MENTAL DISORDERS AS A MAJOR CHALLENGE IN PREVENTION OF WORK DISABILITY

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Mental disorders as a major challenge in prevention of work disability: experiences in Finland, Germany, the Netherlands and Sweden

Edited by
Jorma Järvisalo, Björn Andersson
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Irene Houtman

YHTEENVETO
Mielenterveysongelmat – työkyvyttömyyden ehkäisyn suuri haaste: Suomen, Saksan, Alankomaiden ja Ruotsin tilanteesta

Helsinki 2005

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Abstract

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The current publication has its background in observations that the role of mental ill-health in causing sickness absenteeism and work disability may be increasing in Europe. Prompted by this, researchers from four European countries, all of whom are active in social insurance related research in their respective countries, committed to the idea of preparing country reports that would analyse available statistics on disorders behind sickness absenteeism and work disability, discuss time trends and epidemiological evidence available on morbidity, and attempt to interpret trends and describe what had been done to promote mental health and prevent mental ill-health in Finland, Germany, the Netherlands and Sweden. The core of this report consists of these country reports. In addition it contains one short chapter on gender differences of sickness absenteeism and work disability at the EU level. To improve the readability and coverage of the publication, we prepared a short description of emerging international activities and illustrative country examples in the promotion of mental health and prevention of mental ill-health. Further, we review the evidence available on the effects of such activities and examine what research needs are evident from the social insurance point of view. The findings of the country reports can be summarised in the following statement: mental ill-health issues are an increasing cause of sickness absenteeism and work disability pensions. Yet as mental disorders have a complex aetiology, mental health promotion strategies must take various approaches. A key issue is that prevention of harmful stress and anxiety at work should be addressed primarily at workplaces and in working life – yet good practices of prevention of work stress are well-known but less practised. Another issue is the need to develop good practices for the maintenance, rehabilitation and re-integration into employment of employees who are mentally susceptible to impairment in working life.

Key words: mental ill-health, mental disorders, sickness absenteeism, work disability pensions, prevention of disability, promotion of mental health, prevention of mental disorders, prevention of work stress

Tiivistelmä

Järvisalo J, Andersson B, Boedeker W, Houtman I, toim. **Mielenterveysongelmat – työkyvyttömyyden ehkäisyn suuri haaste: Suomen, Saksan, Alankomaiden ja Ruotsin tilanteesta.** Helsinki: Kela, Sosiaali- ja terveysturvan katsauksia 66, 2005, 183 s. ISBN 951-669-658-9.

Julkaisun taustalla ovat havainnot, että mielenterveysongelmat sairauspoissaolojen ja työkyvyttömyyden syynä ovat lisääntymässä Euroopassa. Suomessa, Saksassa, Alankomaissa ja Ruotsissa on laadittu kutakin maata koskeva katsaus, jossa käsitellään mielenterveysongelmien suhdetta sairauspoissaoloihin ja työkyvyttömyyteen, epidemiologista tietoa mielenterveysongelmien esiintyvyydestä, muuttuneiden sairauspoissaolojen ja työkyvyttömyyden syiden tulkitsemista ja mielenterveyden edistämistä. Lisäksi julkaisu sisältää lyhyen katsauksen sairauspoissaolojen ja työkyvyttömyyden sukupuolieroista. Julkaisussa käsitellään myös mielenterveyden edistämisen kansainvälistä kehitystä ja joidenkin tällä alueella aktiivisimmin toimivien maiden ohjelmia, tämän hetken näyttöä mielenterveyden edistämisen ja mielenter-

veysongelmien ehkäisyn vaikuttavuudesta ja tehokkuudesta sekä keskeisiä jatkotutkimustarpeita sosiaalivakuutuksen näkökulmasta. Keskeinen viesti on, että mielenterveysongelmien merkitys sairauspoissaolojen syynä on lisääntymässä. Mutta mielenterveysongelmien tausta on monisyinen ja ongelmien ehkäisyynkin tarvitaan monia lähestymistapoja. On tärkeää, että työpaikoilla ehkäistään aktiivisesti työelämässä syntyvää henkistä kuormitusta ja ahdistuneisuutta – tarvittavat hyvät käytännöt tunnetaan hyvin, niitä ei vain yleensä noudateta. Kyse ei ole lääketieteellisistä hoitokäytännöistä vaan hyvistä työn organisoinnin, johtamisen ja sosiaalisen yhteistoiminnan mallien käytöstä työpaikoilla. Toinen painoalue on kehittää työssä jatkamista edistäviä, kuntouttavia ja työhön palaamista tukevia toimintamuotoja niille, jotka kuormittuvat, oireilevat tai sairastuvat työelämässä.

Avainsanat: mielenterveysongelmat, mielenterveyden häiriöt, depressio, ahdistuneisuus, sairauspoissaolot, työkyvyttömyyseläkkeet, sosiaalivakuutuksen tilastot, työkyvyttömyyden ehkäisy, mielenterveyden edistäminen, mielenterveyden häiriöiden ehkäisy, työperäisen stressin ehkäisy

Sammandrag

Järvisalo J, Andersson B, Boedeker W, Houtman I, red. **Psykiska problem – en stor utmaning för förebyggande av arbetsoförmåga: erfarenheter i Finland, Tyskland, Nederländerna och Sverige.** Helsingfors: FPA, Social trygghet och hälsa: Rapporter 66, 2005, 183 ss. ISBN 951-669-658-9.

Denna rapport gäller psykiska problem, sjukfrånvaro och pensionering p.g.a. arbetsoförmåga i Finland, Tyskland, Nederländerna och Sverige. Bakgrunden är att man har konstaterat att psykiska problem allt oftare förorsakar sjukfrånvaro och tidig pensionering. Därför beslöt socialförsäkringsforskare i dessa fyra länder att utarbeta rapporter om sjukfrånvaro och pensionering p.g.a. psykiska problem, epidemiologin för psykisk morbiditet och tolkningen av trender samt åtgärder som vidtagits för att främja psykisk hälsa i dessa länder. Rapporten innehåller därtill en kort jämförelse av könsskillnader i sjukfrånvaro och tidig pensionering i Europa, och därtill en beskrivning av hur främjandet av psykisk hälsa har utvecklats internationellt och i länder som uppvisat större aktivitet inom detta område. Den behandlar vidare de vetenskapliga bevis vi har för hur effektiv främjandet av psykisk hälsa är. Avslutningsvis tar rapporten upp vissa ytterligare forskningsbehov sett ur socialförsäkringens synvinkel. Rapporterna från de fyra länderna kan summeras enkelt: psykiska problem har en allt större roll i utvecklingen av sjukfrånvaro och pensionering p.g.a. arbetsoförmåga. Men psykiska problem har en komplex etiologi. Därför måste man ha olika parallella strategier för att förebygga problemen. Det centrala är att arbetslivet och arbetsplatserna aktivt måste förebygga psykisk belastning, stress och ångest i arbetet – man känner väl till god praxis för förebyggandet av arbetsrelaterad stress men den tillämpas sällan. Det är inte fråga om medicinska åtgärder utan om att använda goda och effektiva modeller för att organisera och leda arbetet och den sociala gemenskapen i arbetslivet. En annan central fråga är att utveckla effektiva sätt som bidrar till att arbetstagare som upplever psykisk belastning, psykiska symptom eller psykiska problem skall orka arbeta. Därtill kommer också effektiva och tidiga rehabiliteringsåtgärder och koordinerat stöd för återgång till arbetet.

Nyckelord: psykiska problem, psykiska störningar, depression, ångest, sjukfrånvaro, pensionering p.g.a. arbetsoförmåga, statistik, förebyggande av arbetsoförmåga, främjande av psykisk hälsa, förebyggande av problem, förebyggande av arbetsrelaterad stress

EDITORS' NOTES

The current report has its origins in the observation that mental problems have become increasingly more common as causes of short and long term absenteeism from work. This issue has been discussed within the European Network of Social Insurance for Health (http://www.bkk.de/bkk/powerslave, id,413,nodeid,413.html?id=458). The discussions held brought to light various reasons for the observed trends, which seemed to vary from one country to another. It was therefore felt appropriate to try to document the individual country observations and to publish them, not only to draw attention to the issue but possibly also to help identify needs for research into the underlying mechanisms and the prevention of such processes.

Several individuals and institutions working in the area of social insurance research and development were originally approached and asked if resources could be made available to prepare country descriptions of social protection systems, to provide statistics or survey data on sickness absenteeism and work disability pensions due to mental disorders, to present any epidemiological evidence available on trends surrounding mental disorders, and to discuss what has been done or is being planned in each country to promote mental health and prevent mental disorders. As the project was to be conducted on a voluntary basis, many researchers who had an interest in the issue in the end had to withdraw due to prior commitments. Finally four countries and the editor team remained. The participants recognised that it would have been valuable to compare countries in various sub-regions of Europe.

The purpose of this report is to raise attention and interest among experts and practitioners of social insurance, as well as, in a modest way, to advocate the need for further action, both in working life and in society at large, to promote mental health and to prevent the negative consequences of mental problems.

We wish to thank our collaborators and partners for their help in drafting this material. Special thanks are due to Ms. Joannah Caborn of the International Labour Office for her contribution to Chapter 1 of the report. We also wish to thank Dr. Eero Lahtinen of the Finnish Ministry of Social Affairs and Heath for his help in drafting Chapters 1 and 8 of the report. For help with the Finnish country description, thanks are due to the staffs of the Social Insurance Institution, the Finnish Centre for Pensions and the Finnish Ministry

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The editors are responsible for the authorship of chapters 1, 7, 8 and 9.

This report will also be made available on the website of the Research Department of the Social Insurance Institution in Finland.

The editors

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Chapter 1. Introduction: Public actions to improve mental health through promotion, prevention and care internationally and nationally

WHAT IS THIS REPORT ABOUT?

This report addresses the changing role of mental disorders as causes of sickness absenteeism and disability pension retirement. It appears that this role is expanding in many European countries, including the four countries which this report concerns. It is against this background that we have taken the effort to collate national statistical and research information available in four European countries: Finland, Germany, the Netherlands and Sweden. In this report, we seek to interpret how the factors behind the trends are discussed in each of the four countries and attempt to discover what is known of the effectiveness of preventive measures on mental ill-health and what needs for further research can be identified from the social insurance viewpoint.

Various information sources in health surveillance and monitoring indicate a steady and continuous improvement in health trends among populations in the Western World. Within this overall positive progress, one can, however, see less positive developments: diversity in socio-economic circumstances and poverty, marginalisation, long-term and second-generation unemployment, destruction of the family institution, drug abuse and alcoholism, and in essence also a decline in experienced mental health. While other causes of preventable disability have decreased, the proportion of various income benefits based on mental disorders is increasing. Nor are predictions positive: it is expected that the burden will increase significantly in the coming years (Murray and Lopez 1996). The reasons behind the increase are largely unknown and circumstances may be surprising. For example, while the development of the information society has caused a revolution in the availability of information and in ways of communication, it may over a long term contribute to mental ill-health through social changes in family life and work patterns.

The global economy, various trade treaties and joint international efforts to maintain peace and establish economic growth in various parts of the world have aimed at stability and an increase in well-being. Yet, reflecting well-being merely through the lens of economic benefits and global force politics has its negative side. So the question remains: Is this world better or worse than it was 10 or 20 years ago. A recent independent assessment of the World

Commission on the Social Dimension of Globalisation (2004) indicated that there is much to be done to prevent the negative social consequences of globalisation, but on the other hand a lot can be done, provided that all stakeholders are willing to devote their interest and resources to prevent the negative consequences. In the end, much of what concerns the integration and marginalisation effects of working life actually relates to economic globalisation, for example to demands for higher productivity and better skills and to the management of personnel costs at enterprises, leaving the social protection systems to shoulder the risks of marginalisation.

There are evidently several lines or aspects to the international and national development concerning the prevention of mental disorders and the disability caused by them. One is based on social and labour policy, with a clear emphasis on social cohesion, working life participation and prevention of marginalisation and exclusion. Another is based on health policy, with a clear emphasis on mainstreaming mental health in public health, improving professional competence in care at all levels, preventing stigmatisation due to mental ill-health, and improving general public awareness about mental health. A particular aspect here is the emphasis given to positive mental health as a general resource of life, echoing the reference frequently made in the connection of physical health. A third one concerns the development and evaluation of various forms of prevention and/or rehabilitation interventions, diagnostics, and treatment undertaken by research bodies and professional experts. A fourth line concerns mental ill-health in working life: stress, mental strain, lack of social support and poor management and organisation of work. A fifth one concerns work opportunities for the disabled and more recently also for persons with chronic conditions. Due to this quite scattered picture where coordination may not be readily available, it is not altogether clear who really has the responsibility for preventing work disability caused by mental disorders.

1.1 Mental health in the agenda and actions of international organisations

Since its foundation, the *United Nations* has had health related issues high on its agenda. A majority of the actions undertaken in this area have been carried out by the World Health Organization. Work and safety issues belong to the mandate of the International Labour Office. But the various bodies of the main organisation have also given due attention to the management of disability and more recently to the prevention and management of mental disorders.

As early as in 1975, the General Assembly of the United Nations approved a Declaration on the Rights of Disabled Persons (United Nations 1975). It strongly emphasised the necessity of protecting the human rights of the physically and mentally disadvantaged. The year 1981 was named the International Year of Disabled Persons, and it was celebrated with numerous programmes, research projects, policy innovations and recommendations both internationally and nationwide. To follow up these developments, 1983–1992 was nominated as the UN Decade of Disabled Persons. In 1991, the General Assembly adopted the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. The twenty-five principles defined fundamental freedoms and basic rights. They deal with, *inter alia*, the right to life in the community, the determination of mental illness, provisions for admission to treatment facilities, and the conditions of mental health facilities. They should serve as a guide to Governments, specialised agencies and regional and international organisations, helping them facilitate investigation into problems affecting the application of fundamental freedoms and basic human rights for persons with mental illness. In 1992, the General Assembly appealed to Governments to observe 3 December of each year as the International Day of Disabled Persons. The Assembly further summarised the goals of the United Nations regarding disability and asked the Secretary-General to move from consciousness-raising to action, placing the Organisation in a catalytic leadership role, which would place disability issues on the agendas of future world conferences (United Nations 2003–2004).

As to the work of *the World Health Organization*, physical, mental and social well-being have been highlighted in the Organisation's health definition since the establishment of the organisation after the Second World War. In line with that both the WHO Headquarters and Regional Office programmes have always had specific mental health programmes, and mental stressors have been given due attention also in the occupational health programmes. In 1975, the General Assembly of WHO passed a resolution on the promotion of mental health (WHA 1975). In 1986 the World Health Assembly passed a resolution on the prevention of mental, neurological and psychosocial disorders (WHA 1986), and in 2002 a Resolution on Mental Health (WHA 2002). Mental health was also included in many ways in the WHO Health for All Strategy (World Health Organization, Regional Office for Europe 1985). In the end, the holistic approach with an emphasis on primary health care and health promotion did not leave much space for development in the promotion of mental health or prevention of mental disorders.

It appears evident the national and international developments have, however, warranted strengthening of the efforts. In 2001, the organisation published its World Health Report solely dedicated to mental health (World Health Organization 2001). For some reason, the text is more about diagnostics, treatment, care, research and personnel training and public information than about generic or specific prevention of disorders or promotion of mental health. A visit to the mental health-related Internet pages of both the Headquarters (World Health Organization 2004) and the European Regional Office of WHO (World Health Organization, Regional Office for Europe 2004a and b) reveals a wealth of actions, information and other material. Under the heading of 'Moving ahead', the description of the Mental Health Global Action Programme states that the impact of WHO efforts is already significant and visible, and countries are beginning to act and move forward. The Regional Office for Europe of WHO, the European Commission and the Council of Europe, along with Member States, organised a Ministerial Conference in Helsinki, Finland in January 2005, with the attendence of representatives of all 52 Member States in the WHO/European Region and of selected organisations. According to the information on the World Wide Web the Conference will address key issues of mental health promotion, mental disorder prevention and mental health care. A specific pre-conference meeting, held in Tallinn in October 2004, concerned mental health and working life (World Health Organization, Regional Office for Europe 2004b).

The work of the *International Labour Organization* in the field of labour standards, health and safety at work, occupational health services, social protection, and vocational training and rehabilitation has naturally not been specifically focused on mental health. However, there are a number of standards which address the issue and there have been some research activities concerning mental health at the workplace. The ILO has also addressed the relationship between work organisation and mental ill-health and has proposed an educational programme to improve the situation in enterprises in a preventive, proactive way. While there is no central ILO standard on mental health at work, reference is made to the issue in a number of ILO conventions and recommendations (ILO 2004a). Standards on conditions of work such as the convention on Occupational Safety and Health, 1985, (No. 155) and the Occupational Health Services convention, 1985 (No. 161), address mental health in requiring the establishment and maintenance of a safe and healthy working environment which facilitates optimal physical and mental health in relation to work. Standards on access to employment such as the Employment Services Convention, 1948 (No. 88), and the Employment Promotion and Protec-

tion again Unemployment Convention, 1988 (No. 168), incorporate the basic human rights approach as enshrined in the Discrimination Convention, 1958 (No. 111), in promoting equality of disabled persons, including those with mental disabilities. Apart from conventions which are legally binding once ratified, the ILO also produces Codes of Practice which provide guidance without having the same legal status that conventions can achieve. The Code of Practice on disability (ILO 2002) provides a general framework on managing disability in the workplace as well as guidance on recruitment, promotion, job retention and adjustments for workers with mental and physical disabilities. There is also a Code of Practice addressing Alcohol and Drugs (ILO 2003a), which can be viewed as a mental health problem, and one on Workplace Violence which can have an impact on mental health. Research and publications are a further area of activity pursued by the ILO. Work on the disability side of mental health is carried out by the ILO's Skills, Knowledge and Employability programme (ILO 2004b). Research on stress and violence is the responsibility of the Conditions of Work branch (ILO 2000, 2003b, 2004c). SafeWork's SOLVE programme provides a response to the issue of work organisation and mental ill-health (ILO 2003c). SOLVE is an interactive educational programme designed to assist in the development of policy and action to address psychosocial issues at the workplace including stress, violence, alcohol and drugs, HIV/AIDS and tobacco. It recommends the creation of an integrated enterprise policy to provide a framework for prevention of psychosocial problems and mental ill-health at work by better managing the work environment. It also provides a number of action-oriented follow-up mechanisms and evaluation to ensure the effective functioning of the policy. While the programme is only just over three years old, it has already been able to develop national capacity in over 25 countries in the developing and the developed world alike and continues to meet with enthusiastic responses.

As a UN organisation, the *World Bank*'s major mission is to prevent poverty and its consequences (World Bank 2004a). The organisation performed activities in the field of health promotion in the 1990's. Today a key issue seems to be social capital in respect to its relationships with national and local economies in a wide sense (World Bank 2004b). At a UN Millennium Summit in 2000, the UN member states reaffirmed their commitment to work towards a world in which eliminating poverty and sustaining development would have the highest priority, Consequently 147 heads of state signed the Millennium Declaration. Under this framework, the World Bank has been carrying out work in the health sector in cooperation with the World Health Organization (World Bank 2004c).

The *Council of Europe* has under its social cohesion activities (Council of Europe 2004) dealt with issues like human rights, equal opportunities of the disabled, and social protection standards. The resolutions naturally give equal cover to people with psychological disabilities or mental disorders. Some special work on people with mental disorders has also been carried out. Recent achievements include draft recommendations for protecting the human rights of people with mental disorder (Kingdon et al. 2004). They cover such topics as non-discrimination and mental health promotion, the protection of vulnerable people, the civil and political rights of involuntary patients, environmental and living conditions, professional standards, seclusion and restraint, criteria and procedures for involuntary placement and treatment in emergency, termination of involuntary placement and treatment, review of lawfulness of involuntary placement and treatment, specific treatments, application to minors, involvement of police, courts and prison system, and monitoring standards.

Besides larger international agencies, there are a large number of organisations operating in the area of mental health and mental disorders in Europe that deal with such issues as advocacy, patients' rights and training and education, as well as various professional organisations. There is the World Federation for Mental Health founded in 1948, whose mission is to promote, among all people and nations, the highest possible level of mental health in its broadest biological, medical, educational, and social aspects (World Federation of Mental Health 2003). It has a European regional council named Mental Health Europe (Mental Health Europe 2004), which is specifically devoted to the promotion of mental health. Another the more recent developments are a series of World Conferences on the Promotion of Mental Health and Prevention of Mental and Behavioural Disorders. The first such conference was held at the Carter Center in Atlanta, USA, in 2000 (Onlineparadigm.com 2002), the second one in London (The Second World Conference 2002). The third was held in New Zealand in 2004 (Organizers of the Third ... 2004).

1.2 Mental health issues in the programmes of the European Union

There are two approaches of the European Communities and the European Union that are relevant to mental health. On one hand, the EC/EU has maintained a strong involvement in social protection, social inclusion and health and safety at work since the 1950's. Yet on the other hand, an express mandate on public health came was not spelled out until the Maastricht Treaty.

The European Commission's Directorate General for Employment and Social Affairs covers various perspectives of social policy. The main areas include employment strategies and analyses, the European Social Fund, working conditions and work organisation, social protection, social integration, and gender equality (European Commission. Employment and Social Affairs 2004). Many of the programmes of the Directorate General have direct links with well-being at work. A very effective instrument has been the Framework directive on health and safety at work, adopted as early as in 1989, which has the aim of harmonising the relevant legislation of the Member States. More recently, the actions have included expertise work on the prevention of work-related stress. In 2002, the Directorate General published an executive summary on guidance on work-related stress which was based on rather extensive project work carried out through the public health funds (see below) (European Commission. Employment and Social Affairs 2002). Its message was clear: since enough is already known about work-related stress and its prevention, actions should now be taken with the help of the available knowledge to prevent harmful effects of stress. Currently, the Union and the Commission are in a new situation: the new proposed Constitution, when approved, will most likely create a mandate for the Commission to address health related issues in a wider sense. Probable targets will be social protection in general and its funding, including taxation as a funding method. The basic underlying concepts are a free internal market and free competition. The question of how to reorganise health services and care systems will most likely challenge many EU countries in the years to come. In its report to the Spring European Council of 2004, the Commission proposed the initiation of open coordination with the aim of modernising health care systems.

Two research related organisations are budgeted through the Directorate General for Employment and Social Affairs. The European Foundation for the Improvement of Living and Working Conditions was founded in 1975 (European Foundation for … 2004) to contribute to the planning and establishment of better living and working conditions through action designed to increase and disseminate knowledge likely to assist this development. Today it is a major social policy advisor of the Union, responsible for various monitoring instruments, and carrying out research, development and evaluation activities. Many of its current and past activities have relevance to well-being at work and in general. It also carries out research on the social inclusion of people with disabilities and other chronic conditions, in which mental disorders and ill-health have been given due attention. The other EU organisation funded through the DG for Employment and Social Affairs is the European Agency

for Safety and Health at Work (European Agency for … 2004), which has the aim to contribute to the planning and establishment of better living and working conditions through action designed to increase and disseminate knowledge likely to assist this development. It was established in 1994. Its main task is to pass relevant information on safety and health at work for the improvement of European working conditions. It collects and evaluates information, and its Health and Safety at Work Weeks specifically concentrate on some relevant working life issues. The 2002 European Week focussed on psychosocial issues, especially work-related stress. Both of the institutes are governed by a tripartite body.

The other major actor related to mental health in the European Union is the Directorate General for Health and Consumer Protection of the Commission (European Commission. Health and Consumer Protection 2004a). It is responsible for running the Programme of Community action in the field of public health. The current programme covers the years 2003–2008. When the mandate of the Commission was extended to public health issues in the Maastricht Treaty, the Commission responded by facilitating formation of European networks for certain health problems and settings. Among them were one was established for workplace health promotion, one for mental health promotion and one for mental health policy. The so-called first public health programmes concerned the years 1996–2002. There were eight programmes, of which two – health promotion and health monitoring – were horizontal and the others problem or disease based. The activities under the programmes consisted of projects suggested to the Commission by an open call for proposals. (European Commission. Health and Consumer Protection 2004b). The public health programme 2003–2008 combines all the actions in one programme. Besides general calls for proposals, calls for tenders are used for more specific areas to be covered. Mental health issues fall under health determinants, but they also form an extensive part of the health monitoring system (European Commission. Health and Consumer Protection 2004c). In addition, issues like unemployment, poverty, health inequalities and drugs and alcohol are part of the programme.

The projects focusing on mental health issues that were funded through the health promotion programme in 1996–2002 concerned such topics as the key concepts of mental health promotion, establishment of a European network for mental health, the mental health promotion of children, mental health promotion and social cohesion, unemployment and mental health, involuntary treatment of mentally ill patients, prevention of stress and depression, integra-

tion of mental health promotion with country policies, practices and services, mental health in the European Agenda, and mental health economics (European Commission 2002).

Although the funded projects on mental health have been relatively few, the activities developed have evidently been rather effective and have received a lot of political visibility. The European Council passed a resolution on promotion of mental health in 1999 (European Commission 2000). This resolution was preceded by a series of events and development projects funded through the health programme and EC meetings organized jointly with the World Health Organization. The resolution apparently also formed the basis for a strengthened position on mental health issues taken in the public health programme of 2003–2008. The recitals touch upon the processes related to the issue, highlight the collaboration with WHO and invite the member states and the Commission to develop good quality information systems for mental health and actions to promote mental health. The resolution has been followed by a number of council conclusions focussing on different aspects of mental health, underlining the political commitment of the Council in this area.

In 2003 the Commission published a survey on the mental health status of Europeans based on the Eurobarometer survey. The questions related to mental health were from standardised questionnaires belonging to the 'Minimum data set of European mental health indicators', which was proposed and tested by a European project (1999–2002) and funded from the EU Health Monitoring Programme. An analysis of comparable data is available on the Commission website (The European Opinion Research Group 2003; European Commission. Director-General Health and Consumer Protection. Public health 2004d). A new Mental Health Working Party has also been established to further develop mental health monitoring and to provide expert views on policy development (European Commission. Health and Consumer Protection 2004c).

1.3 National approaches to make the mental health issue part of public health

In many western countries, mental health has been made a truly visible part of the public health programme. The U.S. Surgeon General published a report solely devoted to mental health in 1999. The report's starting point was that much can and has to be done to treat disorders effectively. It was felt that mental health and mental disorders form a continuum, which warrants a pub-

lic health approach. The report also highlighted the disabling nature of mental disorders. Extensive consideration was given to stigmatisation related to mental disorders (Surgeon General 1999). Prevention and promotion received less attention in the report.

In 1995, Health Canada created a Mental Health Promotion Unit (MHPU) to serve as the focal point of its efforts to maintain and improve positive mental health and well-being for the Canadian population (Health Canada 2003). In 2001, mental health service-related functions of the former Health Systems Division (HPCB) were incorporated into the Unit. These functions relate to information on mental disorders and collaborative work with the provinces on mental health service renewal. The new MHPU addressed mental health promotion from a population health perspective that takes into account the broad range of determinants of mental health. The mandate of the restructured unit was to promote and support mental health and reduce the burden of mental health problems and disorders, by contributing to the development, synthesis, dissemination and application of knowledge and to the development, implementation and evaluation of policies, programs and activities designed to promote mental health and to address the needs of people with mental health problems or disorders. The Canadian national public administration was again reorganised in 2002 and the emphasis was moved from health promotion to population health. Population mental health, nevertheless, remains a priority.

In Australia, the Commonwealth and States and Territories launched a National Mental Health Strategy in the early 1990's (Commonwealth of Australia 2004). Its achievements have been actively followed through National Mental Health Reports. The 2002 report indicated that substantial progress continues to be made in the mental health reform, which is essentially a mainstreaming approach to cover the needs of the patients with mental disorders. In the past, the more severely affected people were isolated and treated in psychiatric institutions, and had little opportunity to participate in the life of the community. Recently, things have improved and, although some people with severe mental illness will still require hospitalisation, the emphasis is now on treating and supporting people with a mental illness in their own communities. For community-based treatment of people with an ongoing illness to be effective, they may need access to a range of different services: specialised mental health services that recognise their rights and respect their dignity; general medical services, housing, accommodation support, social support, community and domiciliary care; and income security, employment and training services that can all have a significant impact on the capacity of a person with a mental

illness or psychiatric disability to live in the community, free from discrimination and stigma. It is envisaged that all levels of Australian government have recognised a need to work together to reform services and mental health policy to provide for people with mental disorders similar opportunities as the other Australians have. A significant part of the Australian approach has been mental health promotion carried out either at the national level or by the States. Two examples could be emphasised. At the national level, a major campaign has been run to reduce the stigmatisation of mental ill health (Mental health is everybody's business). A government-funded NGO runs a large anti-depression campaign (Beyondblue).

The New Zealand Government has in its Ministry of Health a special directorate for mental health (Ministry of Health, Mental Health Directorate 2004a). The Directorate has a multifaceted approach to improve mental health policy, services, and research. The Directorate's website also contains copious links to various toolkits, reports, collaborators and other organisations. The current target is to current more and better services. A new national mental health promotion strategy was recently adopted by the Government (Ministry of Health, Mental Health Directorate 2004b).

In the United Kingdom, a major shift of mental health policy is underway (Department of Health 2004). It involves a reorientation and modernisation of services, manpower development and the empowerment of nurses, research base and evaluation. The Mental Health Act of 1983 is also to be reformed, but the reform proposal has raised considerable debate.

This is by no means an exhaustive list of the countries where mental health has entered the public health domain and is emerging as a way to meet needs related to promoting mental health, preventing mental disorders, improving care and services for people with mental disorders, and enhancing the opportunities to working life participation and otherwise of persons with mental strain or mental disorders, including eradicating the stigmatisation that has been attached to the these symptoms, signs and disorders.

Furthermore, one should bear in mind that there is also a risk of labelling various problems of working life as mental problems. The best way to address any problems workers have in fitting into their work environment, whether they are of physical, psychological or social nature, is to remove the problem. This being so, more attention will however be demanded from managers, co-workers and occupational health and other health personnel.

1.4 From programmes to preventive actions, with a special reference to social insurance

As mentioned in the beginning of this document, the background of this publication is in the observation that mental disorders are increasingly causing sickness absenteeism and work disability. The international and national efforts made during the last years look very promising in terms of helping to normalise mental ill-health and disorders: decreasing the stigmatisation, improving the care and its effectiveness, creating better methods for prevention, and enhancing the promotion of mental well-being in general.

However, the situation may be less auspicious from the social insurance management point of view. The trends indicated by the statistics probably relate to the poor management of working life problems, like poor trust or unfairness, poor leadership, excessive productivity demands, too complicated or too simple working tasks, or poor social relationships. In many counties these issues are beyond the influence of social insurance organisations whose primary tasks are to make decisions on income support measures, health services and rehabilitation.

Later in the report we will take a quick look at how the prevention of mental ill-health may be seen from the social insurance viewpoint. One must emphasise that major actions are required both at workplaces and in society at large, and that these actions may in many countries be far from the reach of the social insurance sector.

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Chapter 2. Depression and other mental disorders, sickness absenteeism and work disability pensions in Finland

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2.1 Introduction

This article describes the trend towards a growing role of certain mental disorders, especially depression and related disorders, as diagnosed causes of work disability in Finland over the last two decades.

We start with a short description of the Finnish health insurance and disability pension insurance systems. Then we report on the latest epidemiological findings concerning mental disorders in the country. After this, some figures about trends in sickness allowance and pension statistics are presented. We go on to discuss possible explanatory factors for the trends relating to society at large, to working life and to health care.

A short description of the Finnish social security system

The disease-related decisions and statistics of the social security systems in Finland are mainly based on the use of the WHO International Classification of Diseases (currently its version 10). Work disability, as shown in the statistics, does not necessarily go hand in hand with the epidemiological evidence on the occurrence of the disease states in the country. There are, at least, two obvious reasons behind the discrepancy. Firstly, the legislation on social security normally defines decreased functional, working or earning capacity as the prerequisite for being compensated for absenteeism related loss of income, not the disease states themselves. Secondly, the decision making process of social insurance also takes into account various other factors than the disease state, such as social issues, training and education, and employability, when deciding on the necessity to compensate for the disease driven loss of earning capacity.

In Finland, as in many other western countries, the social security system related to sickness and absenteeism is rather complex: the primary and specialized (hospital) health services are the responsibility of the municipalities

which must provide them for their inhabitants. In addition, the employers are by law obliged to organise occupational health care services for their employees. These services often contain primary care level general medical services. The employers are refunded by fifty per cent of the eligible occupational health care costs by the health insurance. The inhabitants of the country can also use private medical services, the costs of which are partly refunded by the health insurance, administered by the Social Insurance Institution (Kela) (The Social Insurance Institution 2003; Niemelä and Salminen 2003).

The pension insurance is mainly based on two systems: a national (basic) pension, funded by the state and the employers, and an employment pension funded jointly by the employers and employees. The latter is based for some 30 percent on funded funds, the rest being paid out as pay-as-you-go. Before 1996, everyone having been living in the country for 40 years was eligible for a full national pension. Since then the national pension has become employment-pension-deductible, meaning that at an employment pension level higher than some 1000 € a month, the national pension will not be paid at all. The private sector employment pensions are administered by private insurance companies, the public sector pensions mainly by the State Treasury and a municipal pension organisation called the Local Government Pensions Institution (Niemelä and Salminen 2003).

All physicians in the country are authorized to issue medical certificates on sickness absenteeism or disability for work. The social insurance bodies have medical experts who do not examine applicants' disability physically, but base their advice to the decision making on received statements. The insurance organization can, however, refer the applicant to medical services for a further examination.

In the case of sickness absenteeism from work, the employee is often obliged to indicate the reasons for the absenteeism through a medical certificate already from the first day of the sick leave. In the public sector, the certificate is typically required from the fourth day onwards, and in various private enterprises a nurse may write the statement for the first absenteeism days.

The employer is responsible for the compensation of income loss for the first 9 days of a sickness absenteeism episode. In practice the employer often pays full salary or wages for the first 2 to 3 months of the absenteeism as agreed upon by the various collective agreements. The allowance paid by the general

health insurance covers around 70 per cent of the income and it is taxable. If the employer pays a full salary to the employer during the sick leave, the receiver of the health insurance allowance is the employer.

