employed, the picture is similar: those with schizophrenia or personality disorders have more workplace problems than those with affective or neurotic disorders (Panel C).

There is some evidence suggesting that the employment status of psychiatric patients has possibly an independent effect on treatment duration and recovery. Outpatients who are employed also have much shorter treatment durations than unemployed or inactive patients – independent of their illness severity (Figure 5.6, Panel A). Generally, the more severe the health condition is at treatment start, the longer the treatment and the larger the treatment effect, i.e. the improvement of symptoms. But, between patients with the same illness severity (assessed by the treating psychiatrist), the employment status makes a large difference.

Figure 5.5. **Unemployment is generally high in psychiatric patients, but diagnosis-specific differences are substantial**



Note: Substance-use disorders are missing due to n < 10 in this calculation

Source: Panels A and B, Baer, N. et al. (2013), "Depressionen in der Schweizer Bevölkerung", Schweizerisches Gesundheitsobservatorium; Panel C, OECD based on Amsler, F. et al. (2010), "Schlussbericht zur Evaluation der institutionellen ambulanten und teilstationären Psychiatrieversorgung des Kantons Bern unter besonderer Berücksichtigung der Pilotprojekte".

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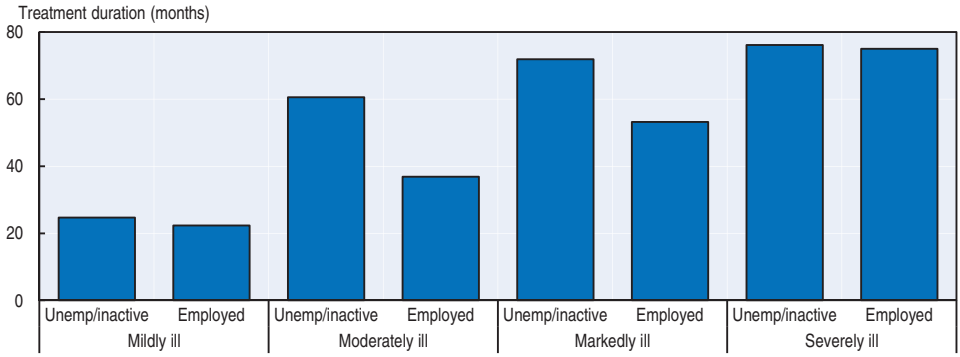
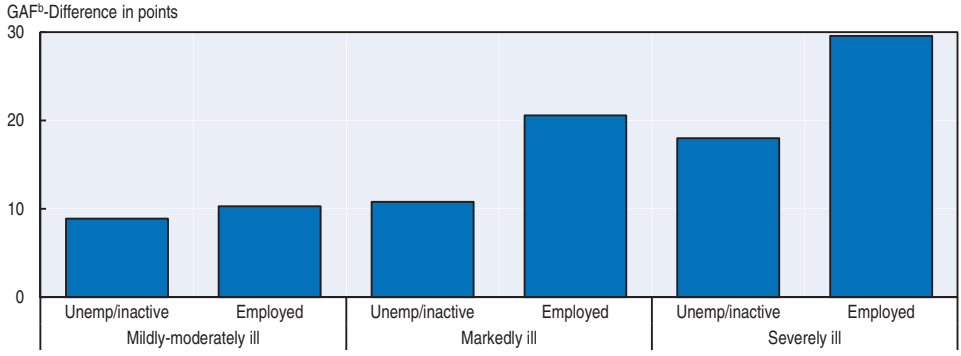
Figure 5.6. **Employed outpatients are treated shorter and recover better, independent from their illness severity**

Panel A. Treatment duration[a] of patients in private psychiatric practice, by illness-severity and employment status, persons aged 18-64, 2009



Panel B. Improvement of functioning since the beginning of treatment, by illness-severity and employment status



Note: Prevalence distribution: Mild-moderately ill (18%), markedly ill (51%), severely ill (31%).

a. "Treatment duration" is the sum of the months already in treatment and the expected number of months patients will stay in treatment in the future; it may comprise several treatment episodes.

b. The Global Assessment of Functioning Scale-GAF (DSM IV-TR) is a rating instrument for professionals to describe illness-severity and disability on a range from 0 (most severe) to 100 (no symptoms, superior functioning); the "GAF-Difference" means the difference in points on the GAF-scale between the current state and the state at the beginning of treatment

Source: Baer, N. et al. (2013), "Depressionen in der Schweizer Bevölkerung", Schweizerisches Gesundheitsobservatorium; calculations based on a survey of private psychiatrists in the canton of Bern [Amsler, F. et al. (2010), "Schlussbericht zur Evaluation der institutionellen ambulanten und teilstationären Psychiatrieversorgung des Kantons Bern unter besonderer Berücksichtigung der Pilotprojekte"].

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While the total treatment duration, i.e. the past and potential future duration, and the treatment outcome in private psychiatrist practices does not vary in mildly-ill patients with respect to their employment status, employment makes a huge difference for moderately and markedly-ill patients. The treatment duration of employed patients with a moderate mental disorder is more than 20 months shorter compared to the unemployed, and for markedly-ill it is more than 15 months shorter. Moreover, most employed patients make more progress in their recovery process than unemployed or inactive patients (Figure 5.6, Panel B). The same result has been shown for inpatients (OECD, 2012). This result has also been found by earlier research about the predictors of inpatient length of stay in Swiss psychiatric clinics, calculating regression models with the same hospitalisation data (Meyer et al., 1998).

While there may be different explanations for the strong relation between employment status, treatment duration and treatment outcome (e.g. that the measure of "illness-severity" may be limited due to its focus on an acute status), such results point to the importance of promoting job retention and quick moves back into work for those not employed.

