

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
<p>1. Employers are not well-equipped to deal with mentally-ill employees and sickness monitoring and management practices are highly variable.</p>	<ul style="list-style-type: none"> • Give employers adequate tools and supports to address psychosocial risks at work. • Monitor workplace <i>outputs</i> (e.g. staff turnover and sickness absence) rather than <i>inputs</i> (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.
<p>2. The disability system is still giving too little attention to the role of employers and the work incentives of employees.</p>	<ul style="list-style-type: none"> • 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.
<p>3. Public employment services (PES) and social welfare offices provide limited support to people with mental disorder.</p>	<ul style="list-style-type: none"> • 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
<p>4. Inter-institutional co-operation (IIZ) falls short of the actual problems.</p>	<ul style="list-style-type: none"> • 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 <i>within</i> the institutions involved.
<p>5. The large resources available in the mental health care system should be allocated so as to deliver better outcomes.</p>	<ul style="list-style-type: none"> • 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.
<p>6. Ineffective use of school resources to address school drop-out and frequent transitions onto disability benefit.</p>	<ul style="list-style-type: none"> • 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.