The sickness allowance can be paid for a maximum of 300 days, inclusive of all workdays for which the allowance has been paid during the two preceding years. If the disability is anticipated to continue longer than this maximum, the person is assumed to apply for a temporary or permanent disability pension. The temporary one is called rehabilitation subsidy, with the indication that it should be typically used for a longer period of rehabilitation or recovery from medical treatment or injury. The employment pension can be granted as full (loss of two thirds) or partial (loss of one third).

The sickness absenteeism data are based mainly on the sickness allowance statistics of the Social Insurance Institution, and hence cover workers who have been away from work for at least 10 consecutive workdays, as explained above (The Social Insurance Institution 2003). In addition, two major employer organisations gather absenteeism information regularly from their member employers. (Palvelutyönantajat 2003; Teollisuuden ja Työnantajain Keskusliitto 2003).

Until the year 2004, the statistics have only contained information about the allowances paid, and in addition, for a sample of 6.6 percent, information about the diagnoses behind the absenteeism and the occupation of the recipients. Since 2004 the diagnosis data concern all paid allowances. One has to note that alcoholism, drug abuse, and many symptom diagnoses of ICD 10 are not, in principle, an accepted criterion of eligibility for a sickness allowance benefit, which means that longer spells due to such reasons are most likely absent from the statistics. Statistics on disability pensions are recorded by the Social Insurance Institution (The Social Insurance Institution 2002), on the national pension side, and by the Finnish Centre for Pensions, on the employment pension side. The two bodies also publish annually a joint book on pensioners in Finland. (The Finnish Centre for Pensions 2003; previously: Central Pension Security Institute 2002).

A major problem in interpreting time series in the sickness allowance or work disability pension statistics is that changes in social protection legislation occur frequently. This makes for a certain degree of uncertainty in the time series. Some issues merit particular mention concerning the tables and figures

in this article. In 1993, the employer responsibility on the first sickness absenteeism days was increased from 7 to 9 days following the day of onset of the illness. This may be expected to have had an effect on both the total number of absenteeism days and the number of absenteeisms. In 1996, as mentioned above, the basic national pension was made employment pension deductible. This had the outcome that the employment pension institutes and the Social Insurance Institution no longer harmonise their decisions on disability pension applications, as was earlier the case. Moreover, the joint disability pension statistics were suspended for a while, making the statistics for the year 1996, and to some extent 1997, particularly questionable. From 1996 onwards, the minimum sickness allowance benefit was no more payable to persons who earned less than a certain limit (840.94 € in 1996). However, for indigent persons a means-tested minimum benefit could still be paid on the basis of a long-term illness (longer than 60 days). In 2002, the regulation was changed again: the minimum benefit was made payable also to persons with no earned income after the disability caused by an illness has lasted 55 days. If it is evident that the disability will last at least 300 days, a person may even be eligible for the sickness allowance after the standard 9-day waiting period. One further labour policy related activity concerning marginalised long-term unemployed persons needs to be mentioned: the fiscal budget has since 2001 contained funding earmarked for assessing the work disability of such persons. The funding was originally available in certain towns only, but is now available countrywide. During 2001–2003, 8 600 persons underwent such an assessment, and some 5 600 were medically certified as disabled for work. A total of 4 443 persons applied for and 2 887 persons were granted a disability pension. One may assume that quite a large proportion of those who applied for a pension show in the statistics for sickness allowance during the years 2001–2003, because one must have received sickness allowance for the maximum period (300 days) before becoming eligible for a disability pension under the National Pension Insurance. All those who have been granted a disability pension should show both in the sickness allowance and the disability pension statistics. So far there is, unfortunately, no information available on the diagnoses behind this disability. There may also be other reasons that complicate the interpretation of time series dealing with sickness allowance payments. One is that the physicians employed in the public sector were on strike from April until August in 2001. This can be assumed to have caused some decline in the number of new grants of disability pension and to have delayed medical treatments that typically cause a longer sickness absenteeism period. Once the strike ended and work resumed on clearing the lengthened patient queues, we might expect an accelerating trend of new disability pension grants.

2.2 The epidemiology of depression in Finland

Two large health interview and examination surveys have been conducted on the Finnish population over 30 years of age. The first one, called the Mini-Finland Health Survey, was carried out in 1978–1980 (Lehtinen et al. 1991), and the second one, called the Health 2000 Survey, in 2000 (Aromaa and Koskinen 2004; Pirkola et al. 2004). Special care has been taken to maintain the comparability of the results of the two surveys, to allow assessment of the secular health trends of the last 20 years.

In the first survey, the age-adjusted prevalence of all diagnosed mental disorders was over 17 percent. The combined prevalence of affective psychoses and neurotic depression was 5.0 per cent. Neurotic depression was more prevalent among women than men (six per cent and four per cent, respectively) and most prevalent in the working-age population (Lehtinen et al. 1991).

According to the latter study, 4.9 percent of the adult population had suffered from one or more episodes of major depression during the preceding 12 months (Aromaa and Koskinen 2004; Pirkola et al. 2005)). They were more frequent among women than men (6.3 per cent and 3.4 per cent, respectively). Including the prevalences of dysthymic disorder, the overall prevalence of depressive disorders was 6.5 per cent, 8.2 per cent for women, 4.5 per cent for men. The prevalence of anxiety disorders was 4.2 per cent, 4.8 per cent for women, 3.7 per cent for men. Alcohol use disorder showed a prevalence of 4.3 per cent, 1.4 per cent for women, 7.3 per cent for men. A comorbid disorder, inclusive of two or more of the three disorders, was present in 19 per cent of those with any disorder. Older age, marriage and employment predicted lower prevalence of mental disorders and comorbidity.

Another series of nationwide health interview surveys, called the Finnish Health Care Surveys, showed that psychic symptoms – dejection or depression, lack of stamina or fatigue, sleeplessness, nervousness or tension, overexertion – were in 1995/96 substantially more frequent among adults than in 1987 (Raitasalo 1992; Kalimo et al. 1993; Arinen et al. 1998).

The number of psychiatric hospital beds has been dramatically reduced in Finland since the 1980's. According to the available statistics, the decline has continued into the first decade of this millennium. On the other hand the average use of hospital beds per patient has declined and the number of in-patients has increased from 30 400 in 1994 to 32 500 in 2002 (i.e. from 6.0 to 6.3 per

1 000 inhabitants. The number of outpatient mental health visits has increased from 1.4 to 2.0 in 2002 (Stakes 2003).

In 2000, six percent of the interviewed persons (who were over 30 years of age) had used health services because of perceived mental health problems during the last 12 months (Aromaa and Koskinen 2004). The earlier interview-based health survey, carried out in 1987 showed that some six percent of interviewed persons, aged 15 years or older, had seen a physician, a psychologist or other mental health professional because of psychic symptoms during the last five months (Raitasalo 1992). Gender differences were similar in both surveys. However, it should be noted that the two populations differed to some extent in terms of age structure.

In conclusion, the results of the Finnish epidemiological surveys seem to indicate that the prevalence of depressive disorders has not been increasing during the past twenty years. At the same time, the provision of mental health services has changed. Milder psychic symptoms may have increased in the adult population. Over the same period – the 1990's – the sales of antidepressant drugs have increased fivefold in Finland, and the growth continues (The National Agency for Medicines, The Social Insurance Institution 2003). This trend seems to be in line with developments in other Western countries.

2.3 Mental disorders as a cause of sickness absenteeism

The total number of new paid sickness allowance spells arising from any cause, as registered by the Social Insurance Institution, decreased from some 450 500 annually in 1990 to 292 000 in 1997, i.e. by 35 per cent. The obvious reason for the decline is the severe recession of the early 1990's, which created higher unemployment and changed general attitudes towards sickness and absenteeism. More recently the number of absenteeism spells has again been on the increase. In 2003, the number of new spells was 343 400 (Figure 1).

The decrease in the 1990's was almost entirely attributable to lower absenteeism due to musculoskeletal disorders (Figure 2). Despite the decrease in the total number of paid sickness allowance spells, the number of spells due to mental disorders increased by 93 per cent from 1990 to 2003. The increase was as great as 136 per cent for women, but only 45 per cent for men (Figure 3). In 2003 musculoskeletal disorders were still the most common reason for

Figure 1. New sickness allowance spells 1990–2003 for men and women.

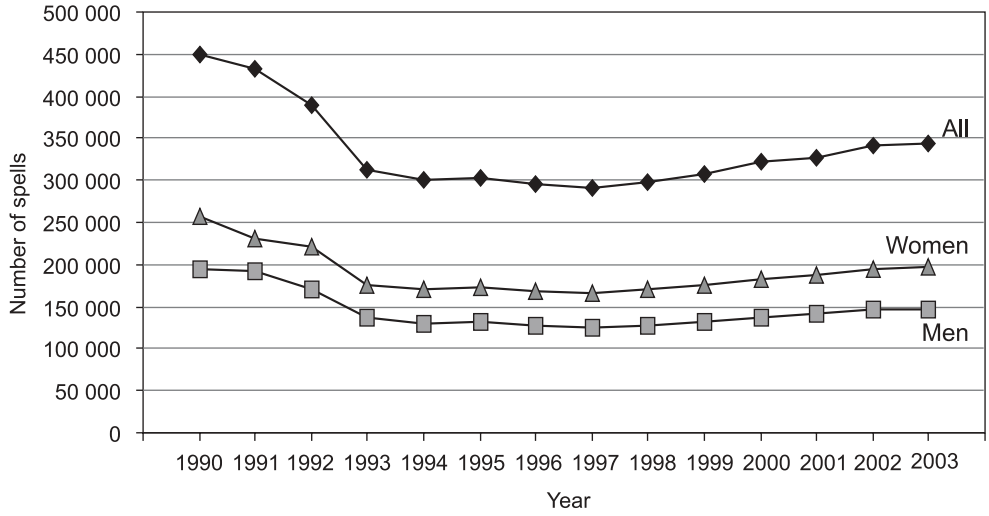
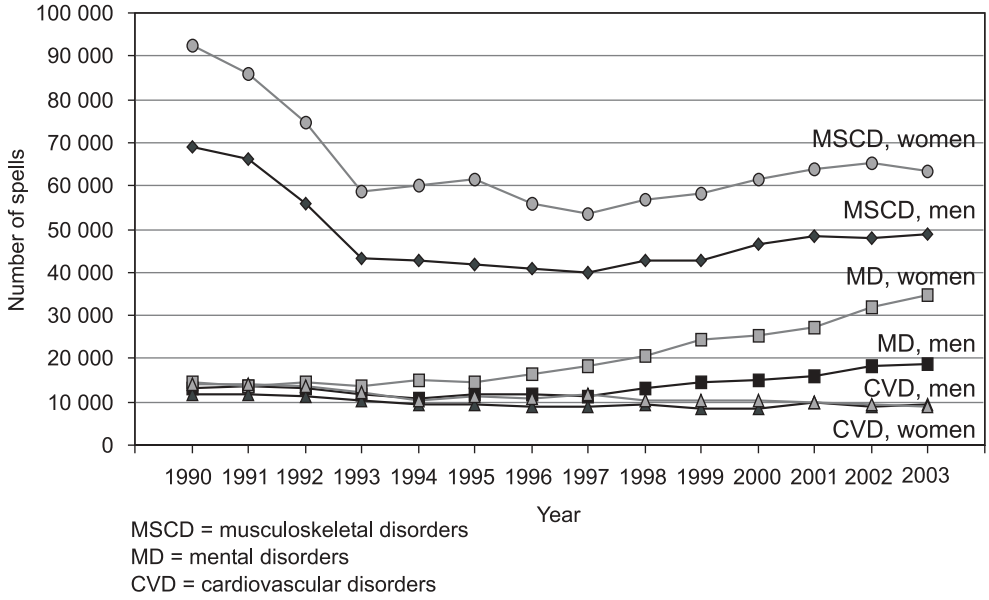
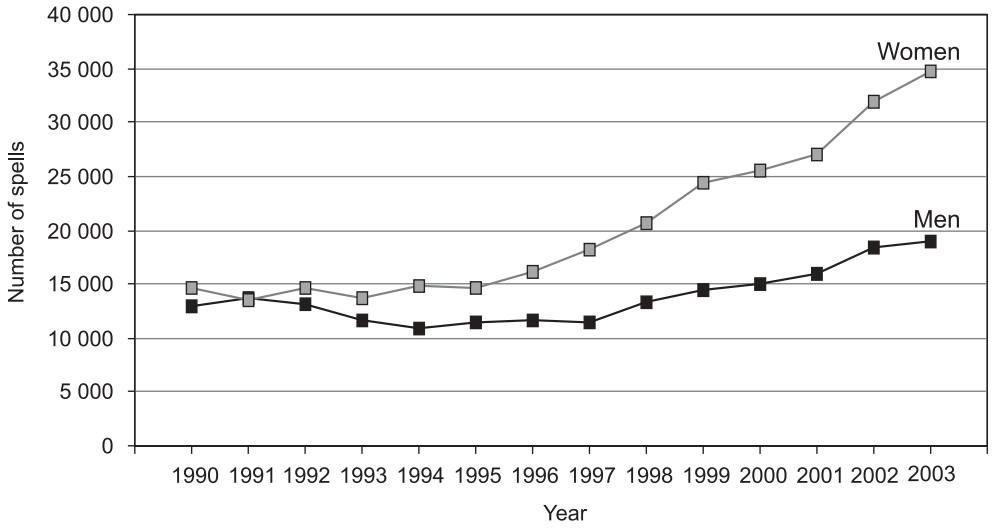


Figure 2. New sickness allowance spells for the most common ICD 10 main categories 1990–2003.



sickness absenteeism, comprising 33 per cent of all cases. Psychiatric disorders had a share of 16 and injuries 14 per cent each. The increase in paid spells due to mental disorders appeared later among men than among women. The rate of increase has been fastest among women and men in the age group of 45 to 54 years.

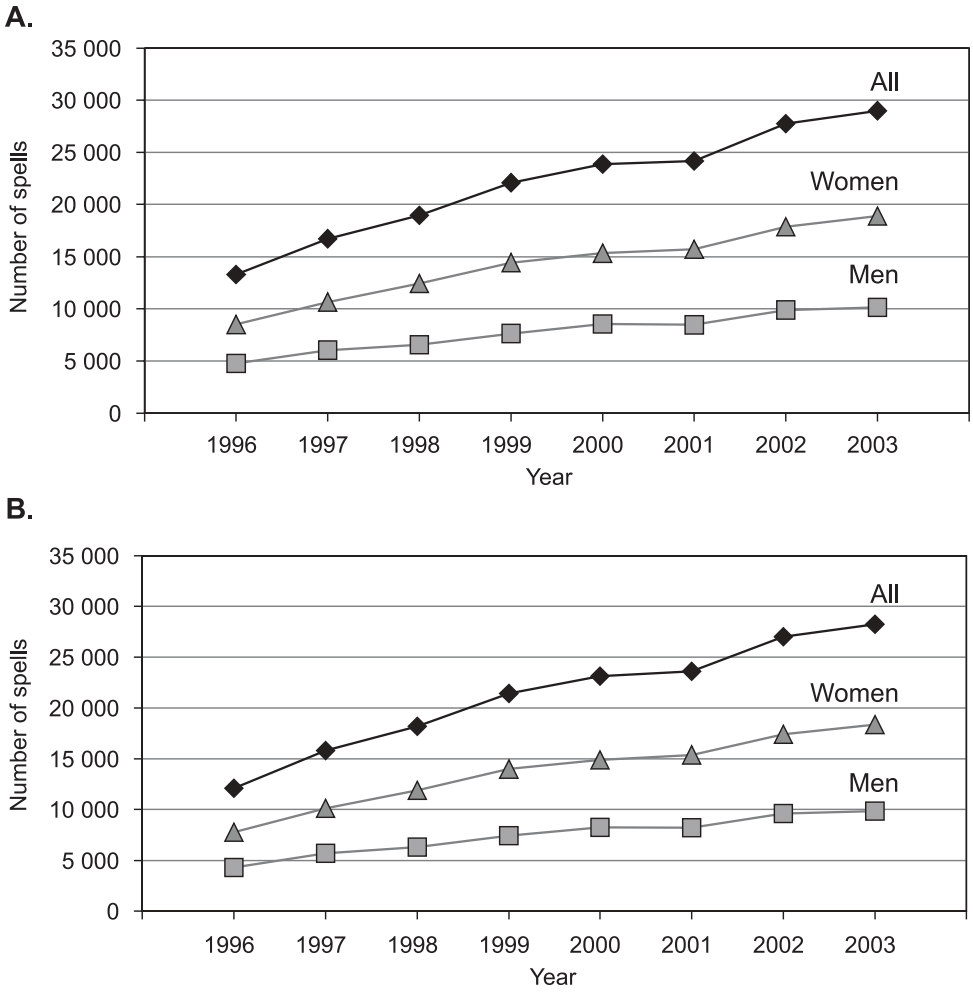
Figure 3. New sickness allowance spells due to mental disorders (ICD 10 F00–F99) 1990–2003.



In the period following 1996, for which more detailed statistics on diagnoses are available, the greatest increase in the annual number of paid sickness allowance spells caused by mental disorders is seen in affective disorders (F30–39 of ICD 10, for the ICD 10 diagnoses of mental disorders, see footnote[1]), among men as well as women. Figure 4 A shows the trends concerning affective disorders of which mania and bipolar (mano-depressive) disorders have been omitted. Figure 4 B shows the figures for depression only (F32–F33). Evidently, the curves of Figures 4 A and B are very similar. In 2002 and 2003, affective disorders comprised about 58 and 56 per cent, respectively, of absenteeism spells due to mental disorders, while neurotic and stress related disorders (F40–F48) accounted for 29 and 31 per cent. Only six and five per cent were due to schizophrenia or other psychoses in these two years, and less than three per cent due to alcohol and other psychoactive drugs related disease. (Figure 5).

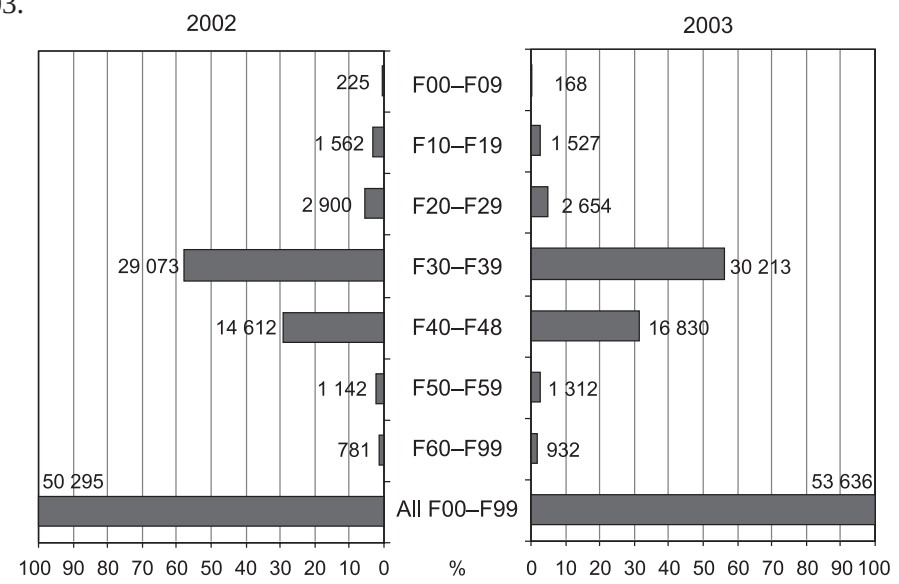
[1] ICD-10 diagnostic groups are the following: F00–F09 Organic, including symptomatic, mental disorders; F10–F19 Mental and behavioural disorders due to psychoactive substance abuse; F20-F29 Schizophrenia, schizotypal and delusional disorders; F30–F39 Mood (affective) disorders; F40–F48 Neurotic, stress related and somatoform disorders; F50–F59 Behavioural syndromes associated with psychological disturbances and physical factors; F60–F69 Disorders of adult personality and behaviour; F70–F79 Mental retardation, F80–F89 Disorders of psychological development, F90–F98 Behavioural emotional disorders with onset usually occurring in childhood or adolescence, F99 Other non-specified mental disorders.

Figure 4. New sickness allowance spells A. due to other affective disorders than mania and bipolar disorders (ICD 10 F32–F39) and B. due to depression (ICD 10 F32–F33) in 1996–2003.



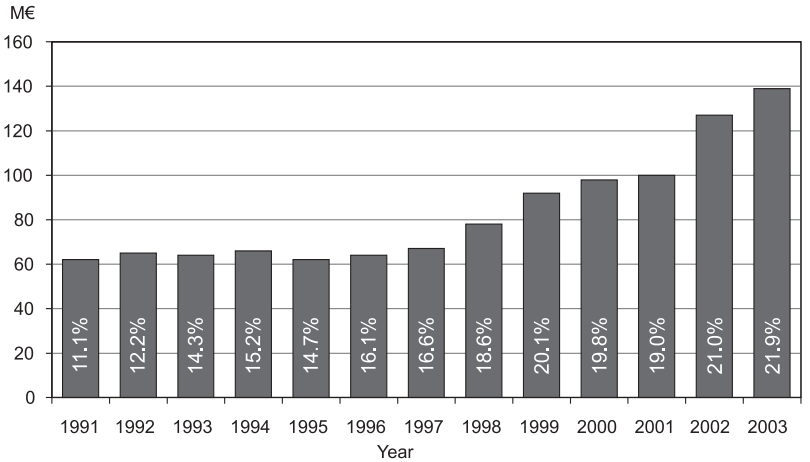
The expenditure on sickness allowance benefits in 2003 due to mental disorders was € 138 million, or 21.9 per cent of all sickness allowance expenditure (€ 634 million in 2003) paid out (Figure 6). Estimated on the basis of epidemiological data (5 per cent one year prevalence amongst the population at the age of 30 years or more and some 2.3 million persons at that working age), some 111 000 persons of working age are annually affected by an episode of major depression. According to the social insurance statistics, some 24 300 persons are on sick leave annually and some 31 800 on depression-related disability pensions, it appears that some 50 per cent of those who suffer from major depression are effectively incapacitated for work on account of it.

Figure 5. New sickness allowance spells due to various mental disorders in 2002 and 2003.



ICD-10 diagnostic groups are the following:
F00–F09 Organic, including symptomatic, mental disorders
F10–F19 Mental and behavioural disorders due to psychoactive substance abuse
F20–F29 Schizophrenia, schizotypal and delusional disorders
F30–F39 Mood (affective) disorders
F40–F48 Neurotic, stress related and somatoform disorders
F50–F59 Behavioural syndromes associated with psychological disturbances and physical factors
F60–F69 Disorders of adult personality and behaviour
F70–F79 Mental retardation
F80–F89 Disorders of psychological development
F90–F98 Behavioural emotional disorders with onset usually occurring in childhood or adolescence
F99 Other nonspecified mental disorders

Figure 6. Share of mental disorders of all expenditure of compensated sickness absenteeism days in 1991–2003.



2.4 Mental disorders and work disability pension

The total number of such recipients of work disability pensions from various Finnish pension schemes in 1981–2003, who lived in Finlad in the end of the year, is shown in Figure 7. After beginning to increase in the mid-1980's, the number of recipients of disability pensions peaked in the early and mid-1990's at around 294 000 recipients. Thereafter, the total number has gradually decreased to approximately the same level in 2003 as in the beginning of the 1980's. The number of persons on disability pensions was in the end of 2003 some 254 000 persons which was 7.4 per cent of persons of working age

The increase in the number of recipients from the mid-1980's till the mid-1990's was almost entirely caused by so-called individual early retirement pensions, a pension alternative introduced in 1986 and 1989, respectively, in the private and public sectors. The main criterion for eligibility was a permanent reduction in working capacity due to an illness, taking into consideration the effects of work demands and the length of employment history. Originally people aged 55 years or over were eligible. The minimum age was raised to 58 years in 1994 and further to 60 years in 2000. At its highest the number of recipients was 60 000. For most recipients, the cause of disability was a musculoskeletal disorder.

Figure 7. Recipients of disability pensions in 1981–2003 who lived in the country in the end of the year.

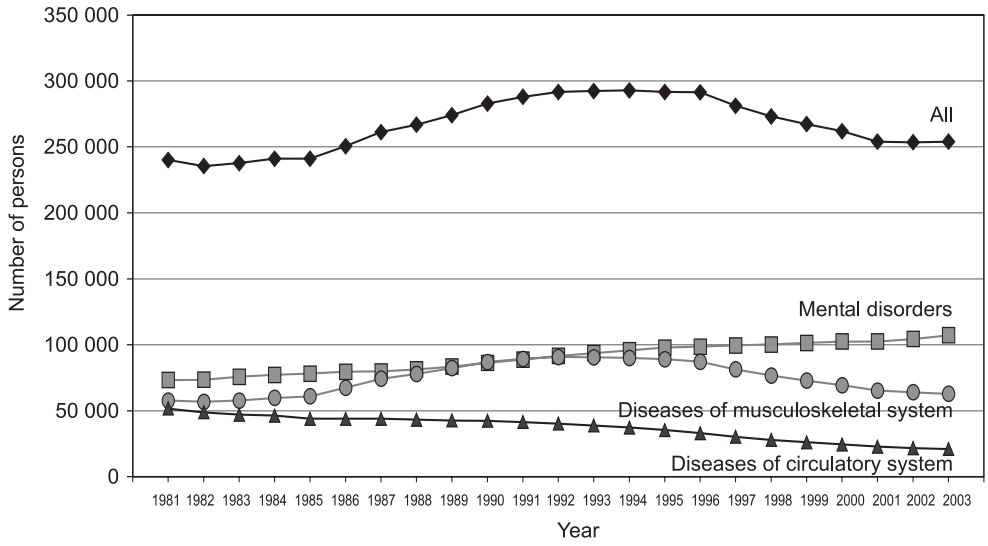
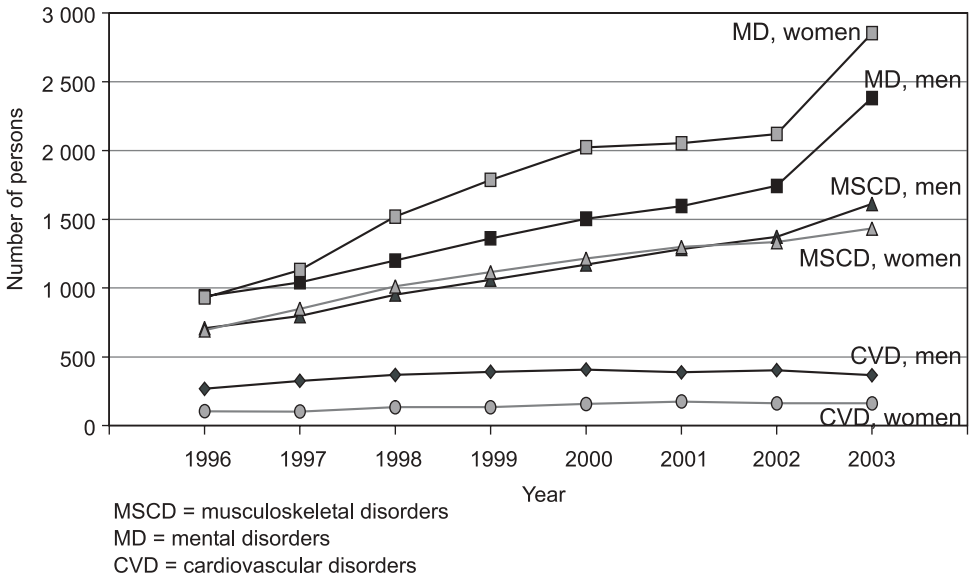


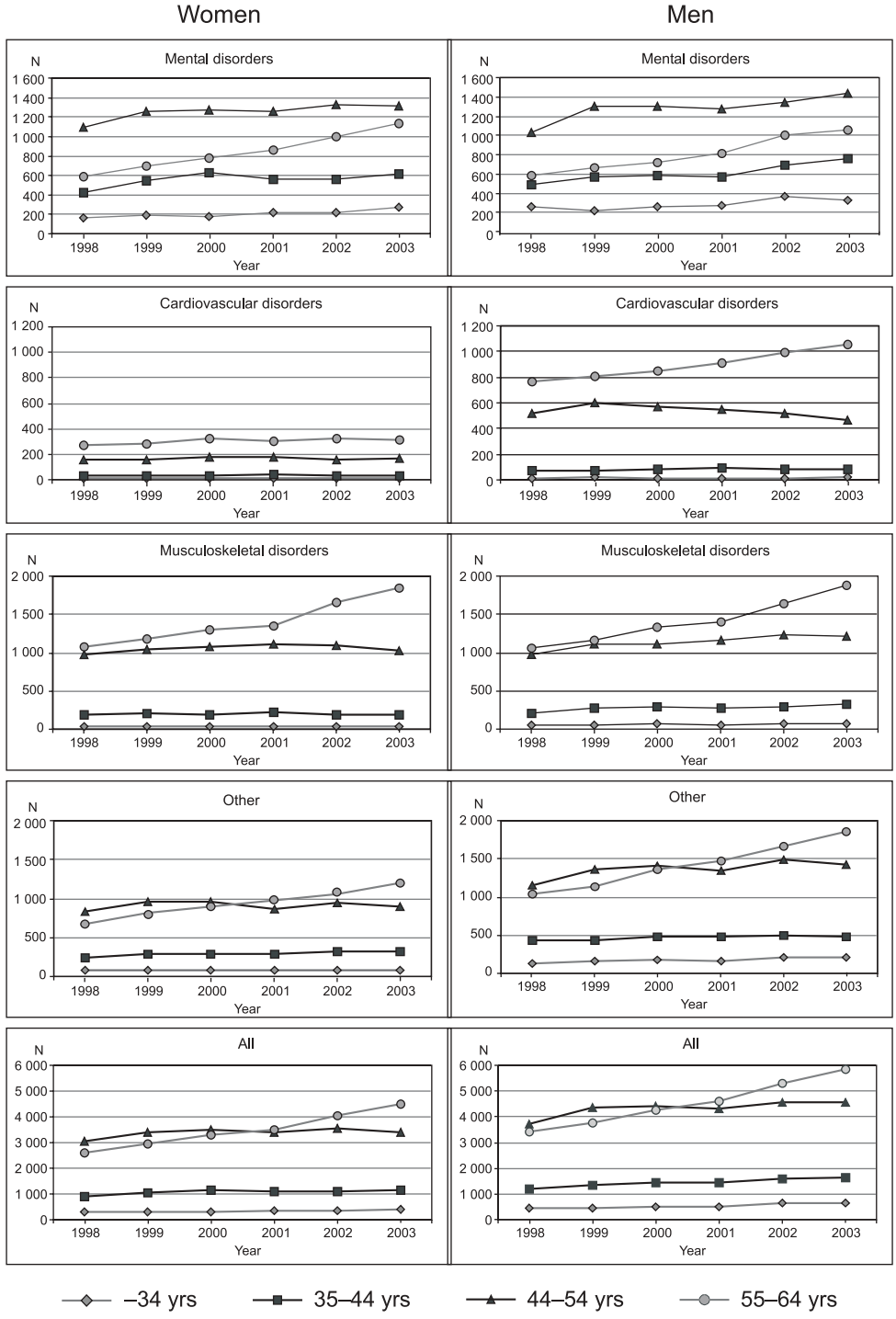
Figure 8. New earnings-related pensions granted for a fixed term in 1996–2003.



Although the number of disability pensions was in 2003 at about the same level as two decades ago, the morbidity behind the disability was quite different. This change has taken place especially during the last ten years. Ten years ago the share of mental disorders among causes of disability was 31 per cent, rising to 42 per cent in 2003. The share of musculoskeletal disorders decreased from 31 to 25 per cent, and the share of cardiovascular diseases from 14 to eight per cent. Of the new disability pensions awarded in 2003, 33 per cent were due to mental disorders, 30 per cent to musculoskeletal diseases, and nine per cent to cardiovascular diseases. Figure 8 indicates a substantial increase in new fixed-term earnings-related pensions granted on account of a mental disorder since 1996.

Figure 9 lists the main causes of new private-sector earnings-related disability pensions in various age groups. The data are shown for the year 1998 and following in order to avoid the effects of a legislative change in 1996 which made national pensions deductible by employment pension and abolished the common basis of pension statistics. Figure 9 indicates that the age group showing the largest increase in new disability pensions due to mental ill-health is for both men and women the oldest one of 55–64 years. Among men, the increase is seen in all of the included disease categories, and among women, in all categories except cardiovascular disorders.

Figure 9. New earnings-related disability pensions in the private sector in 1998–2003.



2.5 Mental disorders and rehabilitation interventions funded by the Social Insurance Institution

Figure 10 shows the diagnoses behind rehabilitation interventions funded by the Social Insurance Institution in 1990–2003. The rehabilitation services provided include individual psychotherapy, rehabilitation or adaptation courses, and vocational and medical rehabilitation (Table 1). When interpreting the changes shown in the Figure 1 has to take a note of the various changes in rehabilitation responsibilities in the country. The legislation concerning rehabilitation was reformed in 1991. More and more of the responsibility for vocational rehabilitation has been transferred to the earnings-related pension system in the course of the 1990's and this decade. Also, the division of tasks and respective roles of the rehabilitation provided as a part primary and specialised medical services and of the rehabilitation funded by the Social Insurance Institution have been a topic regular debate, and the division of tasks remains somewhat ill-defined. The number of rehabilitation clients of the Social Insurance Institution and the cost of these interventions have doubled since from 1993 till 2002 (Figure 10, Table 1).

Figure 10. Rehabilitation clients of the SII by disease category 1990–2003.