Mental health care is not yet prepared for treating work problems

Although cantonal mental health care service plans in Switzerland are based on principles developed by social psychiatry emphasising the significance of social factors for the development, manifestation and outcome of mental disorders (GDK, 2008), mental health care structures are not systematically related to employers or vocational rehabilitation. Furthermore, there are neither principles nor tools for interventions for patients with health-related difficulties at work (Cahn and Baer, 2003).

With respect to patients who are unemployed or inactive but want to gain competitive employment, some psychiatric clinics have developed services based on the model of supported employment, e.g. in the psychiatric university clinics of Zurich (Burns et al., 2007), Bern (Hoffmann et al., 2012) or Lausanne. However, although these services have gained some popularity within mental health care, they i) do not serve a large population; ii) are often not well integrated into routine mental health care, and iii) often do not lead to financial independence from disability benefits. Most supported employment services are not provided by mental health care but by vocational rehabilitation institutions or sheltered workshops which have expanded their services over the past years. There is no systematic co-operation between these employment services and psychiatric institutions

and shared principles, e.g. on how best to assess work problems, plan rehabilitation and support job retention or re-integration are lacking. The psychiatric knowledge about functioning and deficits is not used in work-related services, and vice-versa.

There are several circumstances contributing to this fragmentation. First, rehabilitation professionals usually have a pedagogical background and often distance themselves from medicine in general and diagnosis in particular – in favour of emphasising the rehabilitation potential. Second, GPs and psychiatrists are not well trained in translating psychopathology into functional limitations, and underestimate how important their knowledge about symptoms would be for the assessment of work problems and the planning of rehabilitative interventions. Third, due to different funding arrangements and oversight by different authorities, there are no congruent quality indicators in place to ensure that psychiatric services focus on employment issues, or that employment services bother about the consequences of a mental disorder for work functioning.

The problem of insufficient information on functioning in doctors' reports was found repeatedly (e.g. Ebner et al., 2012). In the meantime, formal recommendations for physicians have been elaborated on how to assess disability e.g. emphasising the significance of a functional assessment and the underlying personality of the claimant. This seems to be a promising step, although it remains to be seen whether this approach delivers.

Beyond medical examination, psychiatrists usually do not seek contact with employers in case their patients are at risk of losing their job or having work problems (Baer et al., 2013). While around 40% of employed patients in private practice have problems at work (Figure 5.6, Panel C), psychiatrists seldom have a direct contact to the employer, only partly because patients do not want such a contact However, psychiatrists do have regular contacts with sheltered employment institutions. This suggests that psychiatrists care about the work situation of their patients, but only for those with severe disability and within a sheltered work framework. This raises the question as to whether psychiatrists feel ill-equipped to communicate with line managers and human resources professionals.

Physicians may be reluctant to give work-related information to the employer to secure the trust in their therapeutic relationship with their patient. However, work-related mental health issues are often not directly related to a specific workplace. It would be sufficient for psychiatrists to translate the predominant symptoms of the mental disorder (e.g. a lack of impulse-control in straining interpersonal situations) into a functional context (e.g. needing more individual work and reduced teamwork) and to let the employers translate this information into their specific work context.

Conclusion

Altogether, Switzerland has a well-functioning and differentiated mental health care system providing a broad range of generalist and specialist outpatient and inpatient services. Readmission rates of discharged inpatients are low compared to other OECD countries. A characteristic of the Swiss mental health care system is the high rate of psychiatrists in private practice; by far the highest in the OECD. Additionally, there are many psychotherapists and psychiatric institutions providing outpatient care.

However, this rich supply of mental health care services comes at a relatively high price: Switzerland invests a lot of financial resources into health care in general and especially into psychiatric hospitals. Mental health care traditionally has a strong inpatient focus with a high number of inpatient beds in psychiatric clinics and a long duration of inpatient hospitalisations, both significantly above the average of OECD countries.

While mental health care seems to be very effective in reducing symptoms, it lacks any links with the employment sphere thereby not doing justice to the strong positive impact employment can have in the recovery process and contributing little to securing existing employment. There are specific on-going problems and potentials which should be addressed in the future.

Integrate fragmented responsibilities

Many actors are responsible for mental health care in Switzerland, including the Federal Office of Public Health (FOPH), the cantons and the health insurance. Because mental health care also concerns patients with social and rehabilitation needs, the communities and the Federal Social Insurance Office (FSIO) are also involved. This fragmentation of legal and financial responsibilities hinders a coherent steering of the mental health care system. No entity is responsible for the interface between work and mental health. There are several efforts to compensate this fragmentation but more could be done in this regard.

- The FOPH should strengthen its steering competence by introducing mandatory employment-related modules in the education, licensing and further education of physicians in general and psychiatrists in particular. The Swiss institute for training and education which has the responsibility for the content of medical education and training should implement such a focus, together with the professional organisations of physicians and the academy of medical science.

- The FOPH should develop employment-related quality indicators for mental health professions.
- The FOPH, the GDK, the FSIO and the psychiatrists' and psychotherapists' associations should develop shared principles for effective health interventions to ensure job retention and re-integration, in co-operation with the employers' associations.

Strengthen the focus on employment issues

Although the working situation is crucial for the pace of illness recovery, mental health care providers do not see the employment situation of their patients as a high-priority problem.

- The FOPH and the GDK should develop employment-related guidelines for mental-health treatment, together with psychiatrists and GPs.
- Institutional inpatient and outpatient mental health care providers should develop support structures for employers in order to prevent longer absenteeism, job loss and disability.
- The development of formal guidelines for functional assessments by psychiatrists, recently initiated by the FSIO, should be broadened to also include work-related guidelines in general, including the handling of medical confidentiality and sickness-absence certification as well as the collaboration with employers and cantonal disability offices.
- Psychiatric clinics should be encouraged to develop an early screening of possible work problems and employment-related support needs of their newly-admitted inpatients.
- Cantons, health insurances and mental health care providers should develop criteria for inpatient and outpatient admission, with the aim to increase the relevance of day hospitals and outpatient care at the expense of unnecessary inpatient treatment.
- Psychiatric day hospitals should be encouraged to recruit employment specialists and to develop vocational rehabilitation measures within their treatment concepts.

Reduce under-treatment and inadequate treatment

Despite very high resources in specialised mental health care, treatment rates are not much higher in Switzerland than in other countries with much lower spending on mental health care. Psychiatrists treat a relatively low

number of selected patients over a long time; GPs treat only a small share of those patients who they are identifying as mentally-ill; and psychotherapists cannot treat enough patients due to structural funding problems.

- Cantons and health insurances should strengthen financial incentives to promote collaboration between GPs and psychiatrists in order to increase treatment up-take and treatment adequacy.
- GPs' and psychiatrists' associations should develop rules for mutual referrals between primary and speciality services.
- Health insurances, psychiatrists' associations and the FOPH should develop recommendations about typical and adequate treatment durations.
- The financing of psychotherapy should be simplified, and therapy be refunded under the mandatory health insurance scheme.

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Chapter 6

The capacity of the Swiss education system to manage mental ill health

This chapter assesses the capacity of the Swiss education system to provide support to vulnerable children and youth with a mental disorder during their school careers and transitions into the labour market. It first examines the effectiveness of the support measures and services available for students with a mental disorder and their teachers and parents. The chapter then discusses the school-to-work transition and addresses the problem of early labour market exit. It concludes by reviewing policies directed at the early identification of problems of mental ill health among school leavers and young adults.

Childhood and adolescence are crucial periods for the promotion of good mental health and the prevention of mental disorders. An extensive literature demonstrates that both biological factors and adverse psychosocial experiences during childhood influence child and youth mental health (see OECD, 2012a, for a discussion). Three-quarters of all mental disorders have their onset by the age of 24, one-quarter already by the age of 7 (Kessler et al., 2005). Most of these young people have a mild or moderate mental illness and can expect a productive life. Yet, their mental health problems can negatively affect their education, and consequently their social and professional life as adults. At the same time, there is a considerable lack of awareness, non-disclosure and under-treatment among adolescents and young adults, with the gap before the first treatment of a mental illness and its first onset being about 12 years on average (Kessler and Wang, 2008). Therefore, the education system has a potentially important role to play in early identification and support of children with mental health issues.

In Switzerland, the main responsibility for education (including special needs education) lies with the 26 cantonal authorities. As a result, the institutional set-up of the education system, which is adapted to local conditions and needs, varies considerably across the country. Cantonal policies are to some extent co-ordinated at the national level by the Swiss Conference of Cantonal Ministers of Education (EDK). In particular, two inter-cantonal agreements have been signed by a majority of the cantons to ensure the harmonisation of structures and objectives, i.e. the Inter-cantonal Agreement on Harmonisation of Compulsory Education (HarmoS Agreement, in force since mid-2009) and the Inter-cantonal Agreement on Special Needs Education (in force since 2011). [1]

Comprehensive service provision in schools

A variety of support measures and services are available in schools or in co-operation with schools, including psychological services, social work services, child and adolescent psychiatric services, therapeutic and pedagogical measures (such as support teaching and psychomotor support), as well as specific programmes targeted at children and youth with behavioural and emotional problems (e.g. Trialog in the city of Winterthur in the canton of Zurich).[2] Each canton is, however, fully free to decide about the type and amount of services offered and no national inventory of the existing programmes is available.

Psychological services are available free of charge for parents, students and teachers to provide help with questions and problems related to the children's development and education. These psychological services are typically co-located physically with the pedagogical and psychiatric services, outside the normal school environment.

School social work services provide low-threshold support to students with social problems and are typically located on the school premises (mainly at the secondary-school level). School social services are, however, decided at the municipal level and not available in all schools.[3] Depending on the municipality, school social workers are hired by the department of social affairs, the department of education or the schools directly. Only a few cantons, e.g. the canton of Bern, have developed their own regulations mandating municipalities to provide school social work and to cover fully or partly all relative expenses. As a result the type and amount of services provided by school social workers vary greatly across Switzerland. Very few schools achieve the ratio of one full-time school social worker per 400 students, as recommended by Avenir Social, the Social Work Association of Switzerland. More commonly, there are 1 000-1 500 students per social worker (Baier and Heeg, 2013).

Despite the range of available services, there is no common framework for mental health promotion and prevention of mental ill-health in schools. It is up to individual schools to introduce their own measures. To some extent, social workers can take up this role, but this depends on the amount of time they have available to work on this. At the national level, two web-based programmes for adolescents exist (i.e. feel-ok.ch and tschau.ch). Some cantons have their own programmes, e.g aus"weg'los! in the canton of Bern and PréSuiFri in the canton of Freiburg.

For students with assessed and diagnosed special needs, three compulsory education options are available: regular classes with individualised support, special needs classes in mainstream schools and special needs schools. The Inter-cantonal Agreement on Special Needs Education sets out the basic provisions, including counselling, support and therapy, as well as quality standards for service providers and a standardised evaluation procedure for the determination of individual needs.