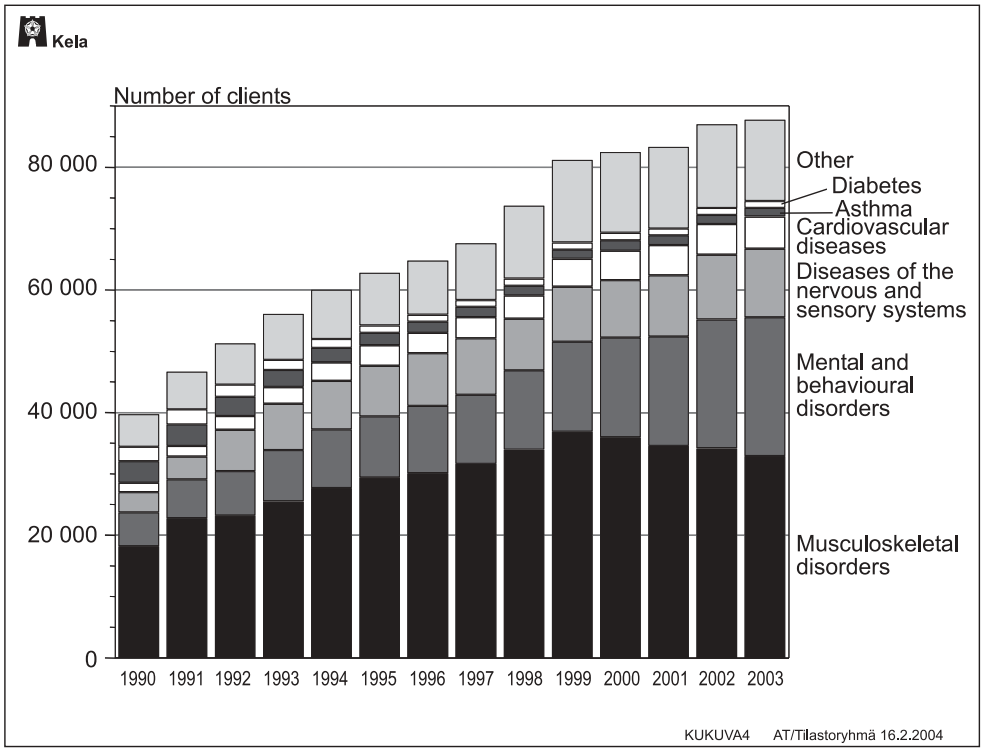


Table 1. Rehabilitation clients and costs, 1993–2002: Optional (KKL 4 §) psychotherapy.

Year	KKL 4 §, all	Psychotherapy	(%)	Costs mill. €
1993[1]	56 093	4 860	(8.7)	7.84
1996[1]	64 773	5 473	(8.4)	7.33
1999[1]	50 038	6 206	(12.4)	9.01
2000[2]	50 169	7 130	(14.2)	10.67
2001[2]	49 784	8 265	(16.6)	12.34
2002[2]	52 729	10 625	(20.2)	17.23

[1] Therapy for persons aged 16–64 years.
[2] Therapy for persons aged 5–64 years.
Please note: In 2002, 1 023 rehabilitation clients were in the age range of 5–15 years, so 9 602 clients (18.2% of all clients of optional (KKL 4 §) rehabilitation) were in the age range of 16–64 years.

2.6 Summary of possible reasons for the increase in mental disorders as a cause of sickness absenteeism and work disability

The prevalence of mental disorders has obviously not increased during the last two decades, yet the experienced mental symptoms, stress and distress have. The number of treatment days in specialized hospital based mental health services declined from 2.96 million in 1992 to 1.96 million in 2002. Yet at the same time the number of treatment periods increased from 37 863 to 52 320, and the average of treatment days declined from 171.6 days to 37.3 days. Outpatient mental care visits increased from 1 434 million in 1995 to 1 983 million in 2002. We assume, however, that qualitative and quantitative changes in the available services may not have played a major role in the increase of work disability caused by mental disorders that has been seen in Finland. The primary reasons should be sought elsewhere. (Stakes 2003.)

We shall discuss the role of the following six issues which may have influenced the trends described above:

– societal factors
– employment and working life in general
– experienced health and disease and health attitudes of the population
– competence and activities of the health care system with regard to mental symptoms and disorders

– introduction of ICD 10 in 1996 and abandoning the use of ICD 9 and DSM III-R
– availability and the role of curative mental health services.

The Finnish economy experienced a particularly severe recession during the early 1990's, with unemployment rising to some 20 per cent, the highest level in Europe. This was partially due to deficiencies in the management of the foreign trade and to globalising economy systems. The gross national product dropped sharply, but started to grow quickly again so that in 1994 it was back at its 1990 level. Management of the high unemployment and poor economy led to a huge expansion of public debt. At the same time Finland, as a result of joining the European Economic Area in 1993 and the European Union in 1995, had to make deep cuts in public spending. Social security was scaled back in many ways. In addition, both the private and public sectors were expected to reorganise their economic structures to enhance productivity and create a basis for stronger economic growth.

Although the protective network of social security still remained relatively inclusive, high unemployment among the youngest and oldest workers had a strong social impact. Today, the unemployment rate is at around 9 per cent. The recession also brought about changes in terms of working life demands and morals. Job security appears to have decreased and ever increasing productivity demands have become a new norm of working life. Flexibility in working life has long been discussed as a means of balancing work demands, family demands and other life needs. However, it is rather difficult to assess what is going on at Finnish workplaces in the area of flexible work arrangements. According to the national survey of working conditions of 1997, the most common type of flexibility reported was working overtime. Almost 60 per cent of the respondents reported working overtime at least once a month, with half receiving compensation for overtime work (Kandolin and Huuhtanen 2000). A sample-based questionnaire survey carried out in 2003 by the Central Organisation of Trade Unions among workers' representatives of mainly blue collar workers and service-sector manual workers, suggested that employer are quite unwilling to hire additional manpower, however great the need may be (SAK 2003). According to a study of the central trade unions (Laukkanen 2003) based on the work force survey of 2001 of Statistics Finland, somewhat more than one fifth of persons who were married and who had children below 18 years of age wanted to shorten their working hours, while one in seven wanted to work longer hours. The differences between married and non-married, or people with or without children, were rather systematic

but also quite small. Julkunen et al. have recently (2004) published a book on the time pressures of the middle class, and IT workers in particular. Their novel finding is that people with high decision latitude and a possibility to organise their work rather freely may run a risk of continuously extending their working times, irrespective of their family situation. Still another aspect is that part-time and non-permanent jobs are today a fact of life in both private and public sectors, regardless of the fact that the Finns typically prefer permanent, full-time jobs.

The high unemployment rate, weaker job security and continuously increasing productivity demands, then, may contribute to diversity in working life. For some people, this may lead to an increased risk of marginalisation and diminishment of coping ability both in economic and social terms. However, detailed information about the immediate and long-term effects of these factors on the population's health status and health-related behaviour is scant. But as noted above, the social safety net afforded by the Nordic-type Finnish welfare society, in helping to mitigate societal conflicts (e.g. Kautto et al. 1999), probably also acts to forestall immediate increase in serious mental disorders. That notwithstanding, it may have left a legacy of latent social coping problems of certain groups of people that may materialise years later, especially if confronted with such adverse social circumstances as marginalisation or social exclusion.

There have been other structural and qualitative changes in working life as well. Information technology is increasingly present in all occupations and sectors of industry. Mastering these new technologies requires special cognitive skills which not all workers, especially the older ones, may be able to attain. A part of the workers may have lacked such skills causing their exclusion from the labour market. Others may have been displaced due to mental health problems. The Finnish workforce is ageing more rapidly than that of any other EU nation. Within 10 years the workforce will definitely be smaller than today, due to retirement of the baby-boomers of the 1940's. The workforce of today is expected to produce a much higher output than that of the mid-to-late 1980's. Quantitative and qualitative increases in work demands place mentally vulnerable workers under additional pressure and elevate their risk of labour market exclusion. This sort of demanding circumstances may well create conditions where people having some sort of misfit with their work due to work demands, experienced stress and strain, limited skills or education are being pushed out from work. Although the problems certainly are work-related and should be resolved at work, through contacts with medi-

cal services, they become medicalised, the person's suffering given a medical diagnosis, like burn-out, depression, exhaustion, or distress.

Awareness of mental health problems and especially depression has increased among Finns. Reasons for this can be found in higher levels of education and awareness, media publicity, and public figures' accounts of their personal experiences with depression, which the general public has received with understanding and interest. Mental health professionals engaged in clinical work have noticed that while patients in the 1970's and 80's were prone to verbalise their mental health problems as *stress*, patients in the 1990's increasingly referred to them as *burnout* or, in the late 90's, as *depression* or *distress*. It has been found that the terms in which the general public communicates mental health problems have to some extent corresponded to changes in the media portrayal of such problems. Increased awareness of mental health issues and the increasing social acceptability of discussing mental health problems have produced changes in the population's health behaviour. People's ability to identify, analyse and verbalise any mental health problems they may have is today more finely tuned, and hence their willingness to use mental health services has grown.

People also move to growth centres at an increasing rate: this is especially true of young, well-educated people with children who seek better life circumstances and better work opportunities. The net loss of inhabitants is of special concern in the north and north-east. This evidently has various types of consequences: family ties and supportive structures weaken, people have to spend more of their income to meet the cost of everyday living, and life in bigger towns can in many ways be much harder for both parents and children.

The Finnish health care system has changed as well. Coverage in the Finnish occupational health care system has for years been at a very high level internationally. While its main purpose was originally the prevention of work-related illnesses and health hazards, today the major emphasis is on the maintenance of work ability and prevention of health hazards. Identification of mental health problems was recognised as a priority in occupational health service provision as early as in the early 1980's. One example of this is seen in the guidelines for occupational health examinations of farmers recommending testing for depression every fourth years (Lääkintöhallitus 1989). This shows the efforts made in the Finnish occupational health care system not only to combat work-related morbidity but to focus on the early detection of depression in health examinations.

Also the primary health care system has undergone thorough changes. A family doctor system has been gradually introduced. Municipalities have long had a high level of autonomy in their service provision. Psychiatric training has been made a more integral part of medical training programmes. The greatest progress has, perhaps, been seen in the screening and diagnosis of depression and the initiation of anti-depressive drug treatments. Depression has also been featured as an important topic in continuing medical education, which is to a great extent funded by pharmaceutical companies. This has predisposed doctors, even in the outpatient setting, to treat mental disorders by medication, perhaps at the expense of consultative therapy and other treatment methods. But on one hand there is some evidence that the patients are treated at too low a dose level or for too short a period to reach amelioration of the depressive symptoms. Another factor is that the pharmaceutical companies have been constantly looking for expansion of their market share.

The Finnish health care system has undergone structural and functional changes that have taken it into two different directions: the availability and use of psychiatric services proper have apparently declined, whereas the detection of depressions in primary health care and occupational health care has improved and the use of antidepressants increased. What links do these changes have to the increase in sickness allowance and disability pension recipiency seen in Finland? Mental disorders, and especially depressions, have become socially more accepted and visible, and hence more common as the medically determined cause of sickness absences and work disability.

The increase in sickness absenteeism caused by mental disorders accelerated in the late-1990s simultaneously with the introduction of ICD-10, at the same time as the application of the diagnostic battery of DSM III-R for the diagnosis mental disorders, which was used in connection of the ICD 9, was terminated in Finland. It may well be that under the new classification, less severe conditions have started to be coded under major depression.

As already noted at the end of the introductory section, changes in the social protection legislation and in the country's employment policy may well have an impact on both sickness allowance and disability pension statistics. The specific government programme to assess the work disability of the marginalised long-term unemployed persons has evidently contributed to an increase in sickness absenteeism spells and days in 2001–2003. It remains to be analysed how widespread mental disorder diagnoses are among persons who have been granted a disability pension (1 252 persons in 2001–2002, 1 635 persons in 2003).

To summarise the explanations we offer for the changed role of mental disorders in absenteeism and work disability: The increase in sickness absenteeism and work disability that can be attributed to mental disorders and particularly depressions is probably a consequence of many changes in society, ranging from various social factors, working life factors, health care issues and cultural and population changes The severe recession of the early 1990's may have resulted in certain long-term effects manifesting as problems of social coping, which have driven up the need for social security benefits. Increasing work demands have contributed to the labour market exclusion of workers susceptible to mental health problems. The population's illness behaviour has also changed, with people becoming more sensitive to mental disorders, especially depressions, and more likely to seek out professional help. The competence of health services in mental health questions is today better than ever. This trend has been reinforced by the introduction and stronger marketing of new anti-depressants by the pharmaceutical industry. As a consequence of all of the above factors, doctors of today may be more likely than before to prescribe psychotropic medication or to issue sickness absenteeism certificates or disability evaluations motivated by depressive or other mental disorders. It appears that previously hidden or undisclosed mental disorders – especially depression – have become more visible, better recognized and more acceptable socially, and have thus blended into the overall morbidity picture of the Finnish population. One may also question if a part of the conditions that in the 1970's , 80's and 90's were called pain-related disorders are today referred to as mental symptoms instead.

All in all, with regard to mental disorders, we can give no direct explanation as to why their proportion as a cause of work disability pension is growing. The process of applying for disability pension is rather complex and the criteria to be met demanding. There is also the fact that the use of medication for various mental disorders has been growing continuously, which should alleviate, not aggravate the consequences of mental disorders such as depression or anxiety. Finally, the expertise of medical professionals regarding the diagnosis and treatment of mental disorders is constantly improving.

2.7 What has been done or is being planned to prevent mental disability?

In order to establish relevant interventions to manage depression, distress, stress, anxiety or related other states behind sickness absenteeism or long-term work disability, one needs to be able to draw conclusions about which factors are either causally related or otherwise serve as means of preventive intervention. The disorders are plainly multi-factorial and complex: more is known of their various medical treatments than of their causality. But cultural issues, personality factors, life events, various (other) diseases, long-lasting stressful conditions, workload and dissatisfaction with job content, work organisation and line management, as well as human relationships in general seem to be related both to the occurrence of disorders and to the absenteeism.

General promotion of mental health and prevention of mental disorders

Promotion of mental health and prevention of mental disorders are closely linked to the promotion of health in general. Various programmes also make specific mention of mental health and mental disorders. Section 19 of the Constitution of Finland, in force since 2000, specifies that the public authorities are responsible for providing health promotion. However, what that means in practical terms must be interpreted in lower-level statutes.

The Strategic Targets for the year 2010 defined by the Ministry of Social Affairs and Health (Ministry of Social Affairs and Health 2001a) set out four strategic lines of action: promoting health and functional capacity, making work more attractive, preventing and combating social exclusion and providing efficient services and income security. Actually all these lines have relevance for promotion of mental health. Finland has also published its new Health for All programme titled the Government Resolution on the Health 2015 public health programme (Ministry of Social Affairs and Health 2001b) which however does not specifically address mental health issues under its lines of action. The issues are, however, better addressed in the monitoring indicators developed for the programme. On the other hand, Finland has worked hard and successfully to get mental health promotion on the agenda of the European Union (Lahtinen et al. 1999; Lavikainen et al. 2000), and mental health is featured in the current EU Public Health Programme (European Commission 2003).

The National Research and Development Centre for Welfare and Health has been very active in assessing and developing mental health services and instruments since the mid-1990's. The projects have included a multifaceted project titled Mieli Maasta! (Get your spirits up!) to improve recognition, diagnosis and treatment in primary and specialised services. The approaches dealt with adult, child and adolescent care (Lehtinen and Taipale 2001).

The Ministry of Social Affairs and Health launched a programme titled Meaningful Life!, which ran from 1998 to 2002 and had the aim of responding to the societal problems generated by the structural changes in mental health services during the 1980's, the recession of the 1990's, and the consequent weakening of the position of people with mental problems. The programme was coordinated by the National Research and Development Centre for Welfare and Health. The programme had a wide set of targets: improving emphasis on mental health and its promotion, increasing coordination between various organisations at the central and local levels, strengthening the involvement of individuals and the organisations that represent them in mental health issues, increasing the versatility of mental health services, improving the well-being of people with mental problems, developing telematic systems for information transfer and collaboration, promoting the psycho-social well-being of children, adolescents and the elderly, and promoting the employability of people with or at risk for mental ill-health. The programme grew to a major coordination activity, encompassing many ministries, provincial and local-level actors, social partners, as well as various NGOs and professional organisations (The Ministry of Social Affairs and Health 2003a). Based on the various activities of the programme a set of further activities and actions were proposed (The Ministry of Social Affairs and Health 2003b).

While research information on various issues related to mental disorders, including poverty, social exclusion and marginalisation, inequity and family problems, has raised concern in Finland, general prevention actions on mental disorders have remained limited. Based on experiences in the USA, a job search programme for the unemployed at risk of depression or discouragement has been operated with success (Vuori et al. 2002). The government has also allocated budget funds for projects focusing on child and adolescent psychiatry. The projects funded have also included a family welfare screening programme, support for early interaction between newborns and their parents (VAVU projects), and assistance to children of parents with mental illness (The Ministry of Social Affairs and Health 2004a).

Prevention of mental disorders in working life

In comparison to the general prevention of mental disorders, research and development programmes related to workplace stress are widespread in Finland. The Finnish Institute of Occupational Health is a leader in this field. Legislation has been revised to cover the mental consequences of working, and provisions concerning the psychosocial aspect of occupational safety and health have been in the legislation since 1987. To what extent the work accomplished so far has affected the well-being of the workforce remains to be determined.

A uniquely Finnish strategic approach to workplace health promotion can be seen in the so-called maintenance of work ability (MWA) (Peltomäki et al. 2002a). The concept first began to develop in the late 1980's. The current definition is: "Workplace activities aiming at maintenance of work ability include all measures that the employer and the employees as well as the co-operative organisations at the workplace take in a united effort to promote and support the work ability and functional capacity of all persons active in working life throughout their working careers". At the workplace level, the actions should be directed to the improvement of the work environment and work organisation and of the professional skills and competence as well as personal health resources and health. MWA arose from a need to change practices in working life so as to avert labour shortages and prevent premature retirement among ageing workers. Now that MWA has been practised for over 10 years, it has become almost a panacea for all concerns of the workforce and working life. It is considered beneficial to the health of working people of all ages, and more recently, has been expanded to include the promotion of training and know-how. It is viewed as providing the long-term unemployed with paths to employment and as increasing the input of ageing workers. All this clearly demonstrates that its general goals have found wide acceptance. An interview of a random sample of Finnish workplaces in 2001 (Peltomäki et al. 2002b) indicates that the activities are common and that there is a strong belief in their effectiveness. The actions are targeted at leadership and management, work atmosphere, participation and quality of working life. One quarter of the interviewed employers, representatives of employees and representatives of the occupational health service report that the work atmosphere and quality of working life has improved as a result of the actions taken. MWA was introduced to the occupational health service legislation in 1992 and a new act, in force since 2002, defines the promotion of work ability as a major task of the services. The new occupational health and safety act, in force since 2003, also

places an emphasis on the promotion of work ability and makes explicit and equal reference to the physical and mental health and safety of employees.

A programme on Well-being at Work 2000–2003 (Työministeriö 2000) was headed by the Ministry of Labour, with the participation of the Ministries of Social Affairs and Health and Education, the social partners, and various expert bodies, including research organisations. The programme was established to prevent detrimental effects of increased productivity demands on the workforce. Its defined objectives include the provision of information and promotion of good practice, utilisation of research results and commissioning new research, implementation of practical development projects and provision of funding support, and development of legislation. The programme was brought to a close in 2003 and subsequently evaluated. It also produced widely available guidance on good practices in promoting well-being at the workplace level. The National VETO Programme 2003–2007, led by the Ministry of Social Affairs and Health, is aimed at promoting the attractiveness of working life (The Ministry of Social Affairs and Health 2003c). It is based on four cornerstones: improving safety and health at work, improving the effectiveness of occupational health services and rehabilitation, improving equity at work, and making work more financially attractive than the passive social security structures.

As for other research and development approaches to prevention of occupational stress, distress, burn-out, fatigue, or any mental overburdening, it is clear that much is known about which working conditions are good for the worker. However, the current economic rules in working life do not necessarily support the application of this knowledge to practice. Also, the economic structure of working life is changing, and the changes impose a risk of marginalisation both for individuals, firms, regions and whole sectors of industry. Further, the Nordic model of social protection and civil rights needs stable funding, which is a major justification for the ever increasing productivity demands in Finnish workplaces both in the private and public sectors.

Secondary prevention at the individual level/medical services

As stated above, awareness of mental depression among providers of medical services (including in Finland the occupational health services) has improved a great deal, while the number of hospital bed sites for mental illnesses has been considerably reduced. There are at least two separate reasons for this:

research on mental disorders has produced instruments for screening for various mental conditions such as depression, anxiety, distress and burn-out. At the same time, much of the continuing medical education on mood-related disorders given to primary care physicians is provided in the context of pharmaceutical marketing, putting an emphasis on the detection and medication of illnesses. What is more, the clinical indications of anti-depressive drugs, among others, have expanded from depression to cover various other states such as pain.

The Finnish Medical Society Duodecim coordinates a programme called Current Care which aims at producing evidence based national medical care recommendations on certain medical conditions. So far more that 50 guidelines have been produced and a patient guideline has been published on the Internet. The collaboration has so far produced one guideline on schizophrenia and another on depression. The evidence is graded in four classes (A to D). According to the guideline on schizophrenia (Duodecim 2001), too little is known about the aetiology of the disease to say anything conclusive about primary prevention. However, quite a lot is known about the factors that increase the risk of schizophrenia, and much is known about secondary prevention, though the level of evidence is not always definitive. The recommendation on depression (Duodecim 2004) states that some 10 per cent of the patients in primary care may have depression but that only some actively seek help for their symptoms. Often other symptoms such as anxiety, personality disorders or drug and alcohol abuse accompany depressive symptoms. There are appropriate tools for screening depression patients at the primary care level, but the guideline proposes targeting patients with multiple social problems, those with obscure somatic symptoms, chronic disorders or pain, persons with a long history of unemployment, as well as persons who suffer from burnout or are heavy users of health services. Patients with mild or moderate symptoms should be treated with medication and/or psychotherapy as long as required. Psychotherapy also constitutes a major part of the individual rehabilitation of the patients.

There is also another aspect to effective care, namely the well-being of the carers. A recent Working Group on the division of labour and work stress in mental health services (specialised care) came to a conclusion that specialised mental health services are in need of various actions to relieve the experienced stress of the employees and to improve the attractiveness of working in this branch of services. With a view to improving the division of labour the Working Group proposed development of specific cooperation models, im-

provements in the labour division between social welfare and health care, co-ordination of specialised psychiatric care and mental health work on a larger scale, and development of new patterns of action. Work stress should be relieved by adjusting the resources and clarifying patterns of action within primary social and health care services and outpatient specialised psychiatric care, securing knowledge and skills, creating a flexible operational culture and by launching societal discussion about the issue. In order to increase the attraction of mental health work the Working Group proposed that its image should be improved, its leadership, content of work and allocation of resources developed, and education in the field reformed. Actions to develop the division of labour, to relieve work stress and to increase the attraction of work in mental health services presuppose concrete measures at the local, sub-regional and hospital district levels. The state and provinces must support mental health work projects carried out in individual hospital districts that aim at developing, experimenting with and studying the proposed reforms and creating new patterns of action. (Ministry of Social Affairs and Health 2004b.)

As noted above, the sickness allowance benefits of the Social Insurance Institution are not payable for certain diagnoses of ICD 10, such as burn-out, fatigue or exhaustion. This decision is based on the interpretation of the disability definition adopted in the Health Insurance system. What effect this limitation has on the diagnoses of approved sickness absenteeism episodes is hard to tell.

Local service co-ordination to prevent long-term disability

The social security and employment service systems are complex entities, and establishing a coordinated way to promote the return to work after a long-term sick leave can be hard, even if the person in question, the service systems, the employment organisations, and the employer of the person are willing to lend their support to the necessary actions.

The local organisation (meaning in this case workplace resources and internal practices, occupational health care, health and safety at work, municipal social and health care services, services provided by the social insurance and employment offices, rehabilitation services and educational measures, etc.) should be reformed into a functioning network with incapacity prevention as its aim. It should be developed into a seamless service entity, which is easily accessible to anyone at any stage of the working life. This seamless care sys-

tem is, however, not yet functional, although there is some experience of trying to force the various municipal, state and private organisations to work together more closely. Long-term absenteeism related to affective disorders can certainly serve as an example of how difficult it can be to re-employ people who have lost their jobs and whose work ability is diminished due to depression or other similar state.

A recent committee report of the Social Insurance Institution (Huunan-Seppälä et al. 2002) outlines a prevention programme carried out by the local offices of the SII. In 1998, the SII implemented a training programme titled 'Tyke', whose aim was to improve both customer services in the SII's local organisation in the area of work ability promotion and to increase interaction at the local level. The training programme was influenced in part by a reform of the pension system implemented in 1996. Increased emphasis was placed on Sickness Allowance periods as an opportunity to activate the assessment of work capacity and the provision of rehabilitation.

The 'Tyke' training process was premised on a practical implementation of the definitions of work ability, on the promotion of work ability, and on extending assessments of customers' needs to activities that support work ability rather than merely choosing the most suitable benefits. The training also covered methods needed in development work and in how to implement them (Nikkarinen et al. 1998). In the next phase, the focus shifted to the implementation of local projects by the local offices, to the improvement of customer services and to the interaction between various interest groups working together to promote customers' work ability. This phase was called 'Working together to improve working lives' – developing customer services and local interaction towards enhanced work capacity in the Social Insurance Institution. At the end of the projects, 82 reports were obtained from a total of 78 insurance districts. Each project tried out and described a new model or practice that improved customer service and local interaction with a view to promoting work ability in the local organisation of the SII (Broms and Brommels 2001; Laine and Islander 2001). The Department of Public Health at the University of Helsinki evaluated the implementation and success of both parts of the programme (Broms and Brommels 1999; Broms and Brommels 2001). The results of the evaluation confirmed that local office employees can improve customer service and coordinate, both internally and externally, the needed action in accordance with set aims and objectives. As the project progressed it changed from a traditional training project into a participant-centred development project. The participants felt that the improvements achieved fulfilled practi-

cal needs. Both the internal interaction and the benefit-orientated external interaction improved. Moreover, it was found that as internal interaction improved so did external interaction. The insurance districts of the Social Insurance Institution have included the activity in their normal client service routines since 2003, but how effective the services actually are remains to be evaluated.

There are also other locally operated programmes that involve the municipal services, the employment offices and the local offices of the Social Insurance Institution. Obviously, none of the actions are specific to mental disorders, but given that they seek to prevent marginalisation and disability and to improve employability, they have relevance also for people with mental health concerns.

2.8 Some priorities for further research from the social protection perspective

Although a lot is known about the causes, diagnosis, treatment, and rehabilitation of patients with mental disorders, there are still gaps and grey areas in our knowledge. In terms of the responsibilities of social protection, the two highest priorities are: first, to gain a much better understanding of what actually lies behind the trends in short and long term absenteeism due to mental disorders or pain both nationally and internationally, and second, to find the means to analyse and implement necessary and effective social protection measures to prevent absenteeism and the resulting work disability.

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Chapter 3. Trends in sickness absence and early retirement due to mental disorders in Germany

Wolfgang Boedeker, Hilke Berkels

Summary

Mental health problems are of growing concern to science as well as to national and international health authorities. In Germany, however, a systematic summary of time trends in morbidity due to mental disorders is still not available. The aim of this paper is to explore how utilization of sickness absence and early retirement due to mental disorders developed in the last two decades, and to summarise data on disability pensions provided under the German Pensions Insurance.

German health insurance data show an increase in sickness absence due to mental disorders from 57 sickness days per 100 members in 1978 to 119 days in 2002. This trend for mental disorders is especially remarkable considering that the general trend in sickness absence in Germany has been declining for the last 20 years. Neurotic disorders (including depression) are the most important subgroup of mental disorders with respect to the absolute number of sickness spells.

Work disability pensions due to mental disorders also show a trend which is clearly distinguished from the development in disability pensions due to other diseases. In Germany, the number of newly granted disability pensions declined from 193 030 in 1986 to 160 438 in 2001. In contrast the number of pensions due to mental disorders doubled in the same period increasing from 22 000 to 44 000. Whereas e.g. in 1986 only 11% of newly granted disability pensions were based on a diagnosis of mental disorders the percentage rose to 28% in 2001.

Several German institutions are addressing the mental health burden and the ways of preventing it. Problems of working life such as stress, burnout, bullying, and harassment are receiving particular attention. However, mental health is so far not a high priority issue in German health politics.

3.1 Introduction

Mental health problems are of growing concern to science as well as to national and international health authorities. The International Labour Organisation (ILO) e.g. estimates that one in ten workers suffers from mental ill-health and that 3–4% of GNP is spent on mental health problems in the European Union (ILO 2000).

In Germany, too, mental disorders are recognised as a major health concern. According to the Federal Health Survey about 32% of the German population (adults between 18 and 65 years) suffered from one or more mental disorders (one-year prevalence) in 1998/1999 (Wittchen et al. 1999; Wittchen and Jacobi 2002). The two most common disorders were anxiety (14.2%) and depressive disorders (11.5%). With respect to the costs, it was calculated that, on average, 30% of the 11 billion EURO caused by mental disorders 1998 can be attributed to work load factors (Boedeker et al. 2002).

However, a systematic summary of time trends in morbidity due to mental disorders seems to be still lacking. The aim of this paper therefore is to explore how the occurrence of mental disorders developed in the last two decades with respect to the utilisation of social insurance services. Sickness absence data of the German health insurance as well as data on disability pensions of the German Pensions Insurance are summarised. Analyses of time trends based on social insurance data are an ambitious undertaking since these systems are often subject to political adjustments. The legal framework and the populations entitled to specific social insurance services have changed substantially in Germany over the last ten years, which in turn partly affects the comparability of figures. This paper consequently serves rather as a sketch of the mental health burden.

3.2 The German social insurance system

The German social insurance system is based on four independent pillars of statutory insurance: the health insurance, the pension insurance, the accident insurance, and the unemployment insurance. In order to study the prevalence of general diseases, the health insurance and pensions insurance are of particular interest since the accidents insurance is liable for work accidents and occupational diseases only. While the main focus of the pensions insurance is on old-age retirement, the system also covers work disability pensions. These

pensions apply in the event of a permanent reduction of an employee's workability due to a specific disease. Disability pensions are converted to old-age pensions by the age of 65 years. The pension insurance consists of separate branches for white and blue collar workers. Also certain professions (e.g. farmers, miners) have their own pension insurance. Membership in a pensions insurance system is compulsory in Germany as long as one's income is lower than a certain limit. More than 95% of the German workforce is a member of a statutory pension insurance.

The German health insurance mainly covers health and medical care. Sickness absence from work for more than three days in a row has to be attested and diagnosed by a physician. The health insurance is organised in five branches for historical reasons (e.g. blue/white collar, regional, professional, company based). The branches comprise some 300 insurance institutions. Membership in a health insurance scheme is compulsory in Germany as long as one's income is lower than a certain limit (this limit is lower than that for the pension insurance). Since 1995 employees are entitled to choose their insurance institution among those offering their services. More than 90% of the German workforce are members of a statutory health insurance.

3.3 Methods and data

Data on sickness absence and on work disability pensions were used to study trends in the occurrence of mental disorders. Sickness absence data are compiled by the member specific health insurance schemes and their federal associations. Part of the data are collected at national level by the German Ministry of Health. Unfortunately, these national figures are published with a considerable time lag. The most up-to-date national figures are available for the year 1996.

The longest time series on sickness absence in Germany is available from the annual statistics of the BKK Federation. One has to keep in mind though, that the membership of the BKK health insurance has changed dramatically since 1995 when employees were first allowed to choose their health insurance provider. As a consequence, company based health insurance schemes gained a larger percentage of younger employees with a higher social status, which undermined the year-on-year comparability of the data. In order to study time trends the BKK data on sickness absence were used to sketch the development since 1980. To allow for a subgroup differentiation of the very heterogeneous

ICD-9 main section *mental disorders* and to ensure comparability across time national figures were additionally used for the period 1992 to 1996.

Table 1. ICD-9 codes for mental disorders (290–319).

290–294	**Organic Psychotic Conditions**
290	Senile and presenile organic psychotic conditions
291	Alcoholic psychoses
292	Drug psychoses
293	Transient organic psychotic conditions
294	Other organic psychotic conditions (chronic)
295–299	**Other Psychoses**
295	Schizophrenic disorders
296	Affective psychoses
297	Paranoid states
298	Other nonorganic psychoses
299	Psychoses with origin specific to childhood
300–316	**Neurotic Disorders, Personality Disorders, and Other Nonpsychotic Mental Disorders**
300	Neurotic disorders
301	Personality disorders
302	Sexual deviations and disorders
303	Alcohol dependence syndrome
304	Drug dependence
305	Nondependent abuse of drugs
306	Physiological malfunction arising from mental factors
307	Special symptoms or syndromes, not elsewhere classified
308	Acute reaction to stress
309	Adjustment reaction
310	Specific nonpsychotic mental disorders due to organic brain damage
311	Depressive disorder, not elsewhere classified
312	Disturbance of conduct, not elsewhere classified
313	Disturbance of emotions specific to childhood and adolescence
314	Hyperkinetic syndrome of childhood
315	Specific delays in development
316	Psychic factors associated with diseases classified elsewhere
317–319	**Mental Retardation**
317	Mild mental retardation
318	Other specified mental retardation
319	Unspecified mental retardation

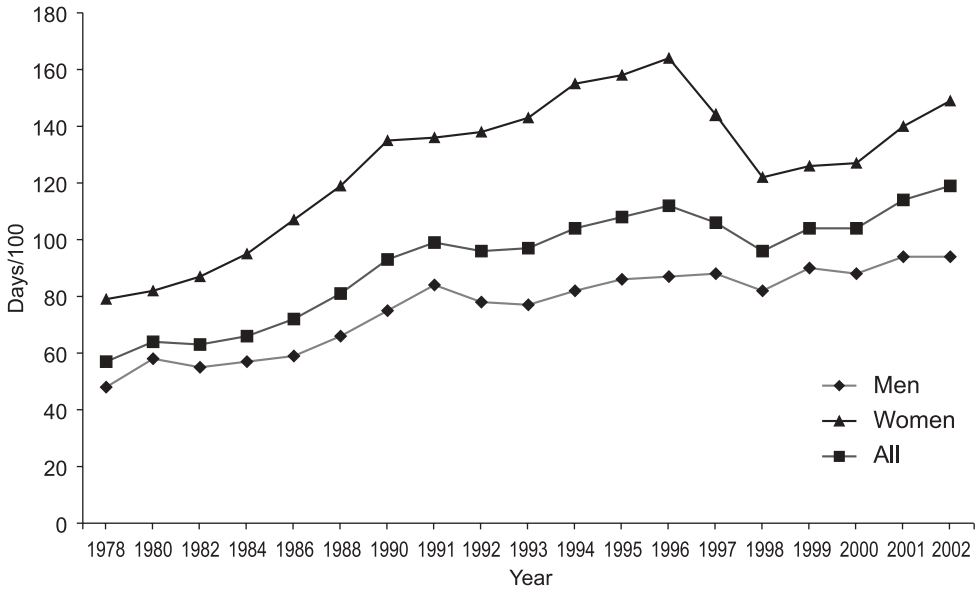
Data on work disability pensions were taken from the statistics of the Federation of German Pension Insurance (VDR). The data comprise all pensions which have been granted to employees because of permanent work disability due to a specific disease. Although in most cases the disability keeps the employees from taking up any kind of job, also those pensions that allow staying at work at a reduced level are included. In Germany, the legal framework for early retirement has been changed frequently during the last 20 years, partly affecting also the utilisation of work disability pensions. The comparability of absolute figures across time is therefore compromised in any case. Relative figures are therefore presented as well.