While there are no national statistics available on the programmes and services offered to students with special needs in mainstream schools,[4] the number of students attending special classes and special schools – respectively 2.1% and 3.3% of all students in compulsory education in Switzerland – is relatively high in comparison with some other OECD countries (Table 6.1). These shares vary significantly from canton to canton, ranging from 1.8% in Valais to 8.7% in Basel-Country (Federal Statistical Office).[5] Children with a migration background are three times more likely than Swiss children to be assigned to a special needs class (SCCRE, 2011). As a result, foreign nationals account for 45% of the students in special needs classes compared with 22% in mainstream classes.

Table 6.1. **Switzerland has a relatively high share of students with special needs**

Number of students with special needs and the relative importance of the special education system, school year 2008-09[a]

	Total number of students	Students with special needs as a percentage of total students			
		All	In special education	In segregated special classes in mainstream schools	In mainstream schools
Austria	802 519	3.6%	1.5%	0.1%	2.0%
Belgium – Fl. Community	863 334	6.6%	5.5%	-	1.1%
Belgium – Fr. Community	687 137	4.5%	4.5%	-	0.0%
Denmark	719 144	4.7%	1.8%	2.6%	0.3%
Netherlands	2 411 194	4.3%	2.7%	-	1.6%
Norway	615 883	7.9%	0.3%	0.9%	6.7%
Sweden[b]	906 189	1.5%	0.1%	1.5%	-
Switzerland[b]	777 394	5.4%	2.1%	3.3%	-
United Kingdom	9 297 319	3.4%	1.2%	0.2%	2.0%

a. The data for the Netherlands and Norway refer to the school year 2009-10, and those of the Flemish Community in Belgium to the school year 2010-11.

b. Data on students with special education needs who are fully included in mainstream classes are not collected in Sweden and Switzerland.

Source: OECD calculations based on data from the European Agency for Development in Special Needs Education, www.european-agency.org.

StatLink http://dx.doi.org/10.1787/888932930518

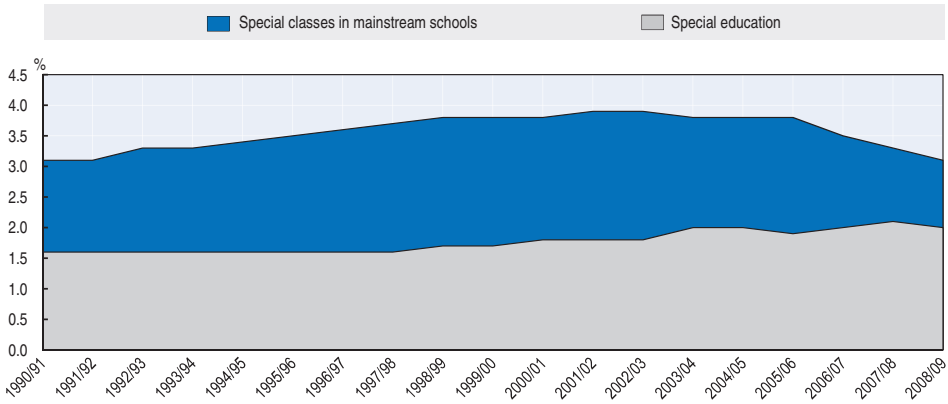
Special schools have the advantage of providing specialised and individual support in a protected environment. However, the disadvantage of such segregation is a risk of further marginalisation, hence jeopardising the students' social integration and a successful transition into the regular labour market later in life (OECD, 2008).

In recent years, the integration of children and adolescents with special educational needs into mainstream schooling has become more important, based on the Federal Law on Equal Rights for Persons with Disabilities and the Intercantonal Agreement on Special Needs Education. These efforts are reflected in the falling number of students in special classes from 2005 onwards (Figure 6.1). Most cantons have developed regulations and guidelines and now offer corresponding provisions to support students in regular schools (European Agency for Development in Special Needs Education, 2013). Since the transfer of all responsibilities over special education schools and special needs measures from the federal to the cantonal authorities in 2008, the cantons

have more flexibility to establish models of schooling that match their demographic and geographic structure. Nevertheless, for pupils with more severe disabilities, integration remains quite rare and the number of students attending special schools has not changed much over the past decade (Figure 6.1). Pupils with behavioural problems tend to be less frequently integrated than pupils with learning problems (European Agency for Development in Special Needs Education, 2013).

Figure 6.1. **Declining number of students in special needs education**

Number of students in special needs classes and schools as a percentage of the total number of students in compulsory education in Switzerland, 1990/91-2008/09



Source: OECD calculations based on data from the Federal Office of Statistics.

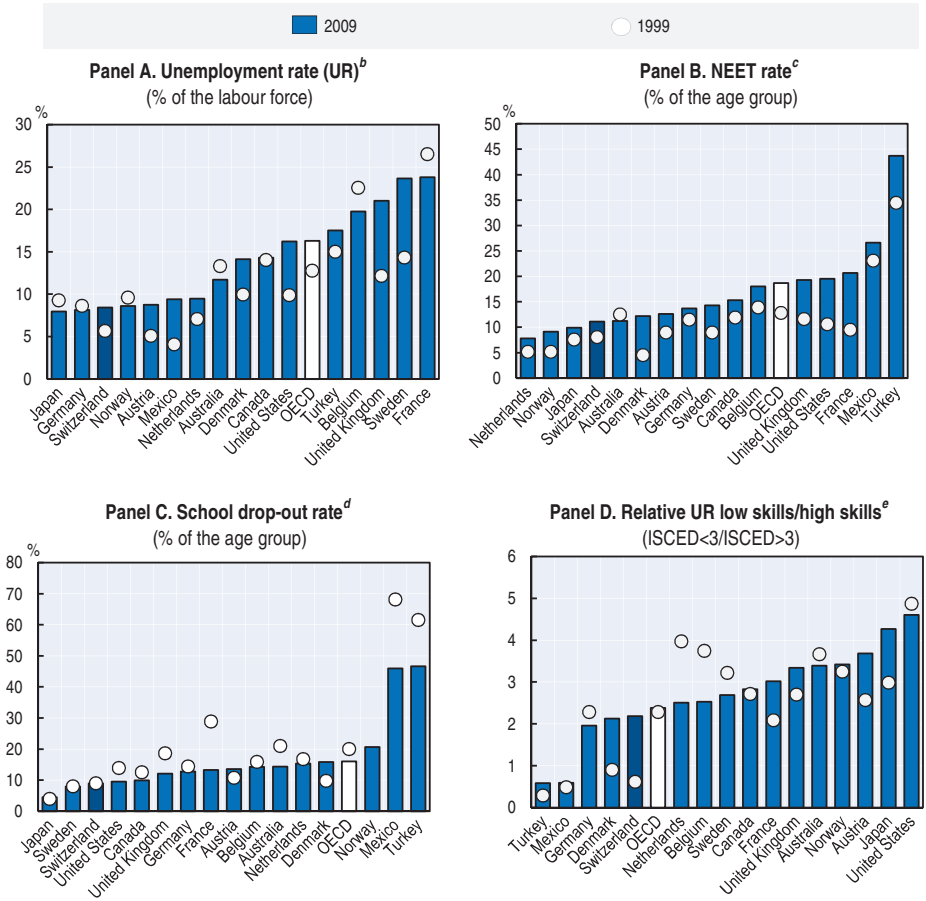
StatLink http://dx.doi.org/10.1787/888932930328

Smooth transition from school to work except for low-skilled youth

The Swiss education system is unusually successful in assuring a smooth transition from education to work for most youth. The unemployment rate for youth aged 15-24 was 8.4% in 2012 – among the lowest in the OECD area and well below the OECD average of 16.3% (Figure 6.2, Panel A). Also both the school drop-out rate – i.e. the share of youth not in education and without upper-secondary education – and the so-called NEET rate – i.e. the share of youth not in employment or in education or in training – are low compared with other OECD countries (Figure 6.2, Panels B and C).

Figure 6.2. **Labour market outcomes are very good for youth in Switzerland, except for young people with low skills**

Key labour market and education indicators for youth aged 15-24[a], 1999 and around 2010



a. Youth aged 16-24 for Sweden, the United Kingdom and the United States

b. Latest data refer to 2012.

c. Not in Employment or in Education or Training (NEET). Latest data refer to 2010.

d. Number of youth aged 20-24 who are not attending school and have not obtained an upper secondary education over all youth aged 20-24. Latest data refer to 2009.

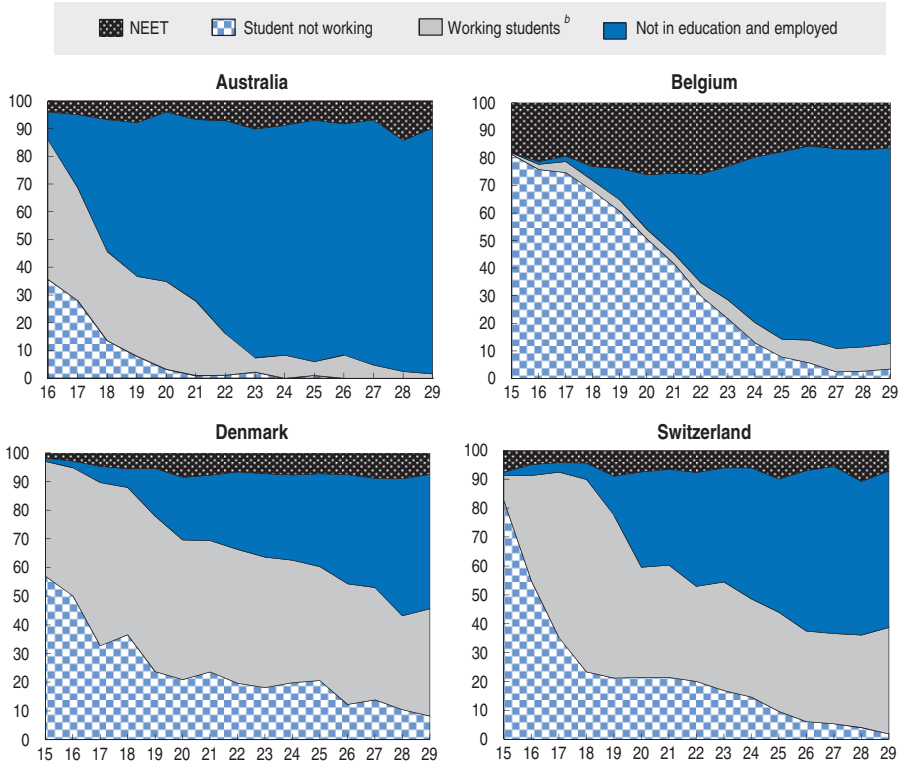
e. Unemployment rate of persons who have not attained upper secondary education over the rate of those who have attained upper secondary education. Latest data refer to 2009.

Source: Panel A: *OECD Database on Unemployment by Duration*, http://dotstat.oecd.org/Index.aspx?DataSetCode=DUR_I; Panels B-D: OECD (2010), *Off to a Good Start? Jobs for Youth*, Table 2.1, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264096127-en.