Sickness absence and work disability pensions are indicated according to the ICD-9 for the main category *mental disorders* (ICD 290–319) and for selected subgroups. Table 1 lists the subgroups along with the 3-digit ICD codes.

3.4 Sickness absence due to mental disorders

The longest time series on sickness absence due to mental disorders in Germany is available from the annual statistics of the BKK Federation (Figure 1). It shows an increase from 57 sickness days per 100 members in 1978 to 119 days in 2002. Whereas for men the trend appears as an almost monotonous increase, for women a peak is shown in 1996. Since 1998 the number of sickness days has been increasing again. The trend for mental disorders is especially remarkable considering that the general trend in sickness absence in Germany has been declining for 20 years (1980: 26 days per member, 2001: 14 days). However, the figures with respect to mental disorders should be considered with the caveat that the membership of the BKK health insurance has changed dramatically since 1995 when employees were allowed to choose their health insurance provider. In consequence the company based health insurance schemes gained a larger percentage of younger employees with a higher social status. The time trends in Figure 1 could therefore be biased by incomparable populations. The time series should ideally be based on standardised figures which unfortunately are not available.

Figure 1. Sickness absence due to mental disorders ICD 290–319 (days per 100 members of the BKK health insurance).



In order to gain a better insight into the sickness absence trends due to mental disorders the disease statistics of the German Ministry of Health were utilised (see Methods). The frequency of sickness absence due to organic psychotic conditions grew from 5.5 in 1992 to 8.0 in 1996 (Figure 2), with a marked increase in the period between 1994 and 1996. This trend also applies to the duration of sickness absence (Figure 3). A somewhat more linear increase of 18% can be observed with respect to other psychoses (Figure 4, Figure 5). Neurotic disorders (including depression) are the most important subgroup of mental disorders with respect to the absolute number of sickness spells. Although an increase in sickness absence can be observed, it again applies more notably, in general, to the duration of absence (Figure 6, Figure 7).

Figure 2. Number of sickness spells due to organic psychotic conditions (ICD 290–294) (BMGS 2003).

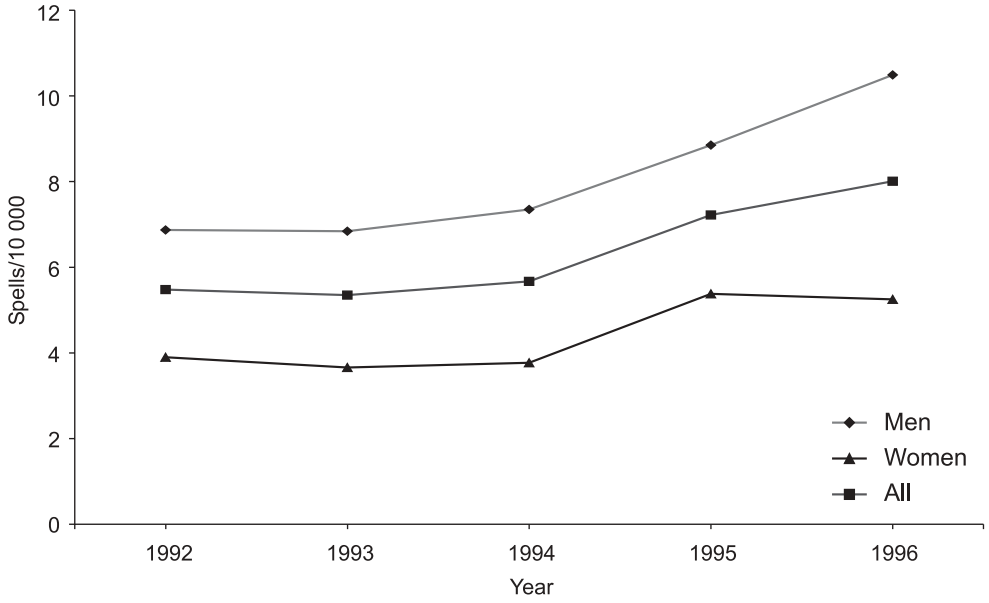


Figure 3. Number of sickness days due to organic psychotic conditions (ICD 290–294) (BMGS 2003).

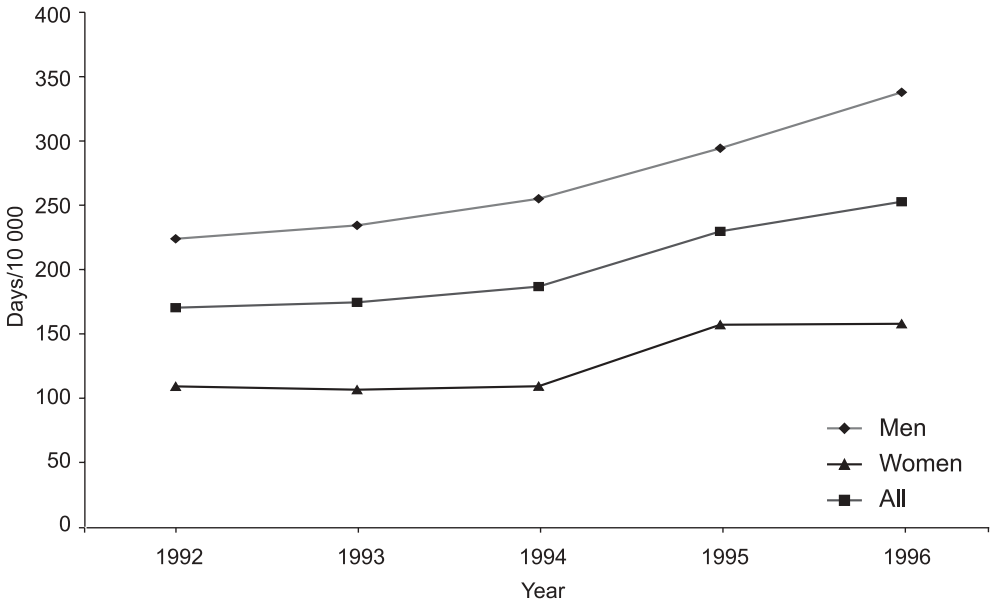


Figure 4. Number of sickness spells due to other psychoses (ICD 295–299) (BMGS 2003).

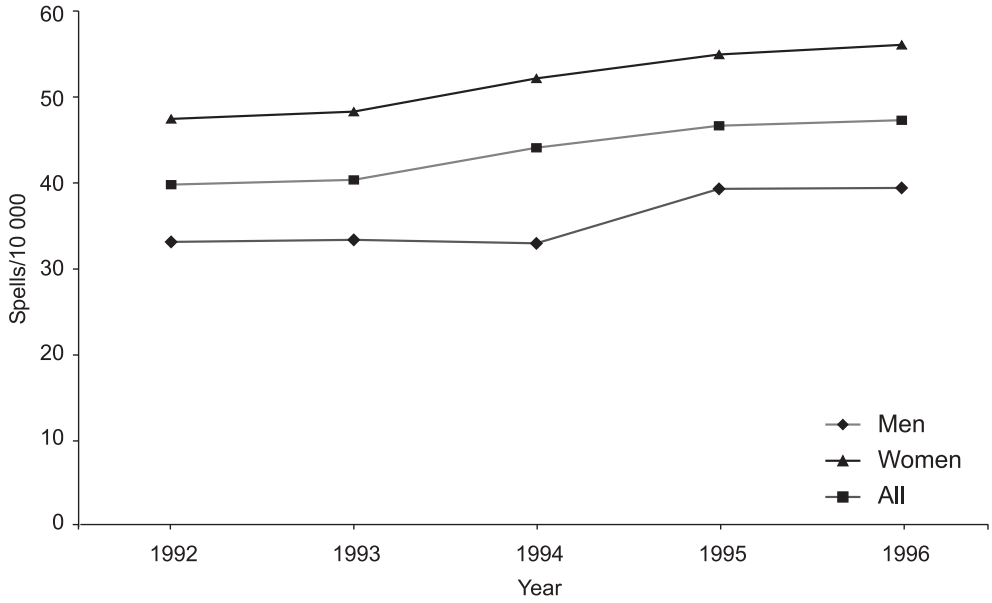


Figure 5. Number of sickness days due to other psychoses (ICD 295–299) (BMGS 2003).

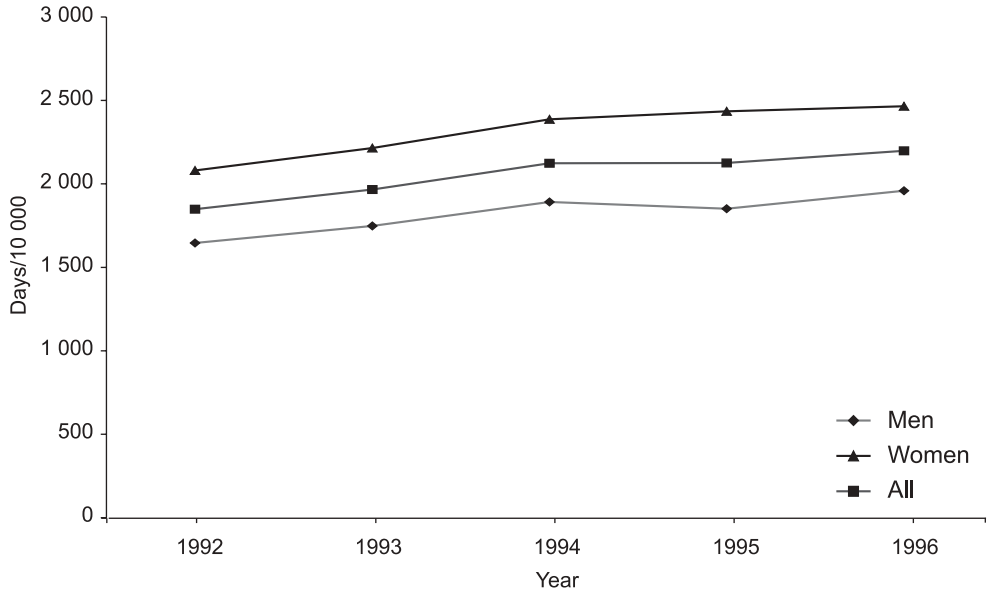


Figure 6. Number of sickness spells due to neurotic disorders (ICD 300-316) (BMGS 2003).

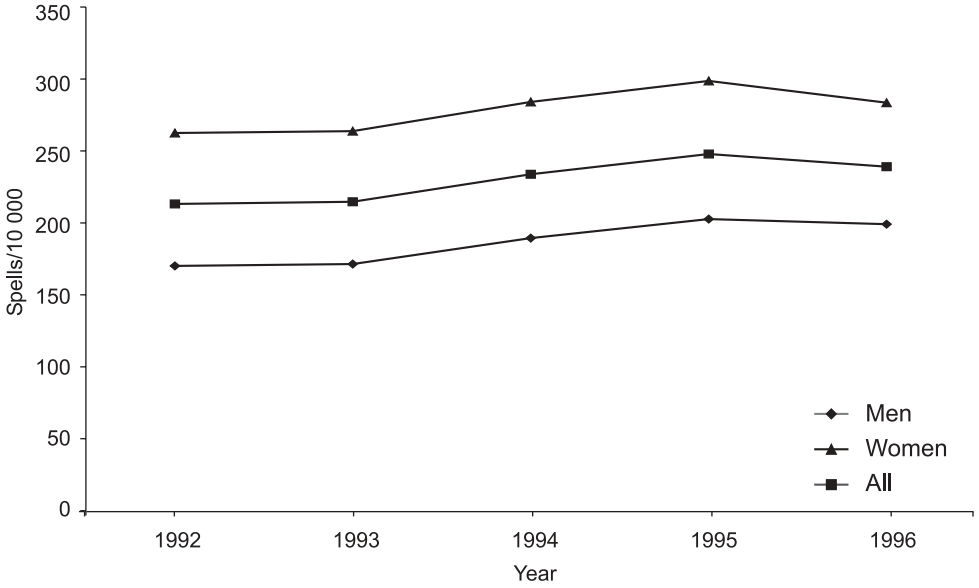
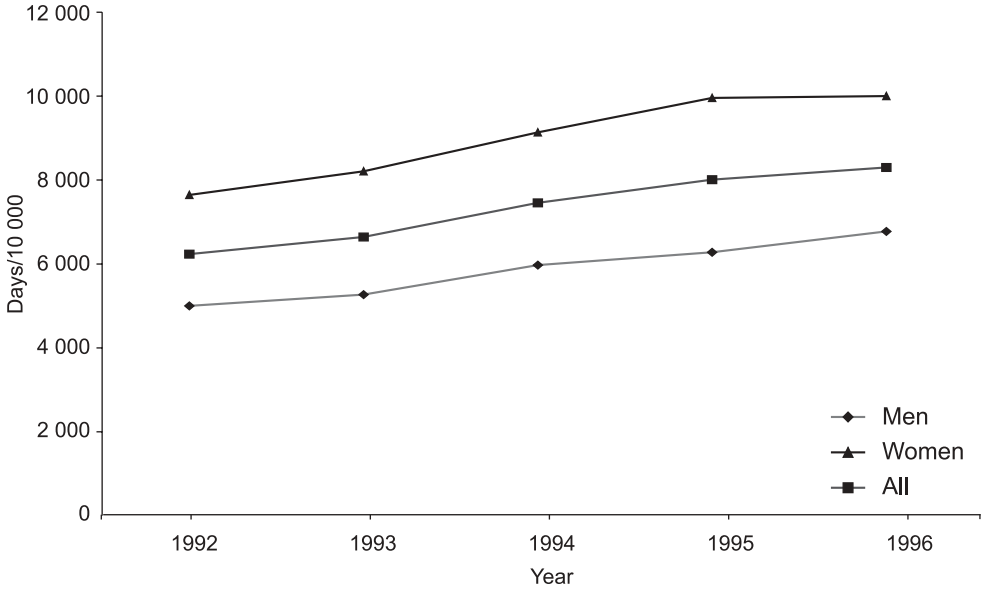


Figure 7. Number of sickness days due to neurotic disorders (ICD 300–316) (BMGS 2003).



3.5 Work disability pensions due to mental disorders

Work disability pensions due to mental disorders show a markedly different trend to disability pensions due to other diseases. In Germany, the number of newly granted disability pensions declined from 193 030 in 1986 to 160 438 in 2001. In contrast the number of pensions due to mental disorders doubled in the same period increasing from 22 000 to 44 000. Similar trends could be observed for both sexes (Figure 8). Mental disorders also increased in proportion to other diseases as a cause for disability pensions. Whereas in 1986, for instance, only 11% of newly granted disability pensions were based on a diagnosis of mental disorders, by 2001 the percentage had risen to 28%. This trend obviously is gender specific. Starting at about the same amount the share of mental disorders grew faster and higher for women (Figure 9). In 2001 more than one third of all newly granted work disability pensions for women were due to mental disorders.

Figure 8. Number of new work disability pensions due to mental disorders (ICD 290–319) in Germany (VDR 2003, old federal states only).

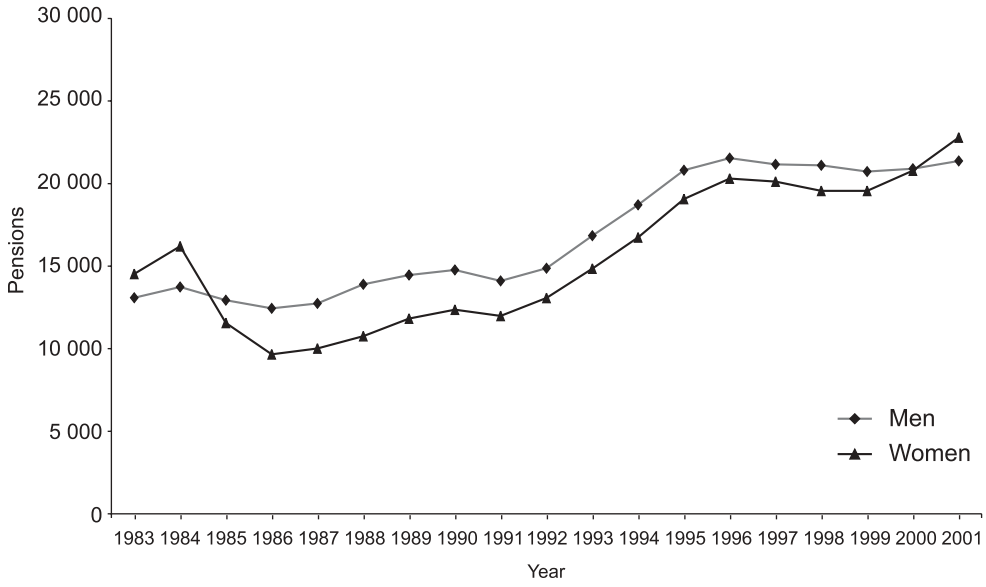
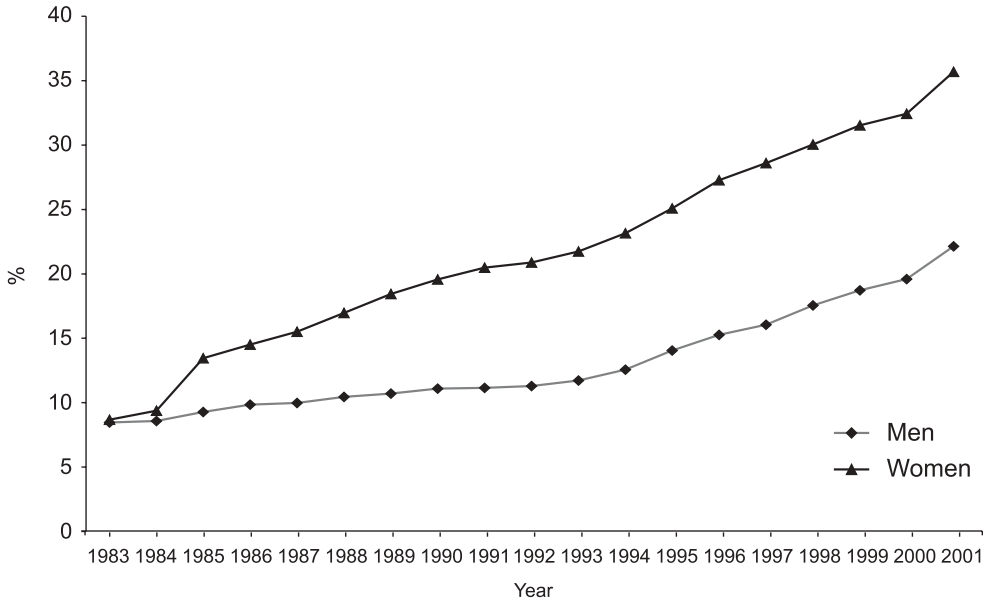


Figure 9. Work disability pensions due to mental disorders (ICD 290–319) in Germany: Percentage of all disability pensions (VDR 2003, old federal states only).



3.6 Mental ill-health – causes and consequences

Work is a major domain of life for the majority of the population. According to data from the German Institute for Employment Research (Institut für Arbeitsmarkt und Berufsforschung – IAB), German employees worked an average of 1445 hours in 2003. Compared to the mean number of working hours per person in 2002, this number has increased by 0.1%.

It is not only the average of working hours that has increased, but also the complaints about and the societal interest in phenomena like stress at work, burnout, bullying and the like. These phenomena are also related to mental ill-health. Most people normally do not use anxiety or depression (a possible consequence e.g. of bullying) as terms to describe personal feelings or the state of their mental health because they may be afraid of stigmatisation. Instead, people often refer to stress, when the demands of their work environment exceed their ability to cope with (or control) them. For that reason attention should be paid to the results of the Third European Survey on Working Conditions 2000, since e.g. 16% of all workers stated that their skills are not suited to the demands of their job (Paoli and Merllié 2000).

In discussing the causes for such complex disease patterns as mental disorders, it should always be kept in mind that most forms of mental disorders have more than a single cause. Health, ill-health and coping with health problems depend on a complex interplay of different factors that go beyond genetic dispositions. Physical, psychological and social factors can be influencing variables. That is why the following listing of working conditions that can lead to mental health problems or even influence the development of depressive episodes or anxiety disorders is not complete: Person-environment misfit, qualitatively or quantitatively too high or too low job demands, time pressure, lack of control and job autonomy, emotionally distressing work e.g. in the human service sector, low social support, poor communication and information, job insecurity, organisational changes such as mergers or downsizing etc., unclear/ambiguous instructions and roles, unclear organisational and personal goals, lack of participation e.g. in goal setting, noxious physical work exposures (e.g. noise), phenomena like bullying, harassment and violence etc.

Relative risks for sickness absence from neurotic disorders have also been studied with respect to workload factors (Boedeker 2001). The strongest and most consistent association was found for low control. Employees exposed to very little control of their work suffer from sickness absence from neurotic disorders three times more often than colleagues not exposed to low control. Psychosocial demands by contrast showed inverse exposure response relations. Hence, employees not exposed to psychosocial demands (time pressure, decision pressure, high responsibility, task interruptions) were about three times more likely to go on sick leave than colleagues who were frequently exposed to such demands. This might rather be an expression of work commitment or pressure to attend than of coping behaviour since *hard* diagnoses were equally concerned. Furthermore, results showed that women are at a twofold risk for sick leave due to neurotic disorders. For employees with the shortest school careers and no apprenticeship a rate ratio of 3 was observed compared to employees with a university diploma. This is in line with the findings of the Whitehall II-Study. Concerning psychiatric illness, which was classified as *neurosis* or *neurosis ill defined*, an association with low employment grade was found and sick leave was more frequent in women (Stansfeld et al. 1995).

Table 2. Workload factors and relative risks for sickness absence from neurotic disorders (ICD 300–309, 311, 316).

Work load factor	Exposure level	Sickness spells	RR[1]	95% CI
Physical demands	very high	8	1.56	1.14–2.15
	high	57	1.05	0.93–1.20
	moderate	702	1.49	1.40–1.59
	low	1 994	1.32	1.25–1.38
	no exposure	398	1.00	1.00–1.00
Low control	very high	242	3.17	2.42–4.16
	high	1 709	2.81	2.16–3.67
	moderate	78	2.43	1.83–3.22
	low	1 069	2.17	1.67–2.83
	no exposure	61	1.00	1.00–1.00
Psychosocial demands	very high	25	0.44	0.36–0.53
	high	555	0.62	0.58–0.66
	moderate	716	0.85	0.81–0.89
	low	284	0.86	0.81–0.91
	no exposure	1 579	1.00	1.00–1.00

[1]RR: Rate ratio adjusted for age, sex, company, education, work hours and duration of employment; CI: Confidence interval.

The above illustration focuses on the possible influence of working conditions on mental health. Yet there are also possible influencing variables resulting, for example, from emotionally taxing incidents in private life such as the death of a loved one, unemployment, divorce, chronic pain and major illness – life events that one might not be able to cope with. Also genetic dispositions and biological factors / bio-chemical imbalance (e.g. lack of serotonin) are believed to trigger many forms of depression, which is one of the most common forms of mental disorders.

Mental health problems can have manifold consequences for the individual and the enterprise as well as for the national economy. The individual can suffer a decline in quality of life. Social relationships might suffer, because mental health problems potentially lead to behavioural changes. Depression for example, (according to the The World Health Report 2001 by the WHO approximately 121 million people world-wide suffer from depression), may cause a non variable sadness extending over several weeks, crying without an obvious reason, sleeping problems, loss of appetite, loss or gain of weight, lack of motivation, lethargy, fatigue, no interest in normal (daily) activities,

poor concentration and memory, hopelessness, pessimism and feelings of being worthless or even suicide ideation. There could also be physiological reactions such as having an increased irregular heart rate, muscular tension with subsequent pain (back, neck or head) or increased blood pressure. These reactions may lead to hypertension or myocardial infarction. According to Kubzansky and Kawachi (2000), anger and depression are related to an enhanced risk of coronary heart disease.

In the context of work, depression can be responsible for not turning up or being tardy, working slowly (productivity loss) or making mistakes more often (quality loss). According to Dewa and Lin (2000) people with mental health problems seem more likely to go to work but require greater effort to maintain their working capacity. Psychiatric illness is also found to be the third most common cause for long spells of sick leave (> 7 days) for women and the fourth for men (Stansfeld et al. 1995). And finally, as mentioned before, an estimated three to four percent of the gross national product (GNP) is spent on mental health problems in the European Union (Gabriel and Liimatainen 2000).

3.7 Mental health promotion and prevention of mental ill-health

The most important step in promoting mental health, preventing mental ill-health and reducing stigmatisation of people with mental health problems is to ensure the availability of relevant information. Information on mental health issues should address the prevalence, potential causes and indicators for mental health problems, their possible consequences, and options for treatment. It should be made clear that mental ill-health can affect all of us, bearing in mind that the causes of mental health problems are multi-faceted and multi-factorial. It is therefore essential, on one hand, to provide positive life settings (e.g. healthy working conditions), and on the other hand to help people develop their own strategies to cope with different challenges in working and private life. People will probably be more resilient if they have positive self-esteem, possess problem solving skills as well as stress and conflict management skills, and can experience feelings of mastery and self-efficacy and rely on positive social support in stressful times.

With regard to mental health at work, employers should aim at improving the person-environment fit (person-job demand fit) or provide for training to improve employees' professional and social/communicative skills, provide

healthy work processes and work places and ensure the communication of information and participation of the employees on topics relevant to them (such as restructuring activities in the enterprise). Integrating guidelines and activities for mental health promotion and prevention of mental ill-health into the enterprise policy will be a major step towards combating the risk of mental health problems among employees.

3.8 Mental health activities in Germany

In Germany, policy makers show great interest in mental health – though it is not a high priority issue – and its impact on the individual, society and of course the economy. Terms such as stress, burnout, bullying and harassment are widely discussed, especially as they relate to mental health at work. Nevertheless, there is in Germany still a huge lack of public policy, strategies and activities focused exclusively on mental health. Inspired by the topic *mental health* of the WHO World Health Day 2001 the federal health minister prepared a press release to highlight the importance of mental health. She also had to admit that the German health system pays less attention to mental ill-health than to somatic ailments, which still may be due to the societal stigmatisation of mental disorders. Stigmatisation in turn may make individuals more likely to conceal experiences or feelings of mental ill-health, less willing to disclose to their social environment that they suffer from some sort of mental disease, and less disposed to seek help.

Germany has been successful in establishing a high quality care system for mentally ill people. There are many projects that, for example, promote networking between the ambulant and stationary sectors. The legislation enacted in 1998 concerning psychotherapists was a further step towards improving the care and psychiatric treatment of people suffering from mental disorders.

On the basis of the German Social Security Code, legislation also endorses the implementation of a German Advisory Council for Concerted Action in Health Care. In 2000/2001 the members of the Council delivered an experts' report which among other things contained information on depression in Germany, including the burden of care imposed by it. The Council published draft recommendations for the government, which made a strong call for raising awareness about the special significance of mental health within a broad concept of health and continuing efforts to reduce existing social prejudices against psychiatric diseases.

Several professional organisations concentrate on mental health and its treatment. They develop new kinds of psychotherapy, promote networking between psychotherapists and other psychosocial health professionals, focus on strengthening the networking between those who suffer from mental ill-health and provide contacts and information for other family members and friends, inform the general public, etc.

Activities to promote mental health often focus on societal subgroups potentially at a higher risk for mental disorders. Such groups include health care professionals, rescue workers, service personnel and teachers. Certain age groups, older people for instance, also seem to be at higher risk for mental ill-health.

Many programmes/projects have been established during the last few years, and are implemented on different levels; local, regional or national. The following list of examples is intended to give a brief overview of activities in Germany focussing on the improvement of working conditions, including mental health at work, and on the treatment and medication of mental ill-health as well as promotion of mental health.

For the workplace:

– INQA (Initiative for New Quality of Work). It is a national co-operative project among different actors including the Federal Government, the Federal States, the social insurance partners, the social partners and enterprises. The programme is approved by the Ministry of Labour and Economy (Germany) – indeed it was originally initiated and financially supported by the Ministry – and on the whole aims at improving employees' health, motivation, qualifications and skills to humanise work and to promote physical and mental health. The programme supports several projects dealing with psychosocial stressors and mental healt.
http://www.inqa.de/bmwa/generator/Inqa/Navigation/english.html

– IG Metall (trade union with estimated 2.8 million employees of the metal-working, textile, timber and plastics industries). A department dealing with Work and Health Protection was established within the union central office, which publishes a monthly bulletin informing employers and employees about health topics, especially mental health and related phenomena like stress and burnout. It also organises seminars and training on health and safety at work

for the stakeholders (in one example, works council members were trained to identify sources of psychological stress) <http://www.igmetall.de/>.

– Joint Initiative Healthful Working in the federal state North Rhine-Westphalia was founded jointly by the provincial government (Ministry for Employment & Social Affairs, Qualification & Technology of North Rhine-Westphalia), by the Employers Liability Insurance Association, by social partners, and by business and health insurance companies. It is planned to last three years. The goal is to demonstrate the importance of a holistic view of health and safety at work for the general public and to highlight the link between health promotion and prevention at enterprises. The campaign uses different media to spread information on subjects of prime interest like mobbing, stress and healthful leadership. They also established a Mobbing Line (= crisis line), which victims as well as managers can call to obtain counselling. Further, the initiative presents a Best-Practice-Award to enterprises that already implement a modern and holistic approach to occupational safety and health. <http://www.gesuender-arbeiten.de/>

– German Network for Workplace Health Promotion <www.dnbgf.de> is part of the European Network for Workplace Health Promotion and also focuses on such issues as psychosocial stressors at work, bullying, work-home conflict, burden of work-related diseases etc.

For the general public:

– GNMH (German Network for Mental Health
<http://www.gnmh.de/english/home.html> is an association of interested groups, social welfare organisations and scientists for the promotion of mental health and prevention of mental ill-health. In cooperation with several international organisations the GNMH is establishing a common structure in policy, social welfare services and research to promote mental health and prevent mental disorders in a much broader sense than in the past. The GMNH aims at:

- Implementing models of good practice and evidence based prevention and mental health promotion instruments. GNMH also supports initiatives and models for prevention and mental health promotion.
- Proposing new policies and laws in the area of prevention and health promotion

- Organising a fluent exchange of expertise and information among all members of the GNMH, international organisations and initiatives as well as interested parties.
- Co-ordinating conferences and other tools for education in mental health promotion and prevention of mental disorders

– BZgA (Federal Centre for Health Education) is part of the Federal Ministry of Health and Social Security. Health education and health promotion are important aspects of the German public health service. Since its establishment over 30 years ago, it has been the objective of the Federal Centre for Health Education to prevent health risks and to support health-promotive life-styles. In addition, a shift is presently taking place in the understanding of health and prevention. Against this background, health education – as a permanent communicative process – must aim at enabling people to determine and take responsibility for their own health. The Centre therefore runs campaigns to educate children on such issues as how to cope with stress or combat eating disorders.

– BApK (Federal Association of the Relatives of Mentally Ill People) is a lobby group that looks after the interests of the relatives of mentally ill people at the national level. The members aim at reducing discrimination and stigmatisation of mentally ill people and their relatives. They also inform the general public about shortcomings in treatment, support and reintegration and try to influence legislative process and the health system. Further, BApK disseminates information through literature and by organising workshops and conferences, for example a meeting between the BApK executive committee and members of the Bundestag at the parliament in Berlin to discuss the situation of mentally ill people and their relatives with the goal of establishing a political lobby within the German government <http://www.bapk.de/>.

– Competency Network for Depression and Suicide is one of 14 medical networks supported by the Federal Ministry of Education and Research since 1999. The network's primary goal is to improve the co-operation and transfer of knowledge between research institutions and health care facilities, and to improve the competence of doctors to detect and treat depressive disorders adequately. Members of the depression network include leading research facilities, university hospitals, district hospitals and state hospitals, psychosomatic clinics, doctors, the Commission of Pharmaceuticals of the German Medical Fraternity, centres for medical biometrics, statistics and didactics,

health insurance companies, representatives of the pharmaceutical industry, cash-medical unions, crisis intervention facilities and self-help groups. One of several regional sub-projects / action programmes is the so-called "Nuremberg Alliance against Depression". This alliance attempts to raise awareness of the issue mental health and combats stigmatisation. It has also installed a hotline especially to help in case of emergency.
<http://www.kompetenznetz-depression.de/>

– Robert–Koch–Institute and the German Federal Office of Statistics provide information on many different health issues. They are responsible for epidemiological research in Germany. The RK-Institute is about to prepare two booklets within the next year(s): one on depression and the other one on anxiety disorders.

There is currently no specific written policy about the prevention of mental disorders or the promotion of mental health in Germany. However, the promotion of mental health and the prevention of mental ill-health are addressed by the national law on Occupational Health and Safety (Occupational Safety Act, ArSchG, 1996).