StatLink *http://dx.doi.org/10.1787/888932930347*

Figure 6.3 **Full-time students versus other categories (working students, employed, NEET)**

Study and activity status by single year of age: full-time students, working students, employed, and not employed and not in education (NEET); selected countries, 2009[a]



a. 2006 for Australia.

b. Including apprenticeship and other work-study programmes. Data on studying (working or not) also include training at upper-secondary or tertiary level started at a later point in life.

Source: OECD calculations based on the European Labour Force Survey 2009 for Belgium, Denmark and Switzerland and Household, Income and Labour Dynamics in Australia Survey 2006 for Australia.

StatLink http://dx.doi.org/10.1787/888932930366

The well-developed upper-secondary vocational education system contributes significantly to these favourable results (Fuentes, 2011). Around 90% of those aged 25-34 have obtained at least an upper-secondary degree, considerably more than the OECD average of 82% in 2010 (OECD, 2012b). The majority of them opt for the dual vocational system, which combines workplace-based vocational training with 1-2 days per week of school-based

education, including both general education and professional skills (Hoeckel et al., 2009). This is reflected in Figure 6.3, which illustrates the pathways from education into employment for Switzerland and three other countries – Australia, Belgium and Denmark – which present very different transition patterns.

At the age of 18, two-thirds of the Swiss youths work while studying, a much higher share than in the other countries. As a result, most of those leaving the education system have accumulated considerable work experience which facilitates their school-to-work transition (Beffy et al., 2009; Murier, 2006).

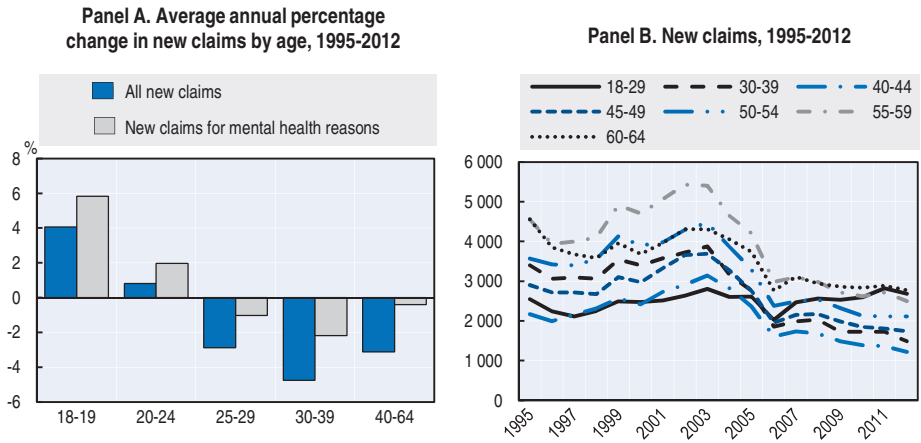
Despite very good overall outcomes, labour market outcomes have deteriorated for low-educated youth. The unemployment rate for youth aged 15-24 without upper-secondary education rose from 13% in 1999 to 30% in 2010, while the unemployment rates for medium-skilled and high-skilled youth were both around 9% in 2010 (OECD, 2012b). The relative unemployment rate of low-skilled to high-skilled youth is now close to the OECD average (Figure 6.2, Panel D). Given the high prevalence of mental disorders among low-skilled people in Switzerland (see Figure 1.2 in Chapter 1), deteriorating labour market outcomes may affect this group particularly hard. Also immigrant youth are overrepresented in the group of early school leavers (Fuentes, 2011, and Liebig et al., 2012).

Rising flow of youth onto disability benefits

While the transition from education to employment is rather smooth in Switzerland in general, there has been an increase in claims for disability benefits at a young age over the period 1995 to 2012 compared with a decline for the older age groups (Figure 6.4, Panel A). The increase in new claims was particularly large for youth with a mental disorder, whereas it remained generally stable for all other age groups. In addition, nearly all young claimants are granted a full disability benefit (Figure 6.5).

Recent reforms of the disability benefit system were very successful in general in curbing the large number of disability benefit claims, but less so for young people. For ages 30 and over, the number of new claims fell sharply from 2003 to 2006 and more or less stabilised or declined somewhat further thereafter, while claim numbers for young adults were much less affected by the reforms (Figure 6.4, Panel B). The increase among youth reflects an OECD-wide phenomenon and requires further attention by policy makers (OECD, 2012a).

Figure 6.4. **New disability claims are rising among youth but declining among other age groups**

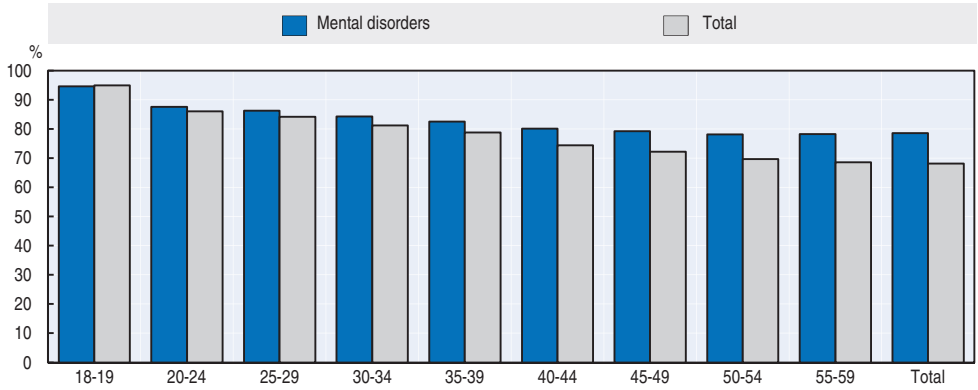


Source: OECD calculations based on data from the Federal Social Insurance Office.