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Chapter 4. Sickness absenteeism and disability due to mental health problems in the Netherlands

Irene Houtman, Sabine Desczka, Veerle Brenninkmeijer

4.1 Introduction

This paper aims to describe the development of sickness absenteeism and disability pensions due to mental disorders in the Netherlands over the last decade. We will first describe some facts about the legislative and regulatory system in the Netherlands on absenteeism and disability. We will then present some epidemiological findings on the role of mental health disorders in the work force, in absenteeism and in disability. An indication of the costs is provided as well. After this, we will provide some analyses as to what caused these trends. Finally, we will describe the preventive programmes that have been launched and planned to manage any problematic trends in long term absenteeism and disability, particularly as related to the issue of mental health.

4.2 Legislation on sickness absenteeism and disability in the Netherlands

Until the 1 January 2004 the Dutch Civil Code stipulated that employers must continue to pay the salary of employees who reported absent for the first year of sickness absenteeism, but no longer than the duration of the contract with the employee. Employees are insured for sickness benefits from the employer if they have an employee contract. Sick pay is at minimum 70% of the salary, but nearly all employees are paid 100% of the last earned salary due to collective agreements. Legally, the employer is within his rights to leave the first two days of sick leave unpaid, if this is stipulated in the employee's contract of employment or the collective agreement, yet in practice such so-called waiting days are never stipulated by labour agreements. Since January 2004 employers have been responsible for paying lost wages for up to *two* years after the employee reported sick. Most employers have an insurance policy to pay off this obligation.

For employees who do not, or no longer have an employer, sickness benefits are available under the Sickness Benefit Act. These individuals may be employees who have lost their job in the first (since 2004: two) year(s) of sick-

ness absenteeism, temporary workers on sick leave who do not have a permanent contract with the temporary employment agency, those self-employed (and others) who are voluntarily insured, individual cases and those placed on the same footing (workers in cottage industries, apprentices), and unemployed persons who are sick. When workers are employed under a specific term contract, the Dutch Civil Code guarantees a sick pay paid by the employer for as long as the worker has a contract with that employer. After that, the worker has to rely on the often lower benefit available under the Sickness Benefit Act. As a consequence of the employer obligations stipulated in the Dutch Civil Code, the Sickness Benefit Act now serves only as a 'safety net'.

During sickness absenteeism, both employee and employer are obliged to promote the reintegration of the sick employee. The obligations of employers and employees with respect to their activities aimed at activation/reintegration are specified in the Gatekeeper Improvement Act (2002). The Social Security Administration (Workers Insurance Authority, UWV) evaluates the reintegration efforts of the employee and the employer on the basis of a reintegration report. If reintegration is unsuccessful because one of the parties concerned does not fulfil his/her obligation, the Social Security Administration has to impose sanctions.

Before 2004, the Social Security Administration automatically reviewed whether the employee in question is entitled to receive a benefit under the statutory Disability Benefit Act (WAO) after 52 weeks of sick leave. Since 2004 the relevant time period has been 104 weeks (2 years). The WAO is an insurance scheme for employees who are diagnosed as disabled for work. The criteria by which one is diagnosed as disabled for work are under heavy political debate. It used to be that the disablement must be at least 15% or more of earnings capacity. The act offers an earnings related benefit payment. At the end of a sickness absenteeism period, the Social Security Administration assesses the individual's potential to work and determines, sometimes in collaboration with a labour expert, if they qualify for a disability benefit or only for the much lower benefit in respect of unemployment. A very recent conclusion on the debate thus far (March 2004) is that one must have at least an 80% disablement for work to qualify for a full disability benefit paid by the Social Security Administration. Partially disabled (35–79%) persons probably remain in their current employment and will be able to receive compensation payments for partial disability. This payment may be made either by a private or a public insurer. However, this point still remains to be determined.

4.3 Statistics and surveys on sickness absenteeism

Figures indicate that sick leave in the private sector initially showed a decline from 1993 to 1994. This is not very surprising since at that time legislation was introduced that changed the disability criterion resulting in a decreased inflow in the disability benefit system (TBA, Terugbrenging Beroep op de Arbeidsongeschiktheidsverzekeringen 1993). Also, employers had to pay their employees a salary for the first 6 to 12 weeks of sick leave (depending on company size; TZ, Terugdringing Ziekteverzuim, Arbo1994), which contributed to an underregistration of sickness absenteeism. This new legislation was developed and implemented with the aim to stimulate employers to become more active in taking preventive measures that would prevent workers from reporting absent or at least minimise the length of the absence. Since 1995 employers have had to pay salaries for one whole year, a change which also ended the absenteeism registration practice that had applied to the entire Dutch work force. The national sickness absenteeism figures have since 1994 been based on employer interviews. Figure 1 shows the development of the volume of sickness absenteeism in the private sector since 1993.

In Table 1 we present a break down by sector. It appears that since 1995 companies in all sectors show an increase in sick leave (see Table 1), except in agriculture.

Figure 1. Trends of absenteeism from work in the private sector (%) (CBS Statline 2004).

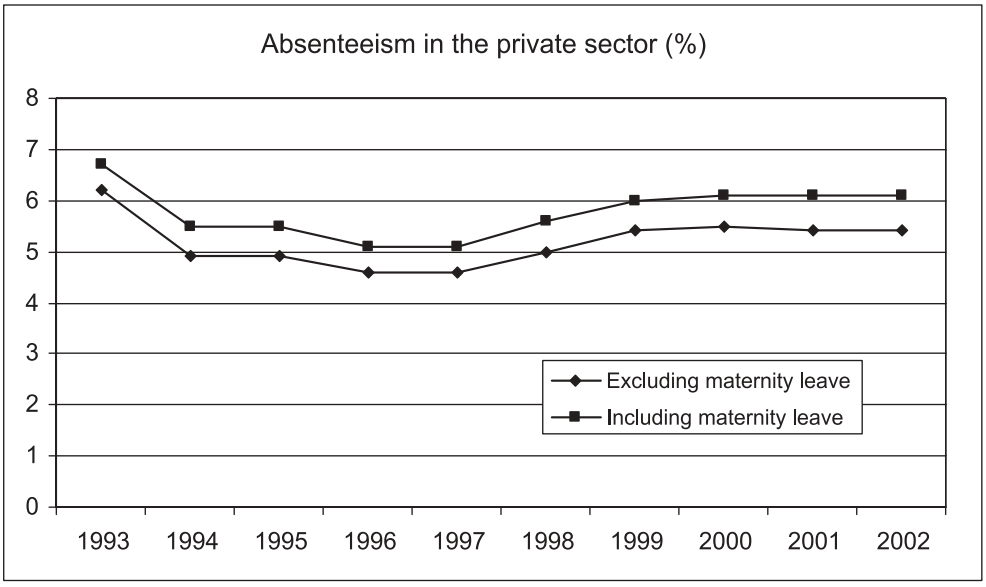
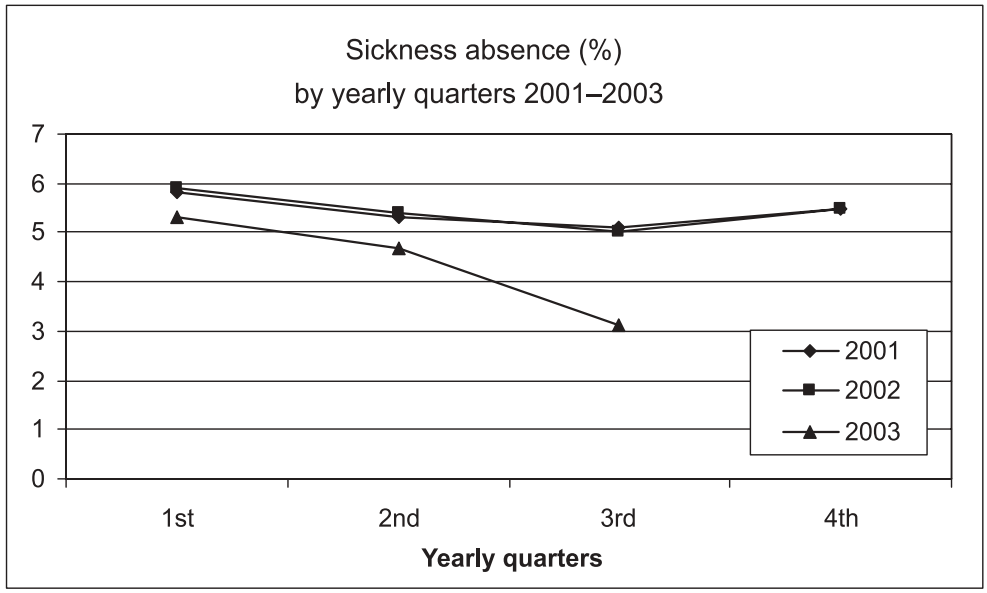


Table1. Absenteeism in the private sector (%) (CBS Statline 2004).

	Excluding maternity leave			Including maternity leave		
	1995	1998	2001	1995	1998	2001
Agriculture	3.8	3.4	3.4	4.0	3.6	3.7
Industry and Construction	5.6	5.7	6.1	5.9	5.9	6.3
Trade, Transport, Financing and other business services	4.1	4.2	4.8	4.8	4.8	5.3
Non-commercial services	6.1	6.4	6.8	7.3	7.7	8.0
Average total %	4.9	5.0	5.4	5.5	5.6	6.1

Although absenteeism was quite stable until 2002, recent figures indicate that it is declining (see Figure 2). Not all data for 2003 are available yet, but it appears that a clear trend has set in. This trend can be observed for all sectors (www.cbs.nl). This decline is associated with the economic recession that set in 2001 and resulted in an increase in unemployment. In the Netherlands it has been observed that in periods of economic recession unemployment rises and absenteeism (as well as disability) drops, whereas the reverse has been observed in periods of economic growth.

Figure 2. Recent changes in sick leave in the private sector (CBS Statline 2004).



In the public sector, sickness absenteeism increased in both central and local governments until 2001 (Table 2), but has since been declining (Figure 3). Sickness absenteeism figures by yearly quarters indicate that the decrease in sickness absenteeism in the public sector is continuing in 2003. In recent years, sickness absenteeism appears to have declined across the board in the Netherlands.

Table 2. Absenteeism in the public sector (%) (CBS Statline 2004).

		Including sickness cases > 1 year										**Excl. cases > 1 year**	
		Excluding maternity leave									Incl. maternity leave	Excl. maternity leave	Incl. maternity leave
		Total	Men	Women	<25 yrs	25–34 yrs	35–44 yrs	45–54 yrs	55–59 yrs	>59 yrs	Total	Total	Total
Central government	1995	6.2	5.3	8.3	5.6	5.7	6.0	6.4	7.9	6.5	6.6	.	.
	1998	6.4	5.6	8.5	4.8	5.8	6.4	6.8	7.9	6.7	6.9	5.8	6.3
	2001	7.8	6.6	10.3	5.7	6.9	7.6	8.3	9.6	8.6	8.3	6.5	7.0
Local government	1995	6.5	.	.							6.9		
	1998	6.6	5.6	6.7							.		
	2001	8.4	7.0	9.4							9.0		

In the Netherlands, there are no regularly updated registers or any other form of monitoring of sickness absenteeism by diagnosis. The Central Bureau of Statistics (CBS) and the sector organisation of the Occupational Health Services, in a collaborative effort, are seeking to combine individual survey data and absenteeism data, including absenteeism in 2004. It is expected that information on this will be made public sometime in 2005. The only information we have today (2004) on absenteeism by diagnosis comes from research on the causes of absenteeism, such as that presented in Table 3 (e.g., Kunnen et al. 1997). In this study some 51% of the absenteeism was reported to be work-related.

Figure 3. Sick leave percentages in the public sector (CBS Statline 2004). These figures may include sickness absences of more than one year.

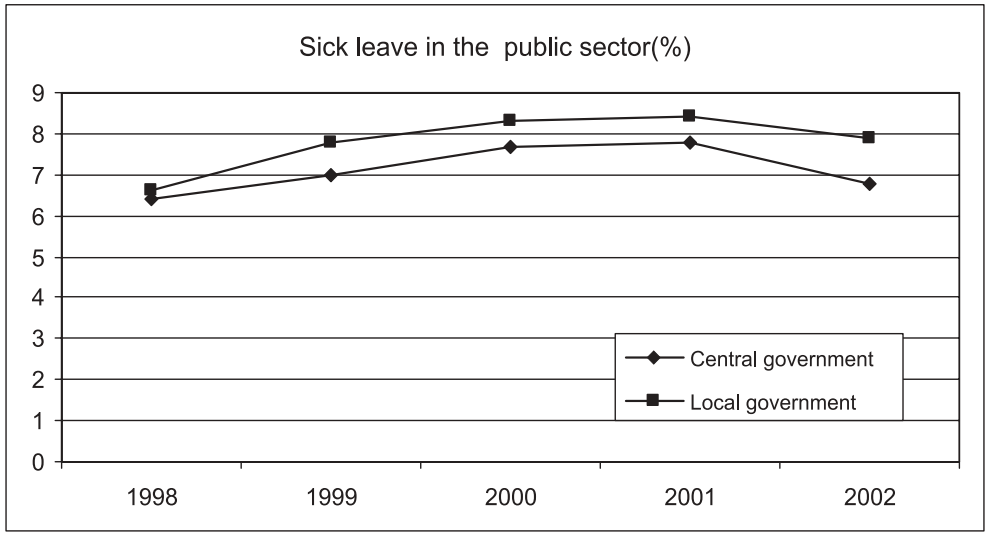


Table 3. Causes of work-related sickness absenteeism lasting longer than two weeks in 1995 (Kunnen et al. 1997).

Reported cause of absenteeism	%
The kind of work I do	31.5
Work pressure	21.0
Conflict with supervisor, boss or colleagues	12.9
Accident at work	11.3
Restructuring, imminent dismissal	4.8
Clients, patients, pupils etc.	0.8
Other	17.7

Since 1996 a question about absences due to high work pressure has been included in the Permanent Quality of Live Survey (POLS, CBS), which indicated that in 1996 14% of the Dutch work force who had reported absent did so due to high work pressure. This percentage rose to 22% in 2002. A recent study by Houtman et al. (2002) indicated that 44% said they were absent because of somatic health problems. Only 11% reported having been absent for

psychological health reasons, 19% said that they were absent because of both psychological and somatic health reasons, and more than 18% said that they reported absent mainly because of their work (work pressure, conflict or other).

It can thus be concluded that sickness absenteeism in general increased in the Netherlands from 1997 to 1999 and then remained stable until 2002. The private sector showed a decline in 2003, whereas the public sector showed this decline already in 2002. An increasing percentage (22%) of the Dutch work force with reported absences identified work pressure as a main reason for this absenteeism.

4.4 Statistics on mental health and occupational diseases

The Dutch work force seems to be a rather healthy one. About 87% of the Dutch work force report their health status to be good or very good. Approximately 10% report having a burnout. Burnout is a state of emotional exhaustion, an increasingly cynical attitude towards work, and/or crumbling professional competence. These figures on health status and burnout have been quite stable for as long as they have been measured (health status has been in the POLS – Permanent Quality of Life Survey – since 1977, whereas burnout is there since 1997). The Dutch work force is relatively healthy as compared to the average European worker, except when work-related arm and leg complaints are concerned (see Table 4). The most recent figures from 2000 indicate, however, that the Dutch are moving towards the European average.

Table 4. Work-related health complaints in 1996 and 2000 in Europe and in the Netherlands (EFILWC 2000).

Aspect of work-related health	Europe		The Netherlands	
	1996	2000	1996	2000
Work causes fatigue (% yes)	20	22	12	19
Work causes stress (% yes)	28	29	19	25
Work causes headache (% yes)	14	15	8	12
Work causes arm and leg problems (% yes)	9	16	11	19

The figures reported above, however, are for self-reported health. Since 1999, occupational health physicians in the Netherlands have an obligation to report any occupational diseases they diagnose in workers (mainly those absent from work). When workers are absent for a longer period of time, it is imperative that they visit the occupational health physician. Depending on the contract between the employer and the occupational health physician, this is 4–6 weeks after the employee reports absent from work. Not all occupational health physicians report the diagnoses they make, and therefore the registration does not provide a complete picture. Table 5 presents the actual numbers of diagnosed occupational diseases based on the report of the occupational health physician.

Table 5. Occupational diseases by diagnosis (percentages in brackets) (NCvB 2003).

Occupational disease	1999	2000	2001	2002
Musculoskeletal	1 831 (45%)	3 116 (51%)	2 698 (48%)	2 278 (43%)
Psychological	939 (23%)	1 484 (24%)	1 517 (27%)	1 159 (22%)
Hearing	805 (20%)	861 (14%)	735 (13%)	1 344 (25%)
Skin	230 (5%)	288 (5%)	270 (5%)	221 (4 %)
Nerve system	77 (2%)	99 (2%)	115 (2%)	71 (1%)
Respiratory	93 (2%)	100 (2%)	107 (2%)	98 (2%)
Digestive	17 (0.4%)	25 (0.4%)	44 (0.8%)	29 (0.5%)
Sight/eye disorders	5 (0.1%)	8 (0.1%)	14 (0.3%)	3 (0.1%)
Cardiovascular	19 (0.5%)	15 (0.2%)	10 (0.2%)	21 (0.4%)
Other	57 (1%)	67 (1%)	101 (2%)	111 (2%)

Between 40 and 50% of the occupational diseases diagnosed by the occupational health physician concern musculoskeletal disorders, with almost a quarter relating to psychological disorders. These are the two main categories of occupational health diseases. It is clear that musculoskeletal disorders are reported for blue collar workers. Psychological disorders are often reported for employees working in education (33 reports per 100 000 workers). Strikingly, the transport sector ranked second highest on the risk for psychological disorders (28 reports per 100 000 workers), with the construction sector ranking third (24 reports per 100 000 workers). Although more psychological disorders were reported by the occupational health physicians for workers in the health care sector, the relative risk of receiving a diagnosis of psychological disorder is lower in the health care sector than in the transport and construction sectors (health care: 22 per 100 000 workers). The relative risk of receiving a diagnosis of psychological disorder when working in public administration was equal to that in the health care sector. (NCvB 2003).

4.5 Disability inflow

The most important *change* in the health characteristics of the Dutch work force is probably the inflow of employees into the disability system. The annual inflow into the disability system increased from 79 000 employees in 1994 to 118 000 in 2001, dropping to 108 000 in 2002. The disability inflow has continued to drop even further and reached 85 060 in 2003 (UWV 2003).

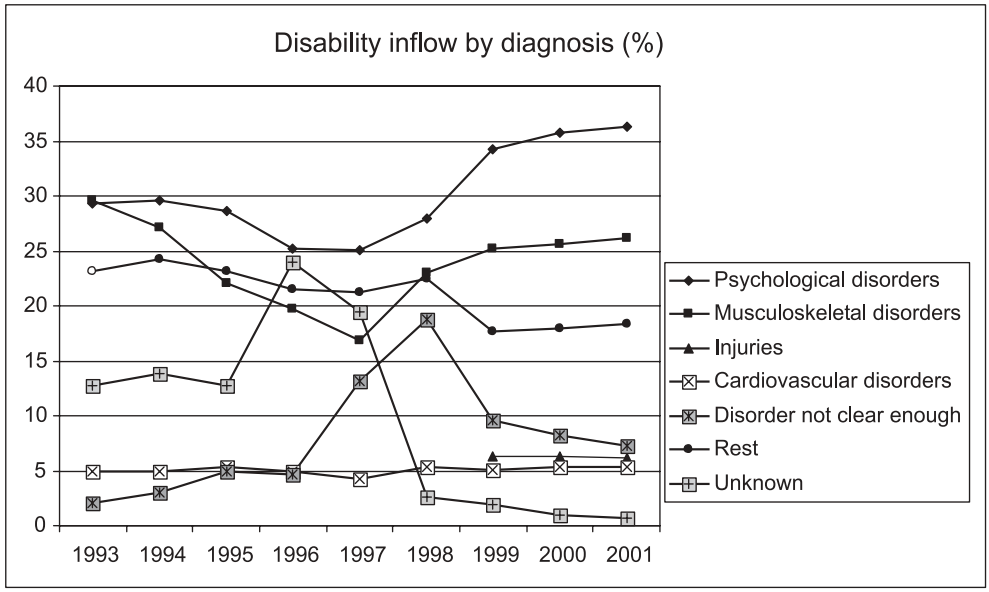
For a long time, it was estimated that the total number of people receiving disability benefits would pass 1 million by 2003. This did not happen, as the rate of disability inflow was strongly reduced in 2003. The figures on the increase (or decrease) may have been somewhat inflated since the work force increased as well (and decreased somewhat in 2002). However, the relative *risk* of becoming disabled from 1993 onward has shown a similar pattern. The risk of disability inflow increased from 1.18 per 1000 insured employees in 1994 to 1.70 per 1000 insured employees in 2001, but dropped to 1.52 per 1000 insured employees in 2002. The figures for 2003 seem to indicate a continued reduction of inflow.

The main reason for being disabled for work are psychological disorders (see Figure 4). Figure 4 also indicates that the percentage of the disability inflow due to psychological disorders is increasing. The 'strange' dip in the period around 1996–1999 is assumed to have been caused by the introduction of a new classification system for diseases (CAS-codes[1]). In the short term, this new classification system resulted in a lot of unexplained diagnoses or diagnoses that could not be fitted into the new classification.

Figure 4 accords with the statistics described above as far as the two main diagnoses are concerned. However, whereas musculoskeletal disorders were the main diagnostic category in the registrations by occupational health physicians, psychological disorders appear to be the most important diagnostic category where disability inflow is concerned. There may be several explanations for this. The first is that workers see the occupational health physician rather

[1] The Dutch Occupational Health Care system uses the CAS-code system to classify occupational diseases. This classification system is more restricted than the ICD-10 or DSM-IV, and has twelve diagnostic categories. The system is appreciated for its usability and endorsed as the norm by the National Union of Occupational Health Physicians. The most important reason is probably that occupational health care deals with early stage situations, where the clinical situation of the patient is not yet so clear as to allow a highly differentiated diagnosis.

Figure 4. Disability inflow by diagnosis (UWV 2002).



early in the absence. At this early stage, the majority of workers report musculoskeletal problems (CBS, POLS) or somatic health problems (Houtman et al. 2002) as the main cause of their absenteeism and, not surprisingly, many occupational health physicians diagnose musculoskeletal problems. Work resumption may be more prevalent in musculoskeletal disorders as compared to psychological disorders, however. This could explain why musculoskeletal disorders may no longer be the major category of diagnosis at disability inflow, i.e. at about 8 to 12 months after the first day of sickness absenteeism. Another explanation may be that some of the prevalent psychological disorders are not really accepted as an occupational disease. One example of this is depression. Depressive symptoms are highly prevalent in those who are diagnosed as disabled for work (see Table 6). By definition, however, depression is not considered to be an occupational disease, whereas burnout (adjustment disorder and overstrain) and response to severe stress (PTSS, Post Traumatic Stress Syndrome) are. In line with this, depression is rarely (only in 3.4% of the cases; NCvB 2003) reported as an occupational disease by the occupational health physician.

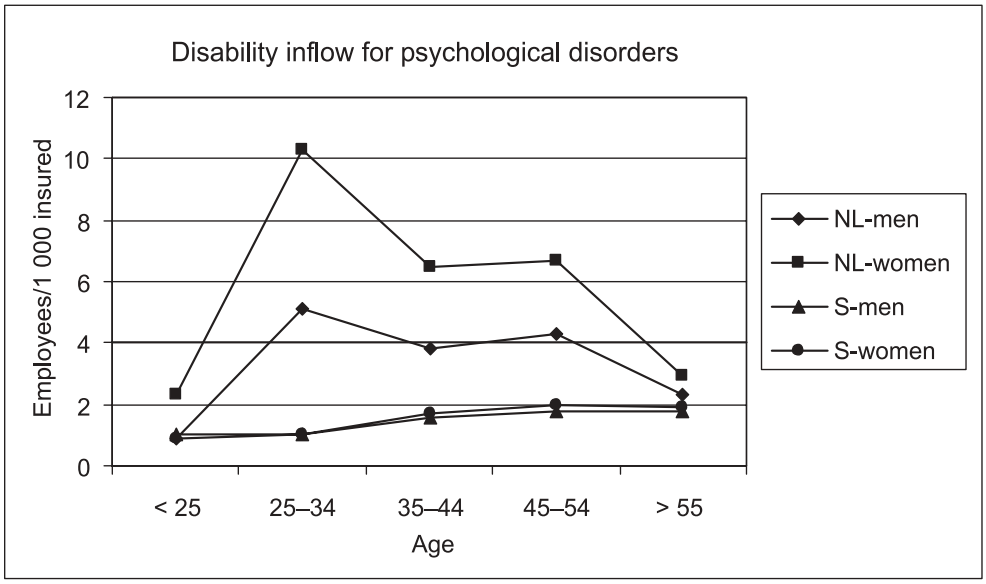
Recently, a comparison of disability inflow figures was made among four EU countries. This comparison was part of a starting document on 'psychological disability' for a committee that was installed to advise the Ministry of Social

Table 6. New disability benefits by subgroups, according to diagnosis and gender, in 1999 (UWV/Lisv 2001).

Main diagnosis: Psychological disorders	Total	Men	Women
Mood disorder/depressive complaints	10 643	4 243	6 400
Adjustment disorder	8 649	3 549	5 100
Response to severe stress	2 861	1 059	1 802
Other psychological disorders	2 047	888	1 159
Overstrain	1 723	669	1 054
Personality disorder	1 539	782	757
Anxiety disorder	1 479	572	907
Non-organic psychosis	926	596	330
Addiction to psychoactive drugs	697	581	116
Somatoform disorder	619	267	352
Organic psychosis	107	81	26
Emotional sleeping disorder	33	15	18
Total	31 323	13 302	18 021

Affairs and Employment and the Ministry of Health in the Netherlands on measures to be taken to reduce the – until recently – rising number of workers who reported sick and were diagnosed to be disabled, particularly those with psychological disorders. Disability figures from the Netherlands were compared with those from Sweden, Germany and Belgium (Veerman et al. 2001). It appeared that the inflow into the disability system was generally high in the Netherlands (year: 1998), but that this was particularly true for disability due to psychological disorders (NL: 5.2/1000 insured; B: 2.2/1000 insured; G: 1.7/1000 insured; S: 1.5/1000 insured). In the Netherlands, the risk of being diagnosed as disabled due to a psychological disorder was particularly high for working women in the age range of 25–34 (see for example Figure 5). This gender difference appears to be absent in Sweden where disability figures are concerned. Swedish data on long-term absence, which can be longer than one year, and can even last until old-age retirement, indicate that women have more long-term absences due to psychological disorders than men (reference: Lennart Hallsten, NIWL, Sweden, personal communication).

Figure 5. Employees newly diagnosed as disabled for psychological disorders (Sweden-Netherlands; Veerman et al. 2001).



4.6 Costs of absenteeism and disability

The societal costs of absenteeism and disability were calculated for 2001. A model was constructed as a tool to operationalise the relevant indicators (see Figure 6).

The basis of the model is that the work input of the individual worker results in the delivery of products, and adds to the productivity of the organisation as a whole. Working conditions may have an effect on health, and unfavourable working conditions may result in ill health or in accidents which in turn may bring about employee drop-out, need for medical care and increased costs. While preventive measures also carry a cost, they can, when effective, prevent workers reporting absent or reduce the number of days lost to sickness absenteeism. For the Netherlands, Koningsveld et al. (2004) calculated that these costs are in total € 12 billion (see Table 7). It is shown that the largest costs are related to work-related sickness absenteeism and work-related disability. In Table 8 these latter costs are related to the main diagnostic categories for absenteeism and disability. In Table 8 the costs of employee drop-out are related to the main categories of absenteeism (estimated on the basis of research) and

Figure 6. A model for analysing the cost of employee drop-out (Koningsveldt et al. 2004).

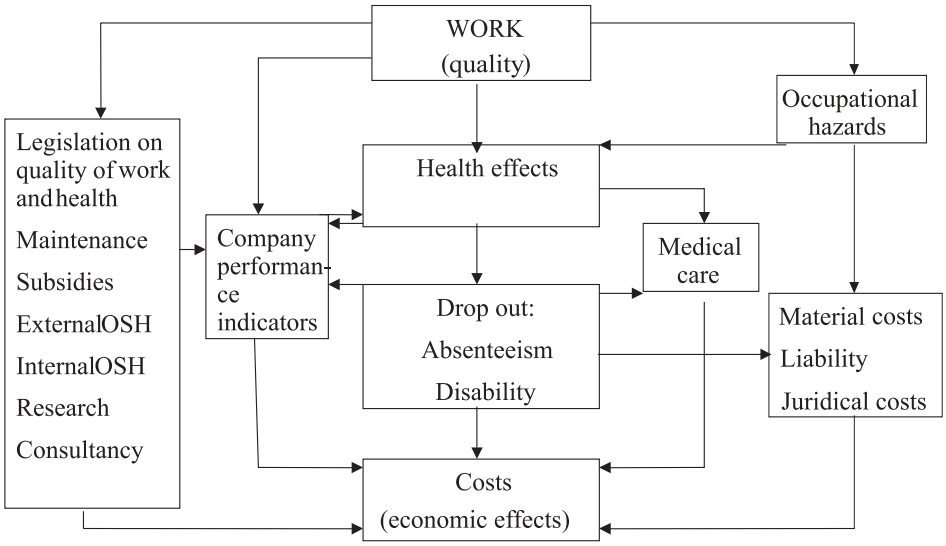


Table 7. The calculation of costs of sickness absenteeism and disability for 2001 (Koningsveld et al. 2004).

	Total amount (million euro)	% of total costs	Per employee (euro)
Costs of employee drop-out			
Work-related costs of sickness absenteeism	3 785	29.8	527
Work-related costs of disability benefits	4 371	34.4	609
Reintegration subsidies	740	5.8	103
Costs of effects on operational management	unknown		
Work-related cost of medical care			
of employees	833	6.6	116
of disabled and other non-workers	92	0.7	13
Costs of occupational health care, OSH legislation and enforcement			
Costs of occupational health care contracts	859	6.8	120
Costs to organise occupational (health) care within the own organisation	1 125	8.9	157
Working conditions research and consultancy	73	0.6	10
Juridical costs	13	0.1	2
Administrative tasks	735	5.8	102
Costs of legislation and enforcement	42	0.3	6
Working conditions -subsidies (FARBO etc.)	22	0.2	3
Total	12 690	100%	1 768

disability (as assessed by the insurance physician). Table 8 shows that the largest costs of employee drop-out are due to psychological and musculoskeletal disorders. They account for about 44% of the total cost related to employee drop-out due to absenteeism and disability, which is about € 3 billion. This is estimated to be 1.2% of GDP. Evidently, both absenteeism and disability due to psychological and musculoskeletal disorders are a major problem in Dutch society.

Table 8. Diagnostic category and the costs of absenteeism and disability (Koningsveld et.al. 2004).

ICD-9 diagnostic category	Share of absenteeism (in %)[a]	Work-related share of all absenteeism (in %)[b]	Costs of work-related absenteeism (million euro)	Share of disability	Benefits (in %) work-related share of all disability (in %) Costs of work-related disability	Benefits (million euro)
Infectious and contagious diseases	1.6	0.1	**8**	1.6	0.1	**6**
Neoplasms	2.5	0.2	**25**	2.5	0.2	**19**
Endocrine diseases	0.8	<0.1	**3**	1.2	<0.1	**3**
Blood diseases	0.3	<0.1	**1**	0.4	<0.1	**1**
Psychological disorders	28.7	11.5	**1 444**	40.2	17.7	**1 630**
Neurological diseases	3.1	0.5	**59**	5.7	1.6	**148**
Cardiovascular diseases	4.6	0.9	**116**	6.8	1.8	**169**
Respiratory diseases	2.3	0.3	**43**	2.1	1.0	**89**
Digestive diseases	2.9	0.1	**11**	2.1	0.1	**6**
Urogenital diseases	2.4	0.1	**9**	1.1	<0.1	**3**
Pregnancy related disorders	7.1	0.1	**18**	0.6	<0.1	**2**
Skin diseases	0.9	0.2	**28**	0.6	0.3	**31**
Musculo-skeletal disorders	32.7	14.7	**1 854**	28.9	11.6	**1 065**
Congenital diseases	0.2	0	**–**	0.5	0.0	**0**
Accidents at work	1.0	1.0	**135**	0.6	0.6	**55**
Other accidents	9.0	0	**–**	5.0	0.0	**0**
Total	100	29.8	**3 754**	99.9	35.0	**3 227**

[a]Source: Koningsveld and Mossink 1997.

[b]Share multiplied by work-related fraction (Koningsveld et al. 2004).

4.7 Determinants of sickness absenteeism and disability

Most studies on the determinants of sickness absenteeism are cross-sectional. This means that real causal relations are difficult to infer from the analyses on these data. Recently, however, the number of longitudinal studies has been increasing. General findings of these studies indicate that a high work pressure, physical risks, lack of decision latitude, social support from the supervisor and colleagues, conflicts at work, and home-work interface were found to be related to psychological disorders and complaints (e.g. Marmot et al. 1999; Houtman et al. 2001; De Jonge et al. 2001). Sector-specific causes for psychological complaints have been identified as well. Taris et al. (2000), for example, found higher levels of burnout among teachers when their relations with colleagues were poor, when they experienced the preparation of their lessons to be a heavy burden, when they experienced little challenge in teaching, when they had to do a lot of additional tasks, or when they experienced a high work pressure. Research among police personnel indicates that specific emotional loads, peculiar to this job, add to the burnout experienced (Van den Heuvel and Houtman 2001).

On the basis of the literature, and together with results from their own research Gründemann and Nijboer (1998) come to the conclusion that determinants of absenteeism and disability can be summarised as shown in Table 9.

Table 9. Factors found systematically to relate to and predict psychological disorders and psychological complaints in people absent from work.

Person characteristic	Work characteristic	Company characteristic
Women	High job demands	Bad financial situation
High age	Low decision latitude	Bad occupational health care
Non-native	Low social support	
Low educational level	Bad social climate	
Not healthy	Physical load	

For the characteristics described in Table 9, several trends can be distinguished in the Netherlands. National trends in person characteristics within the Dutch work force are:

- Increasing labour participation of women
- Increasing age of the Dutch work force due to the aging process, and the reduced inflow of young workers on the labour market.

National trends in working conditions can be characterized as:

- A continuous rise in work pace as reported by Dutch workers of 1.5% a year over the period 1977–1997. It has levelled off since then, but not in all sectors. This trend has been interpreted as a sign of the continuous intensification of work in the Netherlands. The Netherlands ranks second highest for work pace within Europe (EFILWC 2000).
- Less time is available for non-work activities (Breedveld and Van den Broek 2004), which has increasingly negative effects for the work-home interface.

National trends in company characteristics are:

- The economic situation has recently worsened, and the Netherlands has a recession at hand. Although recession may have negative effects on occupational health care arrangements and funding, the short term effect appears to be a reduction in sickness absenteeism and disability figures.
- All companies are required to have a contract with an occupational health service. Companies are, however, not fully satisfied with the quality of the service, although the quality seems to be improving. Research on performance criteria is actively supported by a research programme on 'mental fatigue at work'.

Considering the trends described above it is clear that intensification has increasingly become a main characteristic of work in the Netherlands. Time available outside work appears to have become increasingly sparse as well. The increasing participation of women in the labour market means that combining work and family life is becoming another characteristic of increasing importance for work in the Netherlands. Evidently, the combination may raise concerns, since the disability inflow of women in the age range of 25 to 34 is extremely high. The ageing work force is likely also to have implications for the organisation of work. Keeping older workers at work requires flexible arrangements involving working fewer hours, setting aside time to be used as additional holidays, etc.

Most trends and interpretations have, however, concerned periods of economic growth in the Netherlands, in contrast to the current economic decline. It is difficult to predict what the effects of this change will be. A reduction of absenteeism and disability inflow may be associated with this declining economic situation. Yet in the long run, the consequence may be less money available for occupational health. There is little quantitative evidence on the effectiveness of occupational health services, but the situation evidently calls for such evidence.

4.8 Measures to reduce long term absenteeism and disability inflow due to psychological disorders

In this section we will address several types of measures that are or could be taken to reduce long-term absenteeism and disability inflow due to psychological disorders. We can rank them according to the level at which they address the problems. From macro to micro approaches these levels are:

1. the national level
2. the sectoral level
3. the organisational level
4. the individual worker level.

National level: reforms and policy programmes to reduce sickness absenteeism and disability

The high number of disabled persons (>1 year absenteeism) and persons on sick leave (<1 year) in the late 1990's stimulated a process of reorganisation of the sickness and disability schemes. The government concluded that these high numbers are caused by employees and employers together shifting responsibility to collective insurance arrangements. The solution was to assign responsibility from the social security institute administering the statutory social insurance to employers and employees in individual companies.

Nowadays, the employer pays a minimum of 70% of the salary in the first year of sickness. This period was extended to two years in 1 January 2004. The assumption is that the employer will have an interest in early reintegration of the employee in order to lower the costs of sickness absenteeism. Since 2003, the employer's responsibility for reintegration has been expanded so that if it is not possible to reintegrate employees in their own company, employers

must seek to reintegrate them in another company. This is a two-year responsibility and equal in length to the statutory protection for dismissal. Furthermore, employers are encouraged to employ disabled individuals. For that purpose they can receive subsidies to call in a reintegration company (private company, specialised in revalidation, training and employment-finding) to assist in the reintegration process.

After one year, or since January 2004, two years of persistent sickness absenteeism, the employee may apply for a disability benefit from the statutory disability insurance provider. The right is conditional on efforts by the employer to integrate the employee (under new legislation introduced in 2002). Both the employer and the employee must make *all reasonable efforts* to have the employee resume work within this time period. If one of the parties concerned does not fulfil this obligation according to the judgement of the Social Security Administration, the Administration has to impose sanctions. If the employer does not fulfil his obligation to integrate, the obligation to pay salary will be prolonged (by a maximum of one additional year). If the employee does not cooperate his/her disability benefit may be disallowed.

Additional reforms of the disability legislation are pending. Discussions on this topic are extremely intense, both at the political level as among social partners and in the media. From 2005 onwards the current disability regulation will be split up into regulations for the fully disabled (who have lost more than 80% of their earnings capacity) and those partially disabled (who have lost 35–80% of their earnings capacity). The latter group will remain employed part-time (or will be partly unemployed) and will receive a benefit for the part they are disabled. In contrast to the fully disabled who will receive a public disability benefit, the benefit for the partially disabled may come from a private insurance provider. The decision-making process on this issue is not yet finalised. The 'disability benefit criterion' will probably become more strict.

Additionally, the employer is obliged to call one of the so-called occupational health and safety services for assistance. These are private, competing companies that provide professional assistance on the basis of the European Framework Directive 89/391 on safety and health at work.[2]

[2] The Dutch government interpreted the regulation 89/391 differently from most countries.

Reforms regarding policies and guidelines on psychological diseases and disorders

In 2002 a committee (Donner I) was established to advise on the question of disablement due to psychological disorders. This committee came up with a guideline about how to prevent psychological disorders. The main points of this guideline were that (1) the employer and employee have principal responsibility for taking action in case of absenteeism due to psychological health problems, (2) professional help (e.g. occupational health physician) should be called in for advice at an early stage (within 2–4 weeks of absenteeism), and (3) work itself is the best medicine, and the employee should start working (part time and/or with a reduced workload if so indicated) as soon as possible. At present, this guideline is being implemented in several sectors. An initial process evaluation of this implementation was recently carried out with quite positive results (Van den Heuvel et al. 2004).

Recently, the Ministry of Social Affairs and Employment created a new committee on 'The Working Perspective' (Het werkend perspectief) that stimulates policies and activities contributing to a reduction of sickness absenteeism and a reduction of individuals receiving disability benefits. Members come from employers' and employees' organisations, patient/client organisations, and other institutions involved in absenteeism and disability, such as insurance companies, the Social Security Administration, Occupational Health and Safety Services, and social services.

The committee aims to reduce the number of people entering the disability benefit system by promoting a positive and realistic image among employers and employees about individuals who are (partially) incapacitated for work. The committee aims to improve the knowledge of employers, employees, and advisors about sickness prevention, treatment, and reintegration. Particular attention is to be drawn to specific target groups, such as young and chronically ill persons. The committee aims to change the behaviour of employers, employees and their advisors towards individuals who are (partially) incapacitated for work. A sub-committee will concentrate on the prevention of disability for work due to psychological reasons. This committee is in fact a continuation of the former Donner Committee.

Covenants on Health and Safety at Work

In order to stimulate prevention of sickness absenteeism and disability, the Ministry of Social Affairs and Employment actively encourages and financially supports the arrangement of Covenants on Health and Safety at Work (Arboconvenanten). Although the policy of the covenants is a national one, it is implemented sector by sector. Covenants on Health and Safety at Work are in fact *sectoral* agreements that relate to the quality of work and reintegration of absent employees. Special attention is given to preventing high work pressure, psychological health problems as well as physical load and musculoskeletal problems. Fifty per cent of all costs of the covenant, and the measures agreed to be implemented at sectoral level are reimbursed by the Dutch Ministry of Social Affairs and Employment. The covenants may become of great importance in decreasing occupational risks for employees. Since these covenants were started up at the end of the last decade and will run for several years, their effectiveness has not been evaluated yet, although there are already indications of reductions in absenteeism rates particularly in sectors that have agreed upon and implemented these covenants. It should, however, also be borne in mind that these covenants were purposely presented to those sectors that were 'high risk', either because of their exposure to specific risks, or because of high long-term absenteeism and disability inflow figures due to psychological or musculoskeletal disorders. Part of the progress may therefore be due to a 'regression to the mean' effect.

Stress management at the level of the organisation or the individual

In most reviews on work stress interventions, even the very recent ones (e.g. Semmer 2003) it is concluded that the majority of the research on the effectiveness of work stress interventions focuses on individually directed interventions, which mainly aim at adapting individuals to their environment. Reasons behind this orientation are:

1. Management itself often has the opinion that work stress problems are based on individual factors, particularly on the inability of certain individuals to cope with the work demands imposed upon them.
2. It is also in their interest not to change the organisation too much in response to the problems discovered.

3. It is much easier to study the effect of interventions in an experimentally proper way when an individual, rather than an organisation, or even a part of it, is the target of the intervention study … Issues like randomisation, follow-up of a control group, restricting the intervention only to the experimental group, and avoiding other changes than just the experimental ones are much easier at the level of individuals than at the level of (parts of) the organisation. Some prominent researchers even consider a randomised clinical trial invalid when it focuses on the complex organisational level (e.g. Griffiths 1999; Kristensen 2000).

When considering the outcomes of the studies presented by Van den Bossche et al. (2003), the studies targeting individuals not only showed more consistent and positive results than those dealing with organisations, they were also -in general- of better quality. The latter finding especially may be due to the fact that it has generally been found too difficult to set up a well controlled randomised intervention study at the organisational level. This is well illustrated for example by the review by Landsbergis et al. (1999) which refers to the large amount of 'grey' documentation on the effectiveness of organisational interventions. It has also become a kind of accepted trend to present and publish well documented case studies (e.g. Karasek 1992; Kompier and Cooper 1999; Kompier et al. 2000a & b). Several researchers even see this as a better way to evaluate the implementation of organisational measures, since it is only by a combination of quantitative and qualitative (process) perspectives that one can determine if 'the patient really took the pill', and 'the active ingredient was present' (e.g. Griffiths 1999; Kompier and Kristensen 2001). Major arguments for not considering the 'RCT' as the gold standard for these type of interventions clearly have to do with the fact that at the organisational level it is often not advisable to choose any single organisation as a control, since organisations that are principally opposed to such interventions differ a great deal from the experimental ones in terms of 'motive' (and probably several other relevant issues as well).

Many of the reviews even promote the merits of organisational interventions, and use the following arguments:

1. To prevent is better than to cure.
2. Long term follow-up of stress management at the organisational level in general is not well studied. Therefore it is not convincingly demonstrated that these interventions really are effective.

3. When considering primary prevention, the causes can best be tackled at the organisational level. When done exclusively at the individual level there are problems related to the stigmatisation of marginalisation, and neither the worker nor the manager may be in a position to deal with the issue in a successful way. On the other hand, if the work is really stressful, even the stronger employees will fail to perform and instead will report absent, which certainly will make proper handling of the problem at the organisational level even more time-consuming and difficult.
4. So, in the end, the approach to reduce risks at their source appears most attractive for all.

Yet there is, at present, little research on the effectiveness of organisational interventions, and what research results there are tend to be quite inconclusive.

Regarding the effectiveness of *individual* interventions, a lot of new information is available. This may be partly due to the Dutch Research Programme on Fatigue at Work (NWO-PVA). A meta-analysis was first conducted within the framework of this programme, which aimed to identify the most effective intervention. The cognitive therapy approach appeared to be most effective on the basis of the studies performed thus far (Klink et al. 2001). All of the intervention studies performed within this research programme started out from a very practical and to some extent even uniquely 'Dutch' situation. The intervention studies conducted as part of this research program found that only occupational health physician actions using this cognitive behavioural approach were effective. An additional aspect to the approach applied in these studies was the notion accepted in the 'Donner' guidelines about the importance of early work resumption. Another study tested the effectiveness of two interventions on self-employed persons with a stress related disorder. The 'best practice' according to the meta-analysis, now using only cognitive behavioural therapy (CBT), and a 'combined approach' (CA) which used some minor clinical interventions like CBT by a labour expert, but also stressed the importance of working and work resumption, were tested against the 'usual care' situation (UC), which in the case of the self-employed means that almost no action was taken at all. Results showed that a highly significant reduction in days absent was obtained by the combined approach, whereas CBT alone was no more effective than the 'usual care' option over a 10-month period. The average number of days absent in the CA group was 177, compared to 256

in the CBT group and 252 in the UC group. There were no differences in mental health between the groups. The combined approach appeared to be highly cost-effective. (Blonk and Lagerveld 2003).

4.9 Conclusions

To summarise the main conclusions that can be drawn from the information presented, we present the following list:

- Absenteeism and disability figures have been rising in the last decade. Only recently has there been a decrease, together with a change in the national economic situation.
- Psychological health problems are a major reason for absenteeism and disability in the Netherlands. Several developments have been responsible for this, but changes (intensification) in work conditions are definitely considered to be one of the main causes.
- The Government is actively involved in a variety of ways in preventing a large drop-out of workers, who will be very much needed in the near future, with the workforce growing older and women, who have taken a larger role in the labour market, seemingly at particular risk for disability because of psychological disorders.
    - Legislation has and will be further amended. In the near future, disability benefit will probably be available only those who are fully disabled. Those partially disabled will stay employed (or become unemployed) and will be compensated through a private or public insurance for their partial disablement. Other legislative measures have been taken, including the Gate Keeper Law, which proactively creates additional obligations for employers and employees regarding work resumption after 6 weeks of absenteeism.
    - The 'Covenants on work and health' have been introduced and financially supported to stimulate primary prevention at the sectoral level. The first attempts to evaluate the effectiveness of these covenants appear to be positive.
    - The guidelines issued by the second Donner Committee have been prepared and are being disseminated. A first process evaluation proves them to be practical guidelines which may initiate preventive measures at the sectoral and organisational level, and which are perceived as helpful in preventing absenteeism and disability because of mental health problems.

- o A large research program on mental fatigue has helped to gain more insight into the process of fatigue and its short and long term effects, but above all has resulted in valid instruments and clinically effective management of psychological disease and disorders as well as a reduction of days absent due to these mental health problems.

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Chapter 5. Depression and other mental disorders as causes of sickness absenteeism and work disability pensions in Sweden

Björn Andersson

5.1 Introduction

This paper describes the development of sickness absence and disability pensions due to mental disorders in Sweden during the last decade. The purpose is to highlight the diagnosis perspective behind sickness absenteeism and work disability and the increasing share of mental disorders as the medical reason for not being able to work. This also includes a discussion from the working life and social protection perspective about the background and possible reasons for this development.

The paper is based on a variety of research and studies in the social protection area. A large part of the research has been carried out and published by the Swedish National Social Insurance Board.

The introduction starts with an overview of some key concepts for the sickness insurance discussion and is followed by a description of the Swedish social insurance from the sickness and disability perspective. The subsequent part presents an epidemiological overview with facts and tendencies about mental ill-health in general in Sweden. Thereafter follows a description of mental disorders as causes of sickness absence and disability pension. The next part presents some reflections about possible reasons behind the increase in work disability due to mental disorders. Finally, there is a discussion of what research and studies would be particularly interesting in the sickness and disability area in the years to come.

5.1.1 Illness, disease and sickness

For the following it may be helpful to distinguish between the concepts of illness, disease and sickness. By *illness* can be understood the subjective understanding of the health situation and the individual's feelings. *Disease* refers to a diagnosis, whether it is based on biomedical findings or on an assessment by a physician following the individual's own descriptions of the medical problem. *Sickness* determines the formal status of an individual who is absent from work due to ill-health with benefits from the employer or the sickness insurance (Wikman and Marklund 2003).

The starting point is that these three concepts coincide; a person feels sick, sees a physician who makes a diagnosis and, if the problems have an effect on the work ability, becomes sicklisted. Yet this is not always the case. People may refer to some form of health problem without abstaining from work. Minor problems often occur and may be considered as a bearable part of daily life. However, this does not imply that the extent of the illness determines when work is possible or not. Individuals may be sicklisted without reference to a diagnosis that determines the cause of the sickness absence – which does not necessarily mean that the person is not sick. There are those who suffer from obvious medical problems or disabilities, but who do not consider themselves as sick, mainly because they relate sickness rather to a shift in their health situation than to a chronic state. It is consequently difficult to establish a link between on one hand people's health status, individuals' attitude towards health and what is a reasonable motive for not working, and on the other hand the development of sickness absenteeism and work disability.

5.1.2 The Swedish social insurance system – the sickness insurance and disability pensions perspective

Sweden's social insurance covers the entire population. It provides both basic protection and income related benefits. The social insurance system can be divided into three main areas; pensions, sickness insurance and benefits covering children, family and people with disabilities. A guiding principle for the system is to insure against losses of own labour income.

The National Social Insurance Board and the Social Insurance Offices form the administration of Sweden's social insurance. The National Social Insurance Board is responsible for central direction, supervision and evaluation of the administration's activities. The Social Insurance Offices, one to each county, process individual cases at regional and local level.

The health care sector provides, apart from medical treatment for the individual, control and advice to the social insurance administration. Any physician in Sweden can carry out medical assessments that are relevant to the social insurance. The sickness insurance stipulates that the insuree should present a doctor's certificate on the 8th day of the sickness period to the Social Insurance Office. At day 28 a further specific assessment including *e.g.* an outline for rehabilitation should be handed in to the Social Insurance Office.

Each Social Insurance Office employs a physician as a Medical Adviser (*försäkringsläkare*) to assist in matters that require medical competence and to support the co-operation between the social insurance administration and the treating physicians. This may include the Medical Adviser's formal responsibility to assess the insuree's health status through the treating physician's certificates and to see whether there is sufficient documentation available for making a decision about the insuree. However, the Medical Adviser is not supposed to make any decisions on the insuree's right to a benefit.

The social insurance accounts for a significant share of the economy. In 2002, social insurance benefits amounted to 380 000 million SEK, which corresponds to 15.9 per cent of the GDP. Old age benefits represent the biggest item with 47.8 per cent of the total costs. Sickness and disability benefits add up to 29 per cent of the total. The social insurance funding consists of employers' contributions, taxes and employee's contributions (National Social Insurance Board 2003a)

Sickness benefits

The aim of the sickness insurance is to provide economic security in case of sickness. The benefits are paid when work capacity is reduced by at least 25 per cent. After an initial waiting day the employer covers the sick pay for the first 21 days. The national sickness insurance takes over at day 22.[1] All individuals of the labour force are entitled to a sickness benefit that currently amounts to 77.6% of the individual's salary up to a ceiling.[2] In addition to the sickness insurance most employees receive a supplementary ten per cent through collective agreements. Sickness benefits are paid out on a temporary basis with the intention that it should not be for more than one year, but since there is no formal time limit it is paid out for longer periods.

During the last few years the inflow to the system has increased dramatically. At the beginning of 1998 some 140 000 persons received a benefit from the general sickness insurance, *i.e.* had been sick for 14 days or more, which corresponds to approximately three per cent of the labour force. Five years later,

[1] When introduced in 1992 the sick pay period was 14 days. In January 1997 it was prolonged to 28 days and in March 1998 it was brought back down to 14 days. The present period of 21 days applies since July 2003.

[2] When computing the individual's benefit the income is multiplied by the coefficient 0.97, which reduces the benefit from 80 to 77.6 per cent of income.

in 2003, the number had more than doubled to seven per cent of the labour force. The increase has been especially dramatic in terms of longer sickness periods.[3] Women are increasingly more absent due to sickness than men. At the end of the 1980's women represented 58 per cent of the long-term (defined here as 60 days and more) sicklisted. In 2002 they constituted 65 percent (National Social Insurance Board 2002c) (See chart 1 for the development of the sickness insurance).

From a long-term perspective, sickness absence has varied significantly, and, to a large extent, reflected changes in unemployment. There are several periods where increases in sickness absenteeism occur at the same time as a fall in unemployment; *e.g.* in the beginning of the 1980's when the recession boosted unemployment and sickness absences fell back. When the economy picked up again towards the end of the 1980's unemployment went down and sickness rates increased. The same shifts took place in 1992, when unemployment grew rapidly to more than eight per cent and sickness absence fell, and towards the end of the 1990's when unemployment fell as the economy recovered and sickness absences increased (Lidwall and Skogman Thoursie 2000).

Two main explanations have been proposed to the negative relationship between (short-term) sickness absence and unemployment. Higher levels of unemployment can according to economic theories serve as a disciplining device, which lower the propensity to report sick. Higher unemployment levels would consequently reduce the sickness absence rate among the employees. A second explanation implies that higher unemployment leads to structural changes in the composition of the labour force where those who are frequently absent due to sickness lose their jobs, which eventually results in lower (short-term) sickness absenteeism levels (Lidwall and Skogman Thoursie 2000).

The conditions for rehabilitation are laid down by law and rehabilitation measures are co-ordinated by the Social Insurance Offices. There are several actors involved ranging from employers to the public sector including the social insurance administration, municipalities, health care institutions and the National Labour Market Administration. The employer's responsibilities cover both the funding of rehabilitation and the implementation of the work-related rehabilitation, the evaluation of needs together with the employee and,

[3] Official statistics, *National Social Insurance Board* and *Statistics Sweden*

ultimately, enabling the employee to return to work. When the employer fails to provide rehabilitation efforts, or when there is no employer *e.g.* in the case of the unemployed, the Social Insurance Offices assume the responsibility. The lack of an employer is often detrimental to the rehabilitation process. Studies have demonstrated that long-term sicklisted individuals who are also unemployed face lower a probability of recovery from sickness and a higher risk of ending up on disability pension than sicklisted persons who have a job and an employer to support the return to work through different rehabilitation measures (National Social Insurance Board 1996).

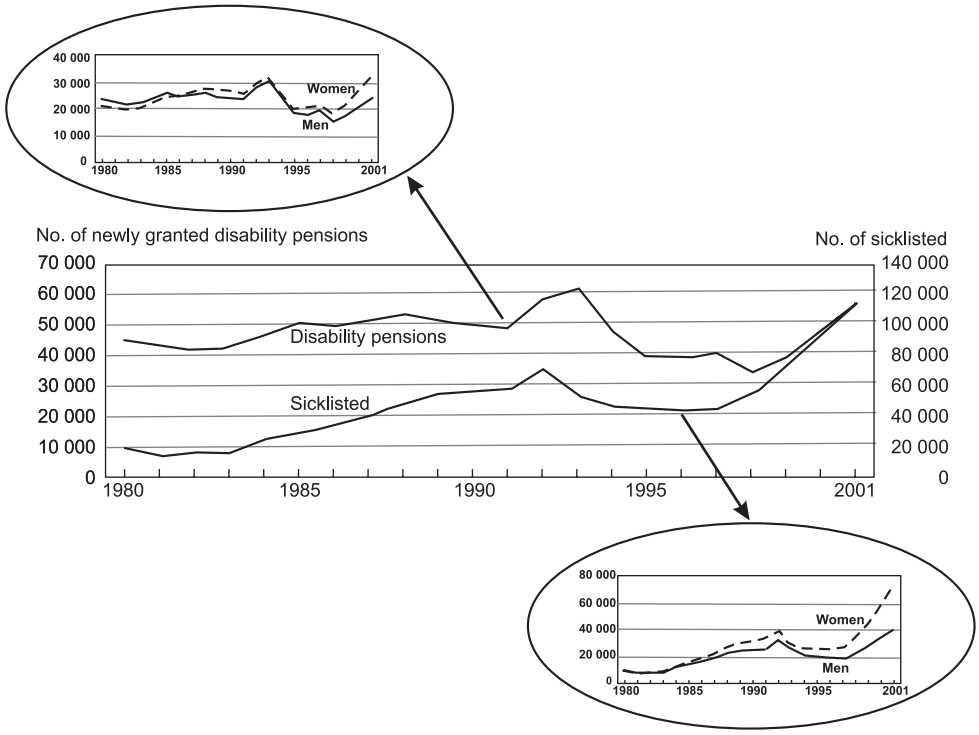
Disability benefits

A disability pension is awarded when the individual's work capacity is reduced by at least 25 per cent. The benefits can be full or partial (25, 50 or 75 percent). In January 2003 the disability pension system was reformed, with new names introduced (*sjukersättning, aktivitetsersättning*) to reflect its closer ties to the sickness insurance and hence to the labour market. Previously, a disability benefit (*förtidspension*) required that the individual was deemed permanently unable to work. A temporary disability benefit (*sjukbidrag*) was awarded if the reduced work capacity was not permanent, but for a considerable time to come. The guiding principle of the present system is that workers should, if possible, return to work. Therefore, work capacity should be re-evaluated every three years to determine if the individual can return to work.

The granting of disability benefits was rather extensive from the second half of the 1980's until the peak in 1993. Thereafter it fell back to historically low levels of around 40 000 per year for a couple of years until an increase in 1999. In 2002 a total of 489 000 persons received a disability benefit. (See Figure 1 for the development of newly granted disability pensions).

Changes in legislation and in the application of the law are decisive for the development of disability pensions. For much of the period between 1970 and up to the beginning of the 1990's, the disability insurance was used as a labour market tool by combining labour market conditions and medical reasons when granting a disability pension for workers approaching retirement age. This meant that medical testing was more lenient if workers of 63 years or older faced poor labour market conditions and risked unemployment. In 1972, a provision was introduced that allowed workers aged 63 to 66 to be awarded disability pensions purely for labour market reasons. As a result workers who

Figure 1. Newly granted disability pensions and long-term sicklisted (more than one year), 1980 to 2001 per annum (National Social Insurance Board).



had exhausted their unemployment insurance benefits could be granted a disability pension without medical testing. In 1974, the age for this provision was lowered to 60 years. In October 1991 this possibility was abolished and work towards more restrictive assessments started. Yet, the shift has been gradual with some exceptions where other reasons than medical ones have been taken into account. This explains *e.g.* the significant increase in 1993 and a smaller increase in 1997 when the number of newly granted disability pensions grew among older workers (Lidwall and Skogman Thoursie 2000; Höög and Stattin 2001).

Another important factor for the granting of disability pensions is the development of long-term sickness absence. Ups and downs in the long-term sickness absence rate have been followed by coinciding changes in the number of newly awarded disability pensions. The sharp drop in the number of long-term sicklisted was followed by a decrease in the number of awards. The pattern has been the same in recent years. In 1997 the sickness absence rate started to increase and was soon followed by growing numbers of awards (National Social Insurance Board 2003b) (see Figure 1).

The gender perspective opens up another comparison between long-term sickness absence and disability pensions. As mentioned above the share of women is larger among the long-term sicklisted, and the increase in the number of long-term sicklisted has been more notable among women, in particular among younger women. This is essentially similar to the trend in recent years in disability pensions where women represent a bigger and increasing share. The more substantial increase among women is a relatively recent phenomenon. Up to the mid 1990's the development was more or less similar for women and men (see Figure 1).

5.2 The extent of mental ill-health in sweden[4]

Mental ill-health is often referred to as one of the largest problems of public health. It causes great suffering and involves widespread social and economic consequences for the afflicted and their families as well as for society in general. A calculation of the total costs for mental ill-health amounted to around 50 000 million SEK for 1997 (National Board of Health and Welfare 1997). Mental ill-health represents the greatest burden of disease for both sexes after cardiovascular diseases.

What mental ill-health really is may be hard to define. It can be considered as a generic term for states that, in different historical or cultural contexts, have been given a number of different designations such as mentally insufficient, mental illness or mental disorders. What mental illness is, and who are counted as mentally ill, depends, however, on scientific developments and the provision of care as well as on people's experiences (Qvarsell 1999).

Since the beginning of the 1990's the term *disorder* has been used instead of disease when referring to mental states. *Severe mental disorder*, the central concept in the current legislation, refers to states of the same degree of severity as psychoses, depression with risk of suicide and certain serious personality disorders[5]. The term *long-term mentally ill* has been abandoned and replaced by *mentally disabled*. This change reflects an altered view – from a disease-oriented perspective to a handicap-oriented one. There is a wish to

[4] The following is an extract and summary of "Chapter 3. Major Health Problems" in *Scandinavian Journal of Public Health* (suppl 58:49–57, 2001). Umeå: Umeå University (Persson et al. 2001).

[5] SOSFS 2000:12.

stress that these states require medical care, but that the people afflicted by them do also depend upon their surroundings to be able to function in everyday life.

The three largest groups of mental disorders are: mood disorders, anxiety states and psychoses, which are states in which one's perception of reality is changed (Table 1). Since Sweden lacks recent national investigations of mental health there is no real knowledge of how common mental disease and mental disorder are. One has to rely on earlier local investigations, *e.g.* the Lundby study and the Rebus study of the 1970's and more recent studies from Stockholm and the region of Skåne during the 1990's, of mental disorders among primary-care patients.

Table 1. Proportion of mental disorders in the adult population, one-year average, (per cent)[a] (Persson G et al. 2001).

Mental disorder	13–15
Neuroses, especially anxiety states	8–10
Depressions	3–5
Psychoses	1 (of which 1/3 schizophrenia)
Dementia (mild, moderate and severe)	8 (at ages over 65 years)
Alcohol dependence	4–6

[a] The figures above are based on estimates from different sources.

The psychiatry committee (Psykiatriutredningen 1972) estimated that 13 per cent of the adult population had some mental disorder. According to the Lundby study almost 15 per cent of the population have a psychiatric diagnosis at a given point (Hagnell 1970) and approximately every other woman and every fourth man is afflicted at some time or other by a depression which may need treatment. The prevalence at a given point is estimated to between three per cent and five per cent (Rorsman et al. 1990; Joukamaa et al. 1994). Preliminary results of a four-year study in Stockholm county of mental health among its population, the PART study[6], show that the extent of mental dis-

[6] The PART study (Swedish initials for psychiatry work relations) is a survey of a selection of 19 000 adults aged 20 to 64 years in Stockholm county, supplemented with clinical examinations of just over 1 100 people regarding the extent and causes of common forms of mental ill-health, depression and anxiety. It was conducted between 1985 and 1999 by the Department of Clinical Neuroscience, Occupational Therapy and Odontology, Karolinska Institute, Huddinge Hospital; Karolinska Institute Department of Public Health Science and Karolinska Hospital Vocational Medical Unit.

orders appears to have remained at largely the same level during the 1990's as twenty years earlier.

In a study at primary care units in Stockholm almost a tenth of the patients had such mental problems that they were considered to need psychiatric care (Stefansson and Svensson 1993). The same proportion was found in a rural district (Orust) and in several Nordic countries (Fink et al. 1997). In one year only approximately three per cent of the adult population seek care from psychiatry and it is therefore clear that primary care encounters many with extensive mental problems.

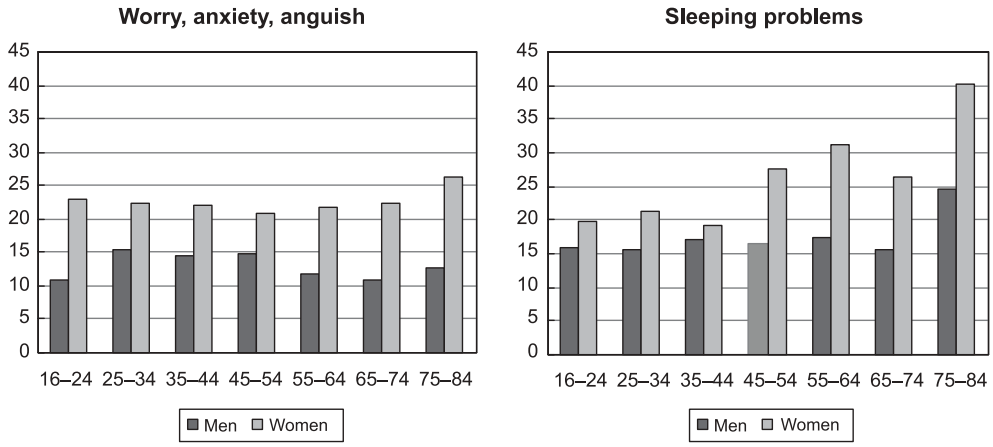
Abuse of alcohol is common. Approximately four to six per cent of the population at any given time are estimated to be dependent upon alcohol. Between ten and 14 per cent are reckoned to be so at some period during their lives, three times as many men as women. Alcohol dependence is more common in metropolitan areas than in the countryside. As many as one in five men in the cities are reckoned to have been dependent on alcohol at some time (Heilig et al. 1999).

Partly on the basis of foreign investigations, the extent of serious mental disorders is considered to have been relatively constant since the 1950's.

Anxiety and depression are more common among women, while men are more often dependent upon alcohol and drugs. Suicide, often triggered by depression, is the ultimate consequence of mental ill-health. Suicide is more common among men, but suicide attempts are more common among women. One alarming sign is that depression among young people and young adults show an increasing trend. According to Swedish data from the 1990's, five per cent of boys and 14 per cent of girls aged 16 to 17 showed signs of depression (Olsson and von Knorring 1997). Alcohol and drug abuse is another growing concern particularly among young people, which in turn leads to abuse related problems where mental disorders are an important element. There is also evidence that suicide attempts are increasing among young abusers. (Figure 2.)

Anxiety and worry, sleep problems and continual feelings of tiredness are often natural reactions to the strains of life. Failure to master these strains may sometimes lead to mental illness. They have proved to be a good barometer for mental well being and have also proved to be connected to factors in social development that touch on people's life situations.

Figure 2. Worry, anxiety, anxiety and sleeping problems at various ages (per cent). (Survey of Living Conditions 1998/99, Statistics Sweden.)



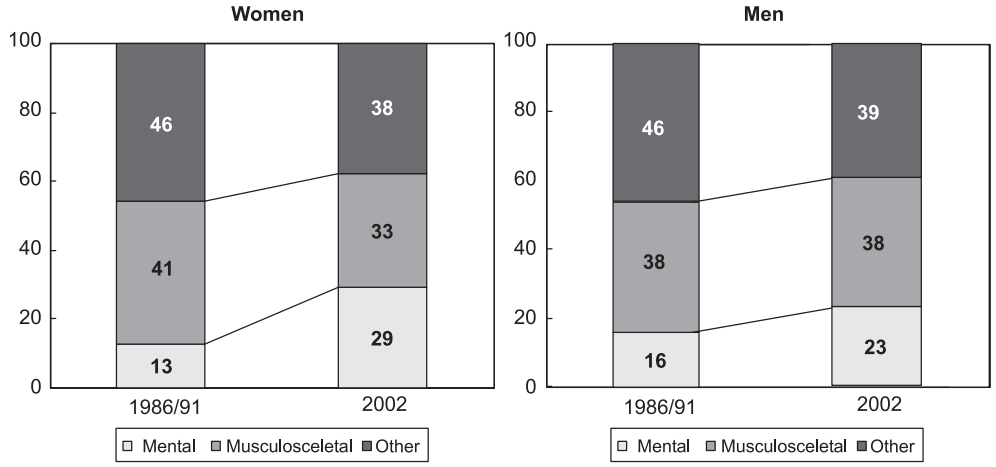
Between 10 and 40 per cent of the population aged 16 and over report in interviews that they suffer from mental complaints such as anxiety, worry, sleep problems or tiredness. Such problems are more common among women than among men and they increase with age. Between 16 and 24 years, 11 to 25 per cent report anxiety, worry, or sleep problems, compared with 13 to 40 per cent in the 75-to-84 year age group. Among children and young people in upper comprehensive school, (grades 5, 7 and 9), between 15 and 40 per cent state that they have headaches or stomach aches, or find it difficult to sleep (Danielsson and Marklund 2000). One third of patients in primary care, according to a 1993 Stockholm survey (Stefansson and Svensson 1993), had mental symptoms such as worry, anxiety and sleep difficulties.