StatLink http://dx.doi.org/10.1787/888932930385

Figure 6.5. **Young claimants with a mental disorder typically receive a full disability benefit**

Share of disability benefits with an incapacity degree of 70-100%, by age, 2012



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

StatLink http://dx.doi.org/10.1787/888932930404

The reasons behind the rise in new disability benefit claims among youth in general and those with mental health problems in particular are

related to a number of factors. First, experiences in other OECD countries suggest that higher demands in the labour market are part of the difficulty young people with mental ill-health are facing in accessing the job market. As youth with mental disorders are highly overrepresented among low-skilled people in Switzerland, even more than in other countries, the worsening labour market conditions for this group may push them onto disability benefits. Second, the disability benefit level is high relative to the wage these young people could earn in the labour market. Financial disincentives to work are thus substantial among youth with difficulties to enter the labour market. Finally, there has been a strong increase in the number of diagnosed attention deficit hyperactivity disorders (ADHD) among young people. Bänziger and Gölz (2011) argue that this phenomenon is related to the high number of child and adolescence psychiatrists in Switzerland and the general medicalisation of problems of young people, i.e. changes in values and medical practices that have produced an elevated diagnosis of ADHD and other "fashionable" illnesses, in turn producing a fast increase in disability benefit claims among young people.

Contrary to other countries, there does not seem to be a direct link in Switzerland between special schooling and disability benefits. Pupils who received special schooling benefits from the disability insurance do not automatically transfer onto disability benefits once they reach adulthood. Table 6.2, Panel B, shows that 62% of those who received special schooling at the age of 15 had not received a disability benefit by the age of 20. Conversely, around 67% of the new disability benefit entrants in 2012 (70% among those with a mental disorder) did not receive special schooling at the age of 15 (Table 6.2, Panel A).

However, it might be that the link between special schools and disability benefits is more complex or indirect. Switzerland has a very large, expensive and rather outdated sheltered employment sector which seems to act as a bridge into disability benefit dependency. According to Bänziger and Gölz (2011), 97% of those people having a sheltered training place eventually end up on a lifetime disability payment. If most of those with special schooling benefits are transferred into sheltered employment, the results shown in Table 6.2 will be misleading because nearly all of these young people will receive a disability benefit sooner or later.

Table 6.2. **Students with special schooling benefits do not automatically transfer onto disability benefits**

Panel A. Percentage of new disability benefit claims in the age category 18-24 by health condition and receipt of special schooling benefit at the age of 15

Special schooling benefit at the age of 15	New disability benefit claims in 2012		
	Mental disorders	Other conditions	Total
Yes	30%	37%	33%
No	70%	63%	67%
Total	100%	100%	100%

Panel B. Share of special schooling benefit recipients at the age of 15 in 2007 who received disability benefits in 2012, by health condition

	Disability benefit recipiency in 2012			Total
	Mental disorders	Other conditions	No benefit	
Special schooling benefit at the age of 15 in 2007	15%	23%	62%	100%

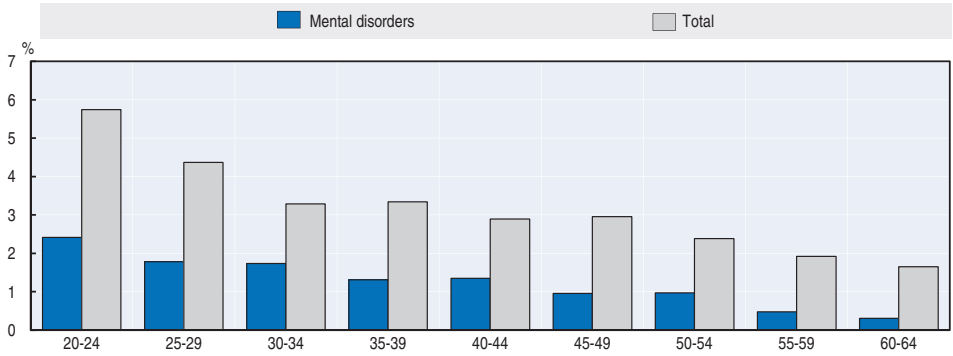
Source: OECD calculations based on data from the Federal Social Insurance Office.

StatLink http://dx.doi.org/10.1787/888932930537

As discussed in OECD (2012a), giving youth with mental health problems access to a long-term benefit may permanently trap them in inactivity and poverty. The probability of returning to work is low once a disability benefit is awarded. Indeed, less than 6% of youth aged 20-24 left the Swiss disability benefit system in 2011 (Figure 6.6). The outflow is much lower for youth with mental health problems. Yet, mental health problems are typically fluctuating in nature, and with the right treatment, services and support, most mental health problems in youth can get better (see Chapter 5). To avoid long-term benefit dependency, it is thus important not to grant disability benefits too early in life and that these youngsters receive adapted support and strong reintegration measures.

Figure 6.6. **People rarely leave a disability benefit, especially when they have a mental disorder**

Outflows of persons with a mental disorder and total as a share of total disability recipients by age, 2012



Note: Outflows for reasons other than death or transfer to old age pension.

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

StatLink http://dx.doi.org/10.1787/888932930423

Supporting the transition into the labour market

The recent reforms in the Swiss disability benefit system target the inflow streams through early intervention with a stronger role for employers, sickness insurers, public employment services (PES), and the individuals themselves (see Chapters 3 and 4). Yet, young people are unlikely to participate in such early intervention measures as the stakeholders involved in decisions to assign people to these measures have little incentives to report potential cases of young people with mental health problems to the disability insurance: young employees typically have a short tenure implying low firing and sickness insurance costs for employers; the young unemployed are generally not entitled to active labour market programmes of the PES as they do not fulfil the minimum contribution requirements; and, finally, youth without work and income do not necessarily apply for benefits as they can (temporarily) continue living at home with their parents.