5.3 Mental disorders as causes of sickness absenteeism

A clear tendency towards a larger share of mental disorders[7] among the sicklisted has emerged over the last decade. In the beginning of the 1990's, 14 per cent of the long-term sicklisted (here defined as 60 days or more) suffered from mental disorders. In 1999 the share increased to 18 per cent and in 2002 to 26 per cent. The share of mental disorders is larger among women than men. In 2002, 29 per cent of women were sicklisted due to mental disorders,

[7] Mental disorders refers to chapter five of *Mental and behavioural disorders of ICD-10*.

Figure 3. Long term sickness absence (60 days or more) by diagnostic group and sex, 1986/91 and 2002 (per cent). (National Social Insurance Board).



compared to 23 per cent of men. Parallel to the increase in mental disorders there has been a decline in the share of musculoskeletal disorders and other diseases (see Figure 3) (National Social Insurance Board 2002a).[8]

The increase of mental disorders is due to a rise in depression and anxiety disorders. In 2002 they represented some 22 per cent of the sicklisted. Job burnout is another diagnosis that comes to the fore as stress related illness increases. Although the notion of burnout is subject to different opinions within the research community there are certain factors to take into account. Christina Maslach[9] argues that job burnout is a prolonged response to chronic emotional and interpersonal stress factors (stressors), which are defined by three dimensions; exhaustion, cynicism, and a sense of inefficacy. Burnout appeared in the ICD-10 of 1997, but remains, with two to three per cent of the sicklisted, a relatively rare diagnosis. However, the lack of a general standard for defining burnout means that individuals in similar situations may be subject to different diagnoses.[10]

[8] Since 1999 the National Social Insurance Board has carried out an annual survey (RFV-LS) among a sample of sicklisted persons that provides information on diagnoses, profession, sector of employment, etc.

[9] Professor of psychology at the University of California at Berkeley.

[10] Ibid.

There are gender specific differences in the development of sickness absence due to psychiatric disorders. Women suffer more frequently from affective and neurotic disorders, while the share of schizotypal and delusional disorders is larger among men. Further, more men experience behavioural disorders due to psychoactive substance abuse, *e.g.* alcoholism and drug abuse.[11]

Mental disorders represent the second biggest item of the sickness insurance's expenditures with 8 400 million kronor, which is equal to 21 per cent of the sickness allowances paid out. Only musculoskeletal diseases account for a larger share (59 per cent).[12] A closer look at the total costs for specific diseases shows that there are several forms of mental disorders among the most costly diseases, *e.g.* depressive episodes, adjustment disorders, anxiety disorders, recurrent depressive disorder, etc (National Social Insurance Board 2002b).

5.4 Mental disorders as causes of disability pensions

As stated above, the granting of disability pensions has fluctuated substantially over the last decades. Since the background to these fluctuations relates to changing criteria for awarding a disability pension, the proportions of different diagnoses behind the granting also change. The most obvious shift is the increase for both women and men in the proportion of mental disorders (see Figure 4).

With respect to this change in medical diagnosis, it is interesting to note the individual's attitude to an award of disability pension. A study by the National Social Insurance Board[13] carried out among individuals demonstrates that it is mostly individuals with musculoskeletal disorders who would like a disability benefit and that the share among those with mental disorders is significantly smaller. This stands in contrast to the fact that the actual disability awards are increasing most among individuals with mental disorders (Bergendorff et al. 2003).

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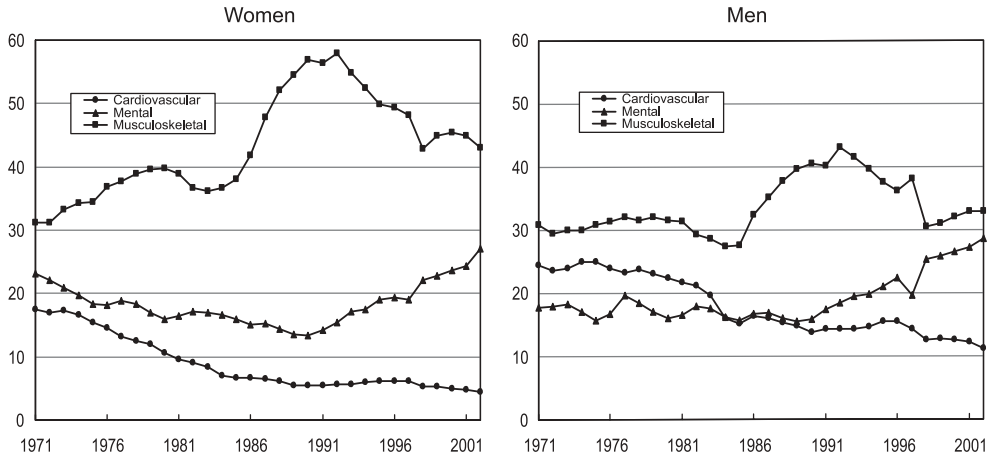
[11] Ibid.

[12] These costs only involve the general sickness insurance and do not include the employers' sick pay or other expenditures relevant to sick absence such as rehabilitation efforts or health care.

[13] The Survey of Health, Working Conditions, Life Situation and Sick Leave (RFV-HALS) among individuals who collected sickness benefits for at least two weeks (May 2002).

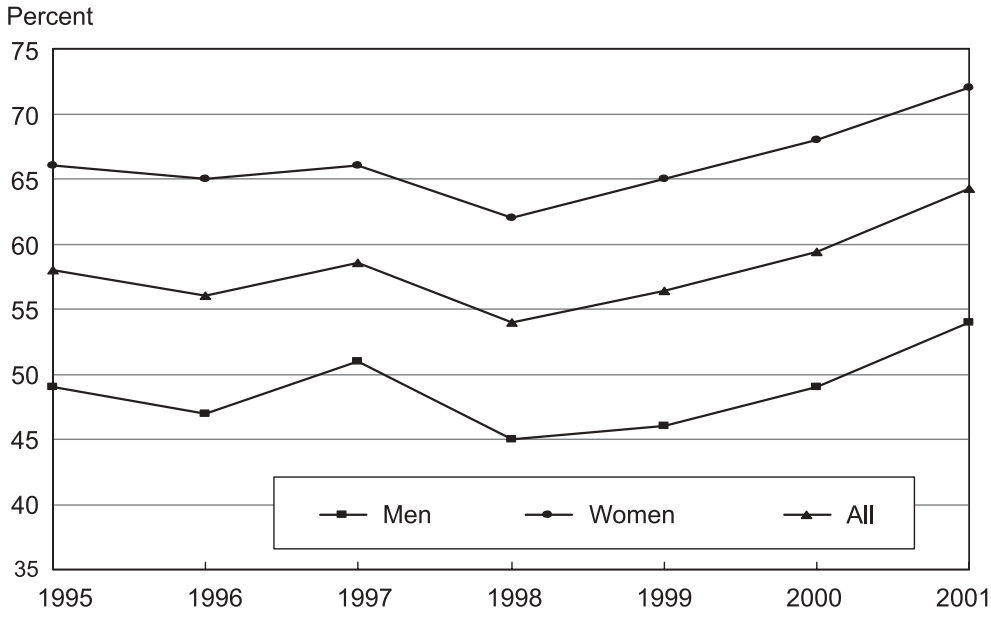
Figure 4. Disability pensions granted in 1971–2002: Proportion of selected diagnoses (per cent). (National Social Insurance Board).



Similarly to sickness absenteeism, there are clear gender differences in the diagnosis profile of disability pensions. The share of cardiovascular diseases is larger among men. The share of musculoskeletal diseases is larger among women. Mental disorders represent a slightly larger share among men, which is a different pattern compared to the situation with regard to sickness absence where the share of mental disorders is bigger among women. One explanation is that men are more likely than women to be awarded disability pensions due to severe forms of mental disorders such as schizophrenia or schizotypal and delusional disorders, or due to mental and behavioural disorders following psychoactive substance abuse (National Social Insurance Board 2003b).

Representing the largest share of mental diagnoses, mood and anxiety disorders also have increased in the last few years, from 58 per cent in 1995 to 64 per cent in 2001. Similar to the diagnosis pattern in sickness absence, women's share of affective and neurotic disorders is larger than men's (see Figure 5) (National Social Insurance Board 2003a).

Figure 5. Newly granted disability pensions due to mood and anxiety disorders (proportion of all mental disorders) (National Social Insurance Board).



5.5 What reasons are considered to be behind the increase in mental disorders as causes of sickness absenteeism and work disability?

The recent years' substantial increase in sickness absence and disability pensions as well as the shift towards a larger share of mental disorders raises questions about the causes of the development. Since the sickness insurance covers the entire population and provides high compensation rates without rigorous control, changes in fundamental societal factors such as the economy, demographic profile, labour market conditions, technological progress, medical science, education, family structures, values, etc. will have direct or indirect implications for the social protection system.

The reasons behind the development in sickness absenteeism and disability pensions and the increasing share of mental disorders are complex and depend on several factors. The following will discuss factors that may be regarded as the most relevant for the working life and social protection perspective. However, such delimitation of the problem does not mean that other aspects would be less interesting or less significant for explaining the problem of sickness absence and work disability.

5.5.1 Changing labour markets and new patterns of work increase psychological risks

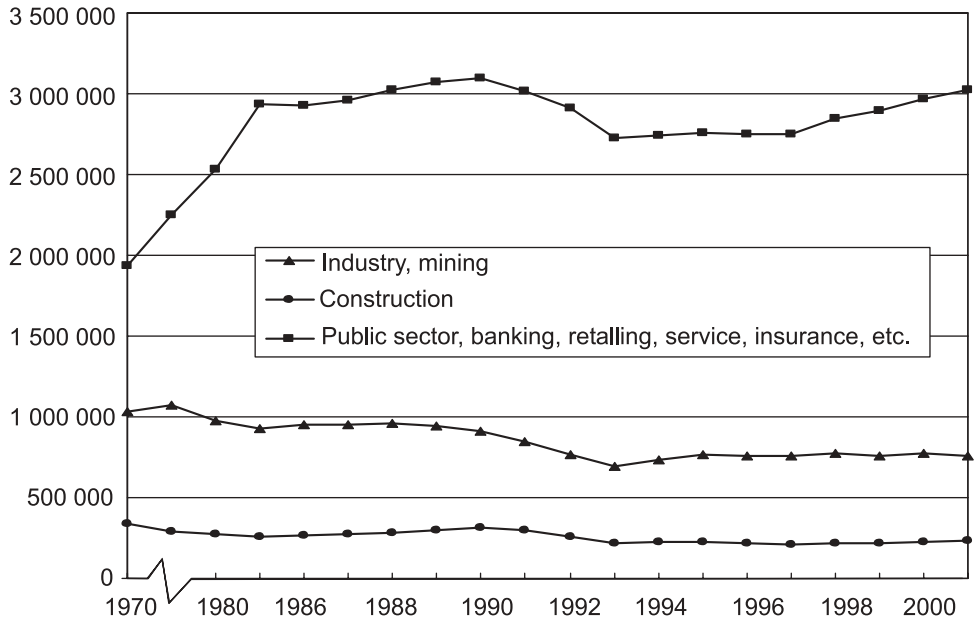
Sweden's labour market has deep roots in an industrial structure that developed after the Second World War and during the 1950's and 1960's when growth was high and the industrial sector with big raw material and processing industries employed almost half of the labour force. Large corporations, sometimes dominating entire cities and regions, provided stability and security for the whole society and for the individual. The industrial sector created the basis for the Swedish social dialogue, for wage formation and for the profile of the social insurance system.

The Swedish model experienced its first crisis during the 1970's as external shocks such as the oil crisis put pressure on the economy, which became increasingly globalised. Swedish firms faced competitive markets abroad, not least outside the western world, as trade barriers fell and financial markets were deregulated. From a long-term perspective, this was the beginning that paved the way for today's labour market and the new patterns of work. Figure 6 illustrates the development of different branches during the last three decades. The number of employees in traditional industrial sectors has gradually decreased, whereas the number of employees in service sector jobs is increasing.

The end of the 20th century saw a complete reorientation of the industrial society or what certain sociologists refer to as the third industrial revolution.[14] Industrial production has never been more intense, but the processes are different from before, based on a new organisation of work and borderless – global competition has never been sharper. At first glance this revolution features a shift of traditional industrial sector jobs to the service sector – this is at least what statistics show – , but it is equally likely to involve a redefinition of certain jobs as a result of technological progress; yesterday's blue collar workers today carry out what used to be white collar jobs. New technologies and modern ways of communication have changed daily life dramatically, not only at work but in social life in general, and have resulted in the continued evolution of production processes around human capital in a knowledge society.

[14] See *e.g.* Magnusson and Ottosson (2003) for discussions about working life and social life in a post-industrial society.

Figure 6. Employees in different branches (Statistics Sweden).



Following this transition, which began in the 1970's, the industrialised world lost millions of jobs and unemployment rose, particularly in areas where traditional industries dominated, to levels unknown since the 1930's. The industrial sector went through fundamental changes with smaller units and decentralised processes and the service sector developed. This happened in such countries as the US, the Netherlands, the UK and Denmark. Other countries, such as Germany, Spain and Finland, have been less successful in this transition.

In Sweden unemployment was low until the 1990's. The crisis of the industrial sector of the 1970's and 1980's was handled through a mixture of high public spending to create jobs in the public sector and economic policies that consisted of changes in the exchange rate and devaluation, especially during the beginning of the 1980's. When unemployment soared in the 1990's it was a symptom of the harsh economic times. Global economic recession, budgetary deficits and an increasing public debt forced both private and public sectors to contain costs, undertake organisational reforms, rationalise production processes and carry out dismissals. The public sector, with its extensive commitments in the education and care sectors, was especially affected by the budgetary restrictions.[15]

[15] See discussions on institutional changes in Palme J. et al. (2003).

What are the consequences of this development, what happens to social life in general and to working life in particular? It is indeed positive that monotonous and dirty industry jobs disappear and that work arrangements can be flexible to better fit the individual. Internationalisation and globalisation also bring advantages; new markets for businesses and new opportunities for the individual, increasing competition drives down prices on consumer goods, travel is easier and more available. But there are downsides to this development: smaller margins, time pressures, greater demands on quality and efficiency. The individualisation of working life can be an advantage for the competitive but risky for the weaker. Personal freedom and ability to influence working arrangements may increase, but there is also an increasing risk of diffuse structures and unclear leadership. Technological improvements certainly offer opportunities, but they also demand cognitive skills that not everyone is able to acquire. Employers must be prepared for sudden changes in the business cycles, which makes employment less stable. Companies become more dependent on temporary labour, overtime, staffing and consulting services, etc. – atypical work and insecure job contracts increase.[16]

Today's working life gives rise to new health aspects. Although it is not possible to link the degree of illness, or the kind of illness, to a certain degree of sickness absenteeism or work disability, it seems clear that people with health problems have difficulties in remaining in working life. To stay "fit and healthy" becomes more and more important. It takes a good deal of vigour to be able to affect a negative work situation. Increasing sickness absence and work disability, however, suggests that people in difficult situations choose to give up and avoid difficulties (Wikman and Marklund 2003).

Another health aspect is the increasing importance of psychological factors. Mental disorders increase as a share of the diagnoses behind sickness absence and disability pensions. Studies demonstrate that there is a clear link between the recent years' increase in sickness absence and deteriorating psychosocial working environment (*e.g.* National Social Insurance Board 2003c). This is particularly the case with jobs associated with high psychological demands, with low self-control and weak social support. A clear example of this are county council and municipality employees in the care and education sectors

[16] See *e.g.* Magnusson & Ottosson (2003) for discussions about working life and social life in a post-industrial society.

where sickness absence to a large extent depends on mental problems. Reversing this tendency calls for substantial improvements of the psychosocial working environment.

5.5.2 Mental disorders are problematic for the administration and the rehabilitation process

Applying the social insurance legislation can be problematic when the policy-maker's intentions are not in tune with the prevailing conditions. Discrepancies between law and practice are particularly problematic for the rehabilitation process. The complexity of the process, with the numerous actors involved and the fundamentally different conditions for different medical problems, makes it difficult to evaluate rehabilitation on a macro-level and to define generally successful pathways for facilitating return to active employment. The result is inevitably that individuals suffering from medical problems that weaken their ability to defend their rights will be disadvantaged when it comes to the distribution of resources.

Studies suggest that there are specific problems in relation to mental disorders. One decisive factor is access to employment rehabilitation and vocational training. Persons with *e.g.* temporary disability pensions due to mental disorders benefit less from employment rehabilitation compared to persons suffering from somatic troubles. When employment rehabilitation is available, the time limits are often too narrow since many severe psychiatric diseases are long lasting – even life-long. These problems are ultimately connected with difficulties in convincing the employers to take on persons with psychiatric disorders, in particular those suffering from severe forms of psychiatric disorders. A further explanation is that the actors responsible for organising employment rehabilitation often point to the need of completing the necessary medical rehabilitation efforts before initiating employment-oriented activities (National Social Insurance Board 1999).

Another important factor is the officials' competence. Social insurance employees responsible for rehabilitation recognise the need for improving their ability to deal with persons with mental disorders. This criticism is also emphasised by medical personnel at psychiatric care institutions (National Social Insurance Board 1999).

Given the specific problems discussed above, the recent years' increase in mental disorders leads to a growing pressure on the social insurance administration and other actors involved in the rehabilitation process. The nature and extent of the mental disorder clearly matters; those suffering from schizotypal and delusional disorders and severe forms of mood and neurotic disorders will be the first to end up in weaker positions as the system is not able to provide all the necessary support. However, the question remains where the limit is and what forms of mental disorders the rehabilitation process is able to support. What is done to handle the increasing share of sickness absence owing to depression and neurotic disorders? A crucial issue is what the social insurance is able to do in order to support those who have the potential of returning to active employment, and thereby avoiding long-term sickness absenteeism or even disability pension.

5.5.3 Values, culture and public debate are decisive for the attitudes to work and mental health

Studies demonstrate that work related conditions and the work place environment are considered important reasons for being long-term sicklisted.[17] This is hardly a surprising conclusion, given the development of the labour market and the psychosocial work environment. Yet it remains clear that there are several other factors that, directly or indirectly, cause the increase in the sickness and disability.

Economic incentives are important for explaining sickness absence and work disability. The debate about the adequacy of the sickness insurance largely focuses on three key factors; the replacement rate, the time limits for paying out benefits and the control mechanisms. Sweden's social security, including general and supplementary schemes, gives most employees between 90 and 100 per cent compensation for income loss in case of sickness. There are in practice no restrictions for paying out benefits for longer periods than one year. The control mechanisms basically consist of a medical certificate that must be presented to the Social Insurance Office on the 8th day of sickness and, if the medical certificate is incomplete, the Social Insurance Office's duty to collect the necessary information.

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[17] The RFV-HALS study reveals that approximately 60 per cent of the persons who have been sicklisted for 120 days consider the work place conditions an important reason for their sickness absence. (National Social Insurance Board 2003d.)

Comparisons with other countries show that the development of the Swedish system depends on the joint effect of high replacement rates, lack of time limits for paying out benefits and weak control mechanisms. The high replacement rate itself does not necessarily lead to high levels of sickness absence, but it is the combination of high replacement rates and the inadequate eligibility control that disincentivises work and leads to high levels of sickness absence (National Social Insurance Board 2003e). The debate is particularly intense about the control mechanism angle. Some argue that the administration must respond by issuing clear-cut guidelines for dealing with sickness absence, examine deviant medical certificates more carefully and limit the time period for paying out a sickness benefit.

A widespread argument is that the weaknesses of the sickness insurance create attitudes that are too passive to be able to handle today's labour market conditions, as manifested for example by unfavourable psychosocial work environments. The easiest solution for dealing with today's problematic work situation is sickness absence, especially if one is in a labour market with few alternative employers. Yet many would argue that the problem is bigger than just lack of incentives; that it is the result of a labour market culture. All actors involved – employers, the individual, physicians, social insurance employees – would be collectively guilty of not living up to the requirements of the system. A vital condition for reversing the trend would be for everyone to realise that maintaining the benefit structure of the Swedish social insurance system under prevailing conditions presupposes strict discipline on behalf of everybody.

It is an open question how this culture relates to the increase of mental disorders. One interpretation is that this culture and its underlying values are nourished by the intensive debate about stress-related risks and psychiatric problems. Who can avoid today's intense discussions about working life conditions, how to handle challenges and obligations in social life in general and what it implies in terms of mental and social pressure? The mass media pays a lot of attention to injurious stress and exposes witnesses and experts with personal experiences of depression and neurotic disorders. Verbalising stress reactions as burnout – a phenomenon that has been intensely exposed but also frequently misrepresented – has become a typical feature of the present mental health debate.

If this debate can be seen as a reflection of what the public opinion thinks is a legitimate motive for sickness absenteeism and work disability, why would one assume that sicklisted persons, employers, social insurance employees, physicians and other relevant actors of the administrative process think differently? Since the administrative process is not guided by clear regulations (there being no clear definitions and rules for handling specific medical problems, for instance), contemporary views, opinions and ideas most likely have an effect on the social insurance practice and thereby the reasons for sickness absence and work disability.

5.5.4 Concluding remarks

Recent studies suggest that social insurance regulations and system characteristics must be taken into account when explaining the high sickness rate in Sweden. (See *e.g.* Bergendorff et al. 2002; National Social Insurance Board 2003e.) Replacement rates, waiting days, control mechanisms, benefit duration etc., can be decisive for the extent of sickness absence and work disability.

The increasing share of mental disorders in sickness and work disability raises questions about the system's ability to handle mental disorders and whether sicklisted persons suffering from mental illness face more difficulties than persons with somatic diseases and injuries. It should be kept in mind that today's rehabilitation model originally was a response to the needs of the male blue-collar industrial worker with disorders in the locomotive system. Can it be that the sickness insurance provisions and the administration must adapt to better accommodate increasing psychological risks in working life? Whatever the possibilities are for improving working life conditions and containing deteriorating psychosocial working environments, it is necessary that the social insurance can cope with reality and form a system that is adapted to the risks. If today's working life entails larger psychological risks the sickness insurance must be able to deal with that.

5.6 Some priorities for further research from the viewpoint of social protection

The high sickness rates in Sweden have led to an increase in studies and research on sickness absenteeism and disability pensions. Although the problem is widely known, there is still plenty of room for improvement. This goes for both social protection research in general and specific studies on diagnosis and mental disorders.

The National Social Insurance Board carries out research and studies that cover many aspects of sickness and disability. The diagnosis perspective, and where appropriate a specific focus on mental disorders, will be included in work on such topics as pathways to sickness absenteeism and work incapacity or work-place environment and sickness absence.

One area where intensified research is necessary is the rehabilitation process. There is a great need to know more about the organisation as well as the realisation of rehabilitation, about its objectives and effects. This could include specific studies on the rehabilitation of persons suffering from mental problems.

Given the substantial increase in sickness absenteeism one can assume that the disability insurance will be subject to increasing pressure in the years to come. History has at least shown that increasing sickness absence is followed by growing numbers of newly awarded disability pensions. One can therefore assume that disability pensions will be a highly topical issue, not least due to the recent reform of the disability insurance. Studies on pathways to disability pension will include mental disorders as one of several variables.

The changes over the last decade in the psychosocial working environment are an important factor in the increasing sickness and work disability rates. There is much more to learn about the mechanisms that shape working life. Such studies should also include the interaction between working life and private life.

Another area to explore is labour market mobility and its implications for the sickness insurance. This is a topical issue since sickness absence is particularly high among certain professional groups that only have a few potential employers to choose between, *e.g.* employees in the health care sector or teachers.

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Chapter 6. Gender differences in sickness absence and disability due to mental health problems in the EU: Figures, regulations, and possible explanations

Irene Houtman, Veerle Brenninkmeijer

6.1 Introduction

Gender differences in absenteeism and disability, particularly when related to mental health problems, are a salient finding in the countries that contributed to this book. In this chapter we will discuss the topic of gender differences in sickness and disability further by presenting absence and disability figures for men and women in the EU, mainly presenting data from the 'old' EU-15 countries[1]. We will describe regulations related to sickness absence and disability for work, and present some explanations to the differences found.

6.2 Sickness absence figures in the EU

Sickness absence figures in the EU may tell us whether the gender differences in Sweden, the Netherlands, Germany, and Finland are also present in other EU countries. Although a comparative study on registered sickness absence in Europe has until recently been lacking (Blikvaer and Helliesen 1997), there are some self-reported data available on sick leave. In general, self-reported sickness absence is considered to be correlated to the registered sickness absence information, and is considered a valid indicator of relative differences and changes in registered sickness absence (e.g., Rees 1993; Harrison and Schaffer 1994). Nevertheless, self-reported sickness absence may reflect an underestimation of the real registered absence, since it is often difficult to recall all sick days over a period of one year.

There are two important sources of information about sickness absence in Europe. One source is the Luxembourg Employment Study (LES) (Blikvaer and Helliesen 1997), which is based on surveys among the national labour force. This study suggests that gender differences vary between different age groups. In almost all LES countries, it was found that among workers of 20–54 years women were more often absent due to sickness than men. Among

[1] Since there is limited comparable data on this we still limit ourselves here to the 'old' EU.

workers of 55–64 years an opposite trend was found: in this age group, absence from work due to sickness was more common among men than among women. There were indications, however, that the distribution of the characteristics 'sex' and 'age' did not explain much of the differences in the total rates of sickness absence between countries studied. Furthermore, this study was hampered by the fact that questions on absenteeism were not the same in the different country surveys.

The second source of information are the surveys of the European Foundation for the Improvement of Living and Working Conditions (Paoli and Merllié 2001), which provides information on work-related absence since 1995. In Figure 1 we present for each country the percentage of men and women that reported to have been absent for 30 days or more in the previous year. This figure shows a gender difference for the EU in general: women, as compared to men, more often report to have been sick for a long period of time[2]. This does, however, not reflect the situation in all EU countries: in some countries long-term sickness is reported more often by men than by women, while in other countries virtually no gender differences appear. As for the countries that contributed to this book, gender differences as depicted in Figure 1 are present in Sweden and the Netherlands, whereas in Finland and Germany the gender gap appears to be absent. The European Survey on Working Conditions (Paoli and Merllié 2001) also reveals large differences in long-term sickness absence between countries, irrespective of gender.

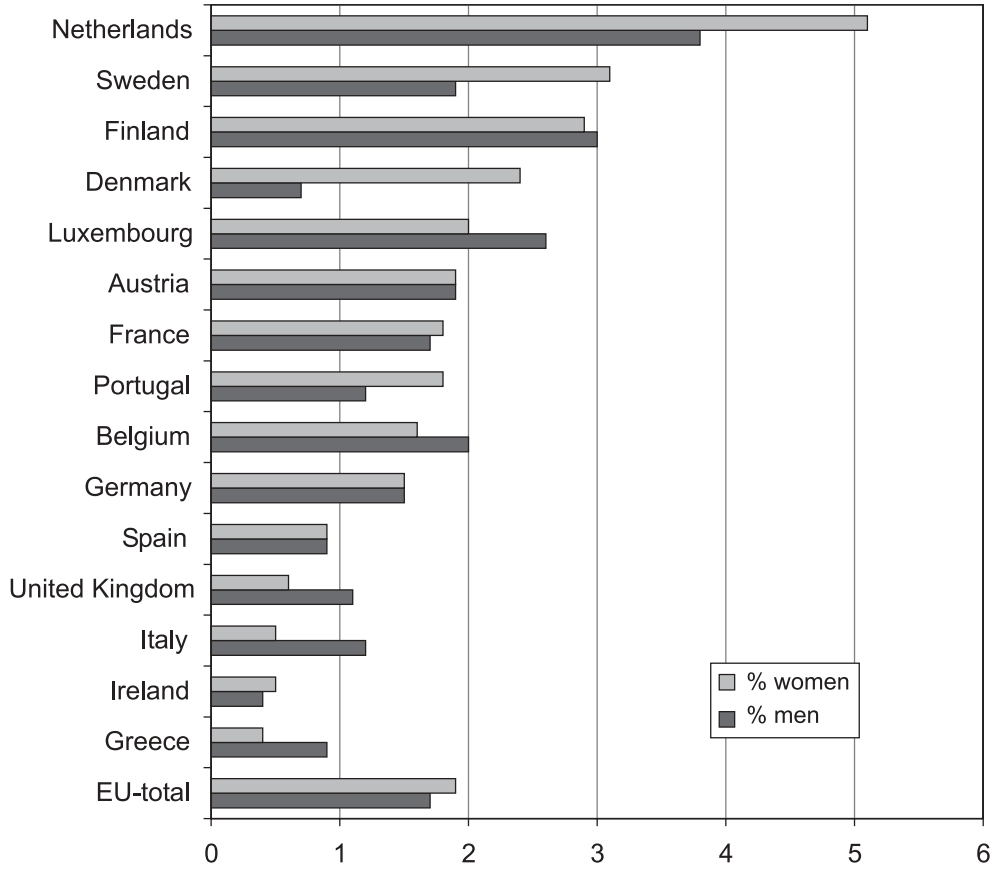
6.3 Regulations for sickness absence in the EU

Gründemann and van Vuuren (1997) summarized the official security regulations for absence due to illness and disability in the Member states of the ('old') EU (and Norway). They concluded that great differences exist between countries. However, it should also be noted that general practice often differs substantially from the official regulations.

In most countries (Austria, Belgium, Finland, France, Germany, Greece, Italy, Luxembourg, Norway, Portugal, Spain, Sweden, and the UK) a certificate

[2] One should take into account that it is not completely clear how the survey respondents handled pregnancy when they were asked to report on sickness absence. It is expected, however, that pregnancy is much less a confounder in self-reported sickness absence than in registered sickness absence.

Figure 1. Percentage of workers who reported to have been on work-related sickness absence for 30 days or more in the previous year (Paoli and Merllié 2001).



from a general practitioner is requested in cases of sick leave. The situation varies somewhat in the different countries as to the number of days of absence after which a certificate is requested. The requirement to produce a doctor's certificate in case of sickness absence is usually intended as a threshold in order to make 'reporting sick' less easy. In practice, however, a medical certificate does not mean much. Employees will go to a doctor whom they know to be willing to sign a certificate. If that doctor will not cooperate, one can always go to another doctor. Nevertheless, research shows that the duty to produce a medical certificate is generally linked to a somewhat lower incidence of sickness absence (see Gründemann and van Vuuren 1997).

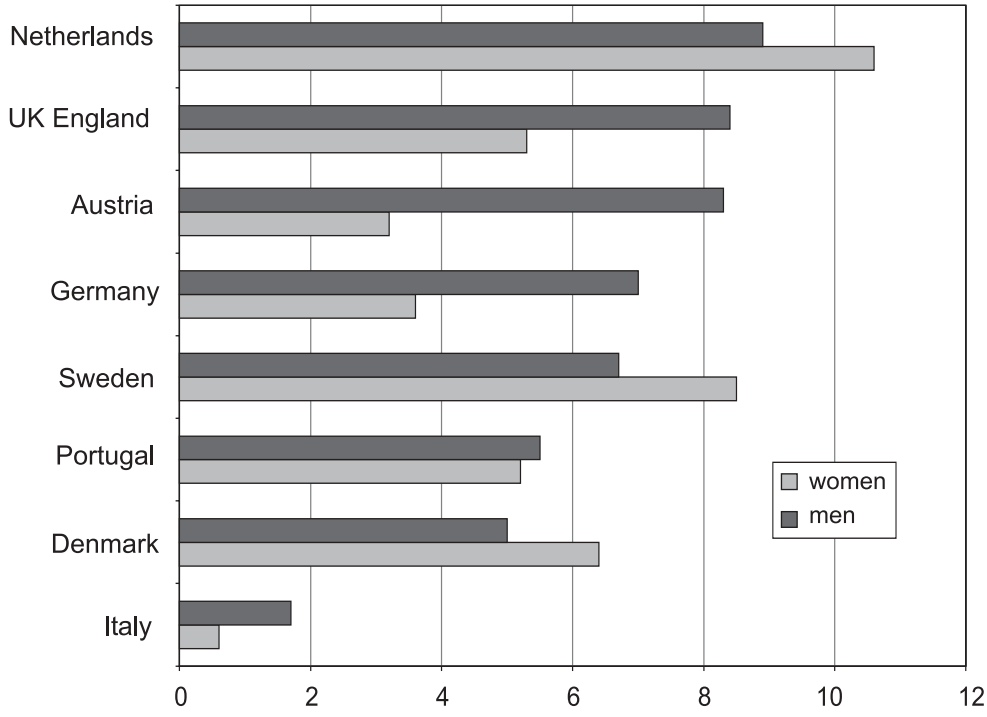
In most countries, the worker who reports sick has to wait one or a few days until he/she will receive benefits. This is called the 'waiting period'. Only in Austria, Germany, Luxembourg and Norway, no waiting days are applied. In the other countries, workers are not paid for the first day (Belgium and Sweden), the first two days (the Netherlands), the first three days (France, Greece, Ireland, Italy, Portugal, Spain and the UK), or the first nine days (Finland[3]). Waiting days are also used as a threshold in absenteeism. The literature shows that waiting days are accompanied by a lower frequency of absenteeism, but will increase the average length of the absence. The effect of the differences in waiting days between the EU countries on the total absence will therefore be nil. In most countries there *officially* is a loss of income in the case of sickness absence, in the sense that salary or wages are not paid or that the benefit percentage paid is less than 100 per cent level of the former salary or wages. Practice is usually less negative than the official rules suggest. In many countries the employer tops up the sickness benefit, in many cases even up to 100%. After the first period of absence, the percentage benefit decreases in most countries. There is a continued full payment of salary or wages in only four countries (Denmark, Luxembourg, the Netherlands and Norway). In the other countries the percentage eventually drops to 50–80% of the last-earned wage. Most countries (eleven) use a maximum period of temporary unfitness for work of approximately one year. In Italy and the UK a shorter maximum period is applied (26 and 28 weeks, respectively). The maximum period of absence has an important influence on the length of sick leave, particularly on the registered length of sick leave. Furthermore, it may influence the attitude towards rehabilitation and may in this way influence the total days of absence. Although all EU countries have regulations for maternity leave, the duration varies greatly from country to country. Particularly in the sickness absence *registrations*, maternity leave may be responsible for a significant part of the sickness absence. For example, in the Dutch health care system an average of 1% to 1,5% of work-time is taken up by maternity leave (Gründemann and van Vuuren 1997).

[3] It should be noted that the first nine days of sickness absence are under Finnish law covered by the employer. The employer will not be refunded for this period by the Social Insurance Institution. In other countries these 'waiting days' are often covered as well in 'collective agreements'.

6.4 Disability figures in the EU

In Figure 2, we can see the latest figures concerning the disability inflow (i.e., the new entries in the disability benefit system per year) for men and women in some European countries in 1999. These figures have been obtained from the national social security systems.

Figure 2. The disability inflow (= new entries into the system) of women and men of 20–64 years, in %, 1999 (these figures pertain to all disabilities, i.e., employees, self employed and those who are already handicapped at a young age)[4] (Einerhand and Van der Stelt 2005).



[4] The figures may still refer to different populations because of system differences. In some countries the whole population may receive benefits when sick or disabled, whereas in other countries (e.g. the Netherlands) people who are not working, and also not actively looking for a job, e.g. housewifes, are excluded from these benefits.

From Figure 2 we can see that particularly the Northern countries (Sweden and Denmark) and the Netherlands show a higher inflow into the disability benefit system for women than for men. This pattern differs from the patterns in other 'continental' countries (Germany, Austria, France, Portugal, Italy) and the UK. In the latter countries the disability inflow is generally higher for men than for women. Comparing Figure 2 to the previous figure on self-reported long-term sickness absence (Figure 1), we see that the patterns of gender differences are generally comparable. In countries where women are over-represented in long-term sick leave, they are also more prone to receive disability benefits. In some countries (Germany and Austria), however, we see no gender differences in long-term sickness absence, but we do see a higher inflow of men into the disability benefit system.

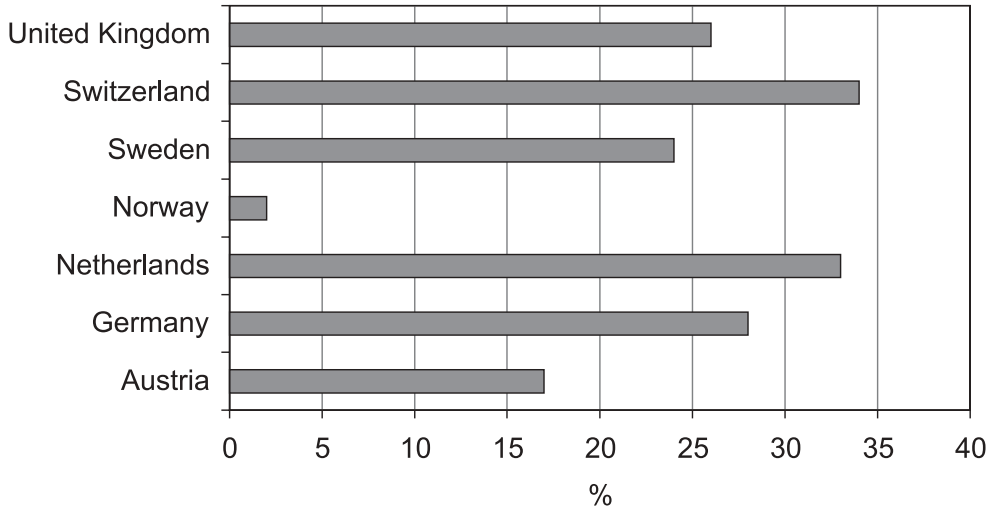
Part of the country differences in disability inflow of men and women could be explained by the fact that in some countries mental health disorders are excluded, or included only under specific restrictions, as a legitimate reason for entering the disability benefit system. In countries where these disorders are considered as a legitimate reason for disability for work, a high percentage of disability inflow of women appears to be related to a high prevalence of workers getting diagnosed to be disabled for work because of psychological and mental health disorders (see Figure 3). This suggests that women are more prone to report or to be diagnosed as having mental health or psychological disorders. This indeed appears to be the case, as shown elsewhere in this book and in the literature (see e.g., a review by Kauppinen et al. 2003).

Regulations for long-term or permanent disability in the EU

In many EU countries (Belgium, Finland, Ireland, Luxembourg, the Netherlands, Norway, Portugal and Spain) the regulations on extended or permanent disability are linked, time-wise, to regulations governing temporary sick leave. In these countries there is a waiting period for the permanent disability benefits, which is equivalent to the maximum period applicable to (non-permanent) sickness absence. In most other countries, it is not essential for the maximum period for (non-permanent) sick leave to have elapsed before a person is entitled to permanent benefit (Gründemann and van Vuuren 1997).

The definitions and conditions of payment are rather diverse. They are often based on a minimum loss of earning capacity or on a minimum percentage of unfitness for work. This minimum may differ considerably between countries,

Figure 3. Disability inflow as related to mental and psychological disorders (%) (Einerhand and Van der Stelt 2005).



as well as the maximum benefit. In Belgium the benefit percentage is dependent on family circumstances. In most countries, there is an additional assessment procedure that is decisive in the assignment of disability benefits or invalidity pension as well. In these additional procedures, differences are found between countries as well (Gründemann and van Vuuren 1997; Boer et al. 2004).

6.5 Gender segregation on the labour market

Gender segregation on the labour market may play an important role in gender differences in absence and disability. Gender segregation on the labour market refers to the fact that men and women mainly work in different occupations and are consequently exposed to different working conditions. Gender segregation is found to be highly present when considering working conditions, and as such these 'causes' may be associated with specific (health) outcomes. We can see that much in the report on Gender, work and health at work in the EU as published by the European Agency for Safety and Health at Work (Kauppinen et al. 2003). In the Netherlands, for instance, more women are working in the health care and social sector and in education (European Foundation for the Improvement of Living and Working Conditions 2004). More men are working in blue-collar sectors (building and construction, transport,

manufacturing and industry). Furthermore, men are present in a more varied number of sectors as compared to women. This pattern of gender segregation has consequences for the exposure to risk factors at work. In some sectors where many women are working, such as health care and the social sector, a lot of physical activity is performed by women. Otherwise, male workers are much more exposed to physical and ergonomic loads than women. Notwithstanding the above, women in the Dutch workforce generally report having less autonomy, less skill discretion and fewer opportunities for personal development, compared with men. They also work more often part-time, they often have lower positions in organisations, and they earn less.

When considering gender segregation on the labour market, gender differences in (mental) health outcomes appear to be reduced to a large extent (Table 1). There are hardly any specific data on long-term sickness absence and disability by gender and occupation, but there is a Dutch cohort study that explores this issue (Vinke et al. 1999). In this study, a large group of employees was followed up for about 3 years after reporting sick. The group was split by gender and by occupation into four subgroups allowing a better insight into gender differences in medical reasons for sickness absence and disability[5]. These four groups were: men working in typical men's jobs (e.g., construction workers, drivers, heavy industry workers etc.), women working in typical women's jobs (e.g., nurse, cleaning personnel, specific administrative jobs, textile industry workers), men working in gender-mixed jobs and women working in gender-mixed-jobs (e.g., professionals, teachers, sales personnel).

Table 1 shows that in typical male and typical female occupations, musculoskeletal problems are the main medical reason for absence and disability for work. For the mixed occupations, mental health disorders appear to be a major reason for both men and women, whereas for women musculo-skeletal disorders are also a major reason for absence and disability. The distribution of medical problems across the four groups is consistent with the workload these employees report when entering the cohort. The men and women in the gender-typical jobs mainly report a high physical workload in their work, whereas both the men and women in the gender-mixed occupations report a high psychosocial workload (Vinke et al. 1999). Table 1 also shows that when gender segregation on the labour market is not taken into account, the picture

[5] Since women tend to work part-time to a large extent, only women working more than 3 days a week were included in this comparison.

Table 1. Percentages of male and female employees and their main diagnoses when absent of disabled, differentiated into gender-typical and gender-mixed occupations (Vinke et al. 1999).

Diagnosis (%)	Gender segregation by occupation			
	Men in typical male occupations	Men in gender-mixed occupations	Women in gender-mixed occupations	Women in typical female occupations
11 months	n = 1 617	n = 425	n = 539	n = 488
Diagnosis:				
– mental health disorder	16.8	30.4	32.1	30.9
– musculo-skeletal disorder	44.6	27.0	36.7	43.3
– other	38.6	42.6	42.6	12.4
1 year absent (disabled)	n = 645	n = 161	n = 209	n = 214
Diagnosis:				
– mental health disorder	19.2	38.5	32.1	30.8
– musculo-skeletal disorder	43.6	26.1	34.0	37.9
– other	33.2	31.1	31.1	28.0
2 years absent (disabled)	n = 455	n = 115	n = 141	n = 157
Diagnosis:				
– mental health disorder	16.0	40.0	32.6	34.4
– musculo-skeletal disorder	47.0	27.8	33.3	35.0
– other	33.4	29.6	32.6	28.7

for men is dominated by the men in the typical male occupations. This may lead to the (wrong) conclusion that men are generally absent because of musculoskeletal problems. In reality, this is only true for typical male occupations. In gender-mixed occupations, mental health disorders are the main health problem among absent men.

Table 1 also indicates that gender segregation appears to have a larger impact on men: the diagnoses in gender-typical versus gender-mixed occupations differ more among men than among women. However, we should also account for the fact that there are large differences in education and income between the men working in typical men's occupations and men working in gender-mixed occupations. This difference is not found between women in gender-typical occupations and women in gender-mixed occupations. Further-

more, it appeared that men working in gender-mixed occupations were quite comparable to women working in gender-mixed and typical women's occupations, apart from the fact that these men much more often have a management position (Vinke et al. 1999).

6.6 Rehabilitation to work

Gender differences in rehabilitation into work may also play a role in gender differences in absence and disability. To our knowledge, however, only little (research) evidence is available on gender differences in rehabilitation to work. Some studies in the Netherlands, particularly older studies, find that fewer women rehabilitate into work after being absent for some time as compared to men (Veerman et al. 2001). More recent studies in the Netherlands indicate that rehabilitation rates are the same for men and women within the first year of absence (Giezen et al. 1998; Giezen 2000; Houtman et al. 2002). On the other hand, women do have a higher risk to be diagnosed as disabled for work after the first year of sickness absence (Houtman et al. 2002). A study on occupational health physicians showed that they considered rehabilitation into work as more important for men than for women, suggesting that they more actively stimulate men to resume work than women (Vinke et al. 1999). Employers appear to be more positive, and more active towards rehabilitation of men as well (Cuelenaere 1997; Vinke et al. 1999). Although the motivation of the employee to resume work after a period of being absent from work does not appear to differ between men and women, women generally expect less from work at the outset of their career, and make room to raise children next to having a career (e.g., Jorna and Offers 1991; Naber 1991; van Schie 1997). In a recent European study it was shown that the health and work of elderly women in particular is neglected in vocational rehabilitation (Doyal et al. 2002).

6.7 Conclusions

In this paragraph the main conclusions in relation to the gender differences in long-term absence and disability can be summarized as follows:

- Gender differences in sickness absence and disability are rather inconsistent in Europe. When considering self-reported absence, some countries (consistently) report longer periods of absenteeism and a higher risk for

inflow into the disability (benefit) system for women. However, this is not a consistent finding in all EU countries, not even within the four countries studied in this report in detail. In case of longer periods of absenteeism and a higher risk for disability inflow for women, mental health problems are often the major explanation. For the countries contributing to this book, these differences may well be related to the way these data are registered, or to the specific time frame used.

- Gender segregation into the labour market may offer an explanation for gender differences in long-term absence and disability figures, as well as in exposure to work-related risk factors. The gender segregation effects are, however, hardly studied in relation to long-term absence and disability. Hence, gender segregation effects would be an important topic for further study. It would be particularly interesting to examine this issue in new EU-member states, where gender segregation appears to be less present (European Foundation for the Improvement of Living and Working Conditions 2003).
- Gender differences in rehabilitation might also offer an explanation for gender differences in sickness absence and disability. This is a topic which has not been studied very often EU-wide and which, in our opinion, deserves further study.

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Chapter 7. Comparison of the absenteeism and work disability information from the four countries

The aim of this chapter is to provide a summary and a general interpretation on the information presented in the country reports. However, this is a demanding task. The four countries overviewed in this report differ in many ways in terms of their social protection systems, country size, or even historical development. By European standards, from the population or workforce point of view, Germany is a big country, Finland a small one, while the Netherlands and Sweden belong to the medium-sized European countries. During the last decade all of the countries have struggled to make their social protection systems sustainable. In Finland, the emphasis has been on the prevention of disability and pension costs. This has been the case also in the Netherlands, although more recently the sectoral *arbocovenants*, which aim at healthy workplaces, have emerged as a particular mechanism for preventing absenteeism. In Sweden sickness absenteeism has been intensely debated, while in Germany both absenteeism rates and the number of disability pensions have raised attention. In Finland and Germany unemployment has ranged around 8 to 9 percent, but has been much lower for both men and women in the other two countries. Yet another point of distinction is that the Netherlands and Sweden are countries with a high proportion of employees working under a part-time contract; in the Netherlands this also concerns men to a great extent. According to Eurostat statistics, in 2002 the average annual working hours were in Germany 1 467 h, in Finland 1693 h, in the Netherlands 1 346 h and in Sweden 1 602 h. The differences have remained relatively stable for the last five years (European Commission, Directorate General Employment and Social Affairs 2004).

In the Third European survey on working conditions 2000 (European Foundation 2004), one third of the respondents in Sweden and Finland indicated that stress at work affects their health, while only one fourth of the respondents in Germany and the Netherlands shared this view. In the same survey, 27% of the German respondents were very satisfied and 61% fairly satisfied with their working conditions. The corresponding figures for the Netherlands were 48 and 39%, for Finland 26 and 66%, and for Sweden 30 and 55%. The health systems in the four countries differ to some extent. In Germany preventive and medical services are based on health insurance, jointly funded by the employer and employees (World Health Organization, Regional Office for Europe 2004). In the Netherlands health services are funded in a rather complex way

through a system of public and private health insurance schemes (World Health Organization, Regional Office for Europe 2004). In Sweden the counties are responsible for funding health services, the actual funding comes from tax funds (World Health Organization, Regional Office for Europe 2004). In Finland, the municipalities are responsible for funding both primary and specialised health services. Primary care is typically organised by municipalities or federations of municipalities, and specialised services exclusively by the latter. The municipalities fund the services with municipal taxes and a state subsidy (some 28 per cent of calculated costs). In 2003 about a fifth of all health service expenditure was, however, covered by social insurance, which provides refunds both for private-sector medical and dental services and for medicinal drugs (Ministry of Social Affairs and Health 2004; World Health Organization, Regional Office for Europe 2004). In Finland, Germany and the Netherlands, employers are under obligation to organise occupational health services for their employees. In Sweden, the organising of such services is mainly based on collective agreements, but certain tasks related to risks in the work environment are specified by the Work Environment Act. (Hämäläinen et al. 2001). In Finland employers are refunded for some 50 per cent of the costs by sickness insurance funds, while in the other countries employers cover all of the costs of these services.

Total health care expenditure as a share of Gross Domestic Expenditure in 2002 was in Finland seven per cent, in Germany eleven per cent, and in both the Netherlands and Sweden nine per cent. The corresponding figures for 1997 were seven, eleven, eight and eight per cent respectively (OECD 2004).

The above statements refer both to similarities and differences in the four countries discussed in this overview. In this chapter, our aim is first to describe the database on mental disorders and short and long term absenteeism from work. Secondly, we shall try to draw conclusions on the available data and on what actions are or should be established to counteract the observed trends.

7.1 The national systems for sick-leaves and disability pensions and the statistical information used

In Finland, when an employee becomes sick and reports absent from work, she or he is obliged to indicate the reasons for the absenteeism through a medical certificate already from the first day of the sick leave. In the public sector, the certificate is typically required from the fourth day onwards, and in various

private enterprises a nurse may write the statement for the first absenteeism days. The employer is responsible for paying a salary or wages for the day the person turned ill plus an additional nine days of each sickness absenteeism episode. In practice, the employer often pays the full salary or wages for the first two to three months of the absenteeism as agreed in various collective agreements. The allowance paid by the general health insurance covers around 70 per cent of the income and it is taxable. If the employer pays a full salary to the employer during the sick leave, the recipient of the health insurance allowance is the employer. The sickness allowance can be paid for a maximum of 300 days, inclusive of all workdays for which the allowance was paid during the two preceding years. If the disability is anticipated to continue longer than this maximum, the person is assumed to apply for a temporary (called rehabilitation subsidy) or permanent disability pension. The pension insurance is mainly based on two systems: a national (basic) pension, funded by the state and the employers, and an employment pension funded jointly by the employers and employees. Before 1996, everyone who had lived in the country for 40 years was eligible for a full national pension. Since then the national pension has become employment-pension-deductible. This caused some turbulence in the ways that the pension statistics were registered, adding uncertainty to time series interpretation. The employment pension can be granted as full (loss of two thirds) or as partial (loss of one third). All physicians in the country are authorised to issue medical certificates on sickness absenteeism or disability for work. The social insurance bodies have medical experts who do not examine applicants' disability physically, but base their advice on the received statements. The insurance organisation can, however, refer the applicant to medical services for a further examination.

In Germany, the health insurance is organised as a statutory insurance in five branches due to historical reasons (e.g. according to blue/white collar, regional, professions, company based). The branches comprise some 300 insurance institutions. Membership in health insurance is compulsory in Germany as long as annual income is lower than € 3488. Since 1995 employees have been entitled to choose their insurance institution. More than 90% of the German workforce belongs to a statutory health insurance. The pension insurance consists of separate branches for white and blue-collar workers. Also certain professions (e.g. farmers, miners) have their own pension insurance. Membership in a pension insurance system is compulsory in Germany as long as income is lower than a certain limit (this limit is higher than for the health insurance and differentiates between old and new federal states). More than 95% of the German workforce belongs to a statutory pension insurance.

In general, sickness absence from work for more than three days in a row has to be attested and diagnosed by a physician. However, based on collective agreements in many economic sectors, sickness absence certificates have to be handed in earlier, often as early as the first days of absence. For the first 6 weeks of sickness absence, employees simply stay on the payroll of their employers, in most cases without any reduction in wages. After 6 weeks of sickness absence, the employer's responsibility ends and the health insurance takes over normally for up to 1 year. In case employability is severely reduced on a permanent basis (or at least for a lengthy period), disability can be assessed and attested individually by a qualified physician. The amount of pension granted depends on former income and degree of disability.

In the Netherlands, until January 2004, the Dutch Civil Code stipulated that employers must continue to pay employees who reported absent their salary for the first year of sickness absenteeism, but not beyond the duration of the employment contract. Sick pay is at minimum 70 per cent of the salary, but nearly all employees are paid 100 per cent of the last earned salary under collective agreements. Legally, the employer is within his rights to leave the first two days of sick leave unpaid, but often these two days are covered through a contract of employment or a collective agreement. Since January 2004 employers have been responsible for paying lost wages for up to *two* years of sickness absenteeism. Most employers make use of secondary insurances to cover their obligation. For employees who do not, or no longer have an employer, sickness benefits are available under the Sickness Benefit Act. These individuals may be employees who have lost their job in the first (since 2004: two) year(s) of sickness absenteeism, or temporary workers on sick leave who do not have a permanent contract with the temporary employment agency, or those self-employed who are voluntarily insured, or various individual cases (e.g. workers in cottage industries, apprentices), and unemployed persons who become ill. When workers work on the basis of a fixed-term contract, the Dutch Civil Code guarantees a sick pay paid by the employer for as long as the worker has a contract with that employer. After that, the worker has to rely on the often lower benefit covered by the Sickness Benefit Act. As a consequence of the employer's obligations as stipulated in the Dutch Civil Code, the Sickness Benefit Act actually now serves only as a 'secondary safety net'. During sickness absenteeism, both the employee and employer are obliged to promote reintegration of the sick employee. The obligations of employers and employees with respect to their activities aimed at activation/reintegration are specified in the Gatekeeper Improvement Act (2002). The Social Security Administration (Workers Insurance Authority, UWV) evaluates the reintegra-

tion efforts by the employee and employer on the basis of a reintegration report. If a reintegration is not successful because one of the parties does not fulfil the obligations, the Social Security Administration will impose sanctions. Before 2004, the Social Security Administration automatically reviewed whether the employee in question is entitled to receive a benefit under the statutory Disability Benefit Act (WAO) after 52 weeks of sick leave. Since 2004, the relevant time period has been extended to 104 weeks (2 years). The WAO is insurance for employees who are diagnosed as disabled for work. The criteria by which one is diagnosed as disabled for work are under heavy political debate. Originally, the disablement had to be at least 15% or more of earnings capacity. The act offers an earnings related benefit payment. At the end of the sickness absenteeism period, the Social Security Administration has to assess the individual's potential to work, and to determine, possibly in co-operation with a labour expert, if they will get a disability benefit or only a (much lower) unemployment benefit. A very recent conclusion on the debate thus far (March 2004) is that one must have at least an 80 per cent disablement for work to qualify for a full disability benefit paid by the Social Security Administration. The partially disabled (35–79 per cent) would need to remain in their current employment and would receive compensation payments for their partial disability. This payment might be a responsibility of a private or public insurer. This whole issue, however, is yet to be determined.

Sweden's social insurance covers the entire population. It provides both basic protection and income related benefits. The social insurance system can be divided into three main areas; pensions, sickness insurance and benefits covering children, family and people with disabilities. A guiding principle for the system is to insure against losses of own labour income. Any physician in Sweden can carry out medical assessments that are relevant to the social insurance. The sickness insurance stipulates that the insuree should present a doctor's certificate on the 8th day of the sickness period to the Social Insurance Office. At day 28 a further specific assessment including *e.g.* an outline for rehabilitation should be handed in to the Social Insurance Office. Each Social Insurance Office employs a physician as a Medical Adviser (*försäkringsläkare*) to assist in matters that require medical competence and to support the co-operation between the social insurance administration and the treating physicians. This may include the Medical Adviser's formal responsibility to assess the insuree's health status through the treating physician's certificates and to see whether there is sufficient documentation available for making a decision about the insuree. However, the Medical Adviser is not supposed to make any decisions on the insuree's right to a benefit. The sickness insurance bene-

fits are paid when the work capacity is reduced by at least 25 per cent. After an initial waiting day the employer covers the sick pay for the first 21 days. The national sickness insurance takes over at day 22. All individuals of the labour force are entitled to a sickness benefit that currently amounts to 77,6% of the individual's salary up to a ceiling. In addition to the sickness insurance most employees receive a supplementary ten per cent through collective agreements. Sickness benefits are paid out on a temporary basis with the intention that it should not be for more than one year, but since there is no formal time limit it is paid out for longer periods. A disability pension is awarded when the individual's work capacity is reduced by at least 25 per cent. The benefits can be full or partial (25, 50 or 75 percent). In January 2003 the disability pension system was reformed and new names (*sjukersättning, aktivitetsersättning*) were introduced to reflect its closer ties to the sickness insurance and hence to the labour market. Previously, a disability benefit (*förtidspension*) required that the individual was deemed permanently unable to work. A temporary disability benefit (*sjukbidrag*) was awarded if the reduced work capacity was not permanent, but still lengthy. The guiding principle of the present system is that workers, if possible, should return to work. Therefore, work capacity should be re-evaluated every three years to determine if the individual could return to work.

7.2 Statistics used for comparing the four countries

In Finland, sickness absenteeism data are mainly based on the sickness allowance statistics of the Social Insurance Institution, and these were used in the time trend assessments. They cover persons who have been off from work the day they became ill plus at least a period of nine consecutive workdays. Until the year 2004, the statistics only contained information on allowances paid, as well as, for a sample of 6.6 percent, information on the diagnoses behind the absenteeism and the occupation of the recipients. Since 2004 the diagnosis data concern all paid allowances. Statistics on disability pensions are compiled by the Social Insurance Institution (for the national pensions) and the Finnish Centre for Pensions (for the employment pensions). The two bodies also publish annually a joint book on pensioners in Finland.

In Germany data on sickness absence are compiled by member specific health insurance schemes and their federal associations. Some of the data is collected at national level by the German Ministry of Health. Unfortunately, these national figures are published with a considerable time lag. The most up-to-date

national figures available in 2003 were for the year 1996. In Germany, the longest time series on sickness absence in Germany are available from the annual statistics of the BKK BV (Bundesverband der Betriebskrankenkassen, The Federal Association of Company Health Insurance Funds). The membership of the BKK health insurance has changed dramatically since 1995 when employees were first allowed to choose their health insurance provider. As a consequence, company based health insurance schemes gained a larger percentage of younger employees with a higher social status, which undermined the year-on-year comparability of the data. In order to study time trends the BKK data on sickness absence were used to sketch the development since 1980. To allow for a subgroup differentiation of the very heterogeneous ICD-9 main section *mental disorder*s and to ensure comparability across time, national figures from the Ministry of Health were additionally used for the period 1992 to 1996. Data on work disability pensions are available from the statistics of the Federation of German Pension Insurance (VDR). The data comprise all pensions granted to employees because of permanent work disability due to a specific disease. Although in most cases the disability keeps the employees from taking up any kind of job, certain types of pension allow a degree of employment activity. In Germany, the legal framework for early retirement has been changed frequently during the last 20 years, which partly affects the utilisation of work disability pensions. The comparability of absolute figures across time is therefore compromised. Sickness absence and work disability pensions are available according to the ICD-9 for the main category *mental disorders* (ICD 290–319) and for selected subgroups.

In the Dutch system, social insurance statistics compiled since 1994 do not cover sickness absenteeism. This information has to be gathered through employer and employee surveys by the Central Bureau of Statistics. The National Bureau of Occupational Diseases collects information on occupational diseases on the basis of assessments made by occupational physicians. However, this information is not complete in coverage. The Social Security Administration (UWV) registers the inflow into and outflow from the disability benefit system and the number of persons receiving disability benefits. A coding system called CAS codes (Nederlandse Vereniging voor Arbeids- en Bedrijfsgeneeskunde (NVAB) 2004) has been developed especially for occupational physicians and the physicians who perform assessments for the Social Security Administration. This system is simpler than ICD-10 or DSM III but is related to both.

In Sweden, the social insurance system is responsible both for sickness allowances after three weeks of absenteeism and for disability pensions. The statistics used in the report are based on registers as well as survey data from the National Social Insurance Board. The diagnoses follow the International Classification of Diseases of WHO, version 10.

7.3 Epidemiology of depression and related states

In Finland, the available evidence seems to suggest that the prevalence of depression has not increased when comparing the results of the Mini-Suomi Health Survey, performed in 1978–1980 and the Health 2000 Survey of the year 2000 (Lehtinen et al. 1991; Aromaa and Koskinen 2002). The disorder is more common among women than men. These data have been obtained through interviews, questionnaires and health examinations. On the other hand, evidence in the form of time series of health interview data (Kalimo et al. 1992; Raitasalo 1992; Arinen et al. 1998) seems to indicate that psychic symptoms were substantially more frequent among adults in 1995/1996 than in 1987. The Finnish Current Care Guideline on Depression states that the point prevalence of clinically relevant depression states is five per cent, and depression states are 1.5 to 2 times more common among women than men. Only a minority of those suffering from depression actively seek medical care from the health services (Duodecim 2004).

In Sweden quite a large proportion of the information available dates back to the 1970's. The overall conclusion, based on the older data from the 1940's to the 1970's and a more recent PART study carried out in 1985 and 1999 in Stockholm County, is that the extent of mental disorders appears to have remained largely the same. A recent systematic review of the Swedish Council on Technology Assessment in Health Care on the treatment of depression (Swedish Council on Technology Assessment in Health Care 2004) analysed in detail the availability of epidemiological evidence on the prevalence of depression. The conclusion was that there is wide variation in published studies, but the prevalence seems to be higher in women than in men. The Lundby study performed in the late 1940's and repeated 25 years later (Hagnell et al. 1990) found that while the incidence of depression had increased between these time points, the increase was only seen in mild or moderate depression and not in severe depression states, which had in fact decreased.

In Germany, epidemiological evidence on the prevalence or incidence of mental disorders is scanty. However, in the Federal Health Survey of 1998/1999 the one-year prevalences for anxiety and depression were 14.5 and 11.5 per cent, respectively, both figures being high compared to the figures given in Finnish and Swedish reports. According to a recent WHO study on prevalence, severity and unmet need for treatment of mental disorders (WHO Mental Health Survey Consortium 2004), which was based on a version of the WHO Composite International Diagnostic Interview (CIDI) used in structured lay-interview, the twelve-month prevalences of anxiety and mood disorders were 6.2 and 3.6 per cent, respectively.

In the Netherlands both the prevalence and the gender and age specific incidences of psychiatric disorders have been assessed in the NEMESIS study (Bijl et al. 1998; Bijl et al. 2002). The project used DSM-III-R as a basis for the diagnoses and the Composite International Diagnostic Interview to assess the disease states. The 12-month prevalence of mood disorders was found to be 5.5 per cent for men, 4.1 per cent of which was attributable to major depression. The corresponding figures for women were 9.7 and 7.5 per cent. For all anxiety disorders the 12-month prevalence figures were 8.3 per cent for men and 16.6 for women. The prevalences showed considerable variation according to various demographic characteristics. The 12-month prevalence of anxiety and mood disorders in the Netherlands in the above mentioned WHO study using DSM-VI diagnoses and a CIDI modification (WHO Mental Health Survey Consortium 2004) were 8.8 and 6.9, respectively, *i.e.* considerably higher than in the German sub sample (see above). However, no long-term follow-up studies on Germany or the Netherlands are available to test the possibility that the prevalence of depression or anxiety had actually changed over time.

7.4 Mental disorders and absenteeism from work

The overall impression about the absenteeism data presented in the country reports can be described briefly as follows: all of the reports indicate an increased role for mental problems as a cause of sickness absenteeism. However, this statement needs to be scrutinised with care due to the presented data itself and the rather different country situations. In Finland the statistics presented are based on sickness absences which were compensated by the Social Insurance Institution in the form of sickness allowances and thus lasted a minimum of 10 days after the onset of incapacity. There has been rather exten-

sive variation in the overall number of sickness allowance spells granted in 1991–2002. Among women, the number of spells granted for mental disorders started to rise several years before a similar trend was observed for men. But besides the growth due to mental disorders, also the number of spells due to musculoskeletal disorders has been increasing since the second half of the 1990's. Affective disorders are the main reason behind the increase in the absenteeism spells due to mental disorders (in 2002 58 per cent of the spells due to mental disorders). One should note that symptom diagnoses like fatigue, exhaustion or burnouts do not apply, as they are not accepted as grounds for providing a sickness allowance. Another point to consider is that the period covered by the data includes various changes in social insurance legislation, among them the increase in 1993 in the number of absenteeism days covered by employer payments from seven to nine. It should be noted that changes in the pension and unemployment benefit legislation, too, may indirectly bring about changes in sickness absenteeism practices.

In Sweden the statistical basis of sickness absenteeism is rather similar to Finland. However, the employer responsibility for the first absenteeism days is a bit longer: two weeks until 2003 and currently three weeks. The Swedishn sickness insurance benefits have mostly been tax funded and not based on the insurance principle as in Finland. The share of mental disorders as a cause of long-term (60 days or more) sickness absenteeism in any case increased from 1986/1991 to 2002, from an average of 13 per cent to 29 per cent among women and from an average of 16 per cent to 23 per cent among men. The most common reasons were depression and anxiety. Job burnout is an accepted diagnosis but only accounts for two to three per cent of the absenteeism.

In the case of Germany, the register data presented are a bit more complex. First, the diagnoses behind the statistics are based on the International Classification of Diseases 9. Second, statistical information for the whole country is only available until 1996 from the Federal Ministry of Health. These statistics show both sickness absenteeism spells and absence days due to neurotic disorders (ICD 9 codes 300–316) gradually increasing from 1992 till 1996. Both the number of sickness spells and absence days were much higher for women throughout this period. The number of sickness absenteeism spells and days due to psychotic condition (ICD 9 codes 290–294) showed even faster growth, although the absolute numbers were considerably less than those for neurotic conditions. As for psychotic disorders, the number of absenteeism days and spells among men was about double that among women. The BKK Federation

statistics described in the report provide data on psychotic and neurotic conditions based on ICD 9. The number of absenteeism days grew constantly from 1978 until 1996 both for men and women, but then declined, from a point at which the female rate was about double the male rate, until 1997–1998, particularly among women. After levelling off in 1999 and 2000, growth resumed in 2001. Two things must be kept in mind when interpreting the data: the Health Act was revised in 1995 to allow all insured persons to select their insurance company, as a result of which the number of persons insured by BKK increased rapidly, the newcomers being younger and better off economically. The second point is that the overall absenteeism rate was almost halved from 1980 until 2001. The growth rates for mental health should be seen against this background.

In the Netherlands, there are no longer any sickness allowance based registers, as employers have carried the cost of income compensation during sickness absenteeism since 1994. Two available sources are an employer interview performed by the Central Bureau of Statistics. Absenteeism is also addressed in the Permanent Quality