To improve early identification and avoid life-long benefit dependency, there is a need for better transition services for youth with mental disorders, and in particular for those coming from the mainstream school system. While lots of resources are available for children and youth at school, very little support is available once they leave school. Youngsters dropping out of post-compulsory schooling (between age 15 and 18) are not followed up and

no support is provided for them for the transition into the labour market. Also vocational education and training (VET) case management for difficult students – students aged 13 to 25 who have problems at school and who are at high risk of dropping out receive guidance and are closely followed by a case manager – stops at the moment they receive their diploma. The situation is slightly better for those dropping out from the vocational system. Professional inspectors of the responsible canton try to avoid termination of apprenticeship trainings but, nevertheless, only limited tools are available if termination does occur.

While school drop-out is low in Switzerland compared with many other countries, in the past few years efforts have been made to increase the proportion of each cohort completing secondary education from 90% to 95%. Since 2008, VET case management is being implemented in each canton, with financial support from the federal government (Landert, 2011). The aim being that youth dropping out of the education system are guided by a case manager in their career planning and helped through co-ordination of available social and other support measures. The ultimate aim is that every youth dropping out from either higher secondary school or vocational training is being notified to the cantonal case management unit.

No data is available on the prevalence of mental disorders among school drop-outs, but young people with mental disorders are highly overrepresented among those with a low level of educational attainment. Moreover, most available case-management services are not specialised in addressing mental health problems, or in fact not paying attention to such problems in any way. As a result, mental health issues often remain unaddressed even though they will often have been the root cause of premature school leaving.

Conclusion

Switzerland has a wide range of services for children and youth with special needs both in specialised schools and classes and in the mainstream school system, including psychological and psychiatric services, social work services, as well as therapeutic and pedagogical measures. Children with a diagnosed mental illness in need of support are thus likely to have access to specialised services, although a national overview of the existing programmes is not available and practices may vary significantly across municipalities and cantons. Nonetheless, over-identification and segregation into special classes and schools could weaken rather than strengthen these pupils and should therefore be avoided.

In general, Swiss youth seem to experience little difficulties in transitioning from school to work, in part thanks to the well-developed

vocational education system and the tendency to combine school and work. Nevertheless, labour market outcomes have worsened over the past decade for low-skilled youth, a group which has a significantly higher rate of mental disorders. Also new claims into the disability benefit system have kept rising among youth, in contrast to other age groups. These outcomes call for more attention to the needs of youth with mental disorders who are more likely to leave the education system without an upper-secondary diploma and therefore experience difficulties entering the labour market.

In particular, services for youth who drop out from school are underdeveloped and the few services that are available do not address problems in an integrated way. In addition, the relatively high special disability benefit for young people with congenital disability discourages them from entering the labour market. Recent disability benefit reforms helped reduce the number of benefit claims through a new focus on early identification and intervention, but this approach has not helped young people who never entered the open labour market. For this group, other means and tools will have to be developed – with schools and transition services taking the role of employers and sickness insurers.

Make the comprehensive school resources more effective

- *Promote mainstream schooling.* Keep students with special needs, in particular those with behavioural problems and mental ill-health, in the mainstream school system to promote their social integration and develop support measures targeted at their needs.
- *Take stock of available support measures*. A national inventory of the existing support programmes for pupils with health problems (and other special needs) would facilitate the sharing of best practices across cantons and across schools.
- P*rovide a framework for intervention.* Schools need more information about the set of services they should have, and for which children services could be used and in what way. In this regard, it will also be important to better co-ordinate the various services that are available.

Promote a better transition into the labour market

- *Develop transition services for school leavers.* Provide support for vulnerable youth to enter the labour market. Assure close co-operation of VET case managers with both the PES and the disability insurance.

- *Address mental health issues among early school leavers*. The high prevalence of mental illness in the population with uncompleted education should be addressed, by involving health services in both VET case management and school-to-work transition services.
- *Avoid disability benefit claims of young people.* Strengthen work incentives for young people to make sure work always pays. To achieve this, disability benefit should be phased out gradually when work is taken up, and the payment level also needs reconsideration (e.g. the initial payment level may be too high for the youngest and could increase with age).

Notes

1. By 2013, 15 of the 26 cantons adopted the Inter-cantonal Agreement on Special Needs Education (see www.edk.ch/dyn/19100.php – accessed 24 September 2013). Also the HarmoS Agreement was adopted by 15 cantons – though different ones (see www.edk.ch/dyn/12536.php – accessed 24 September 2013).
2. www.trialog-winterthur.ch/ (accessed 4 March 2013)
3. By the end of 2009, there were approximately 450 school social workers employed in approximately 1 000 schools (Baier and Heeg, 2013).
4. The Federal Statistical Office of Switzerland is currently setting up a new data collection system which intends to collect information about the integration of students with special needs in mainstream schools. The first data collection is planned for the school year 2014-15.
5. The large differences in the share of students in special classes or schools are in part related to the cantons' geographical situations – e.g. Valais is less densely populated and thus needs to rely more on integrated schooling – but also to the approach taken – e.g. Ticino, located in the Italian-speaking part of Switzerland, followed to some extent the Italian model of integration with teacher and pupil support in mainstream schools and has no educational segregation for the less severe forms of special needs (SCCRE, 2011).

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Mental Health and Work

SWITZERLAND

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Further reading

Sick on the Job? Myths and Realities about Mental Health and Work (2012)
Mental Health and Work: Belgium (2013)
Mental Health and Work: Denmark (2013)
Mental Health and Work: Sweden (2013)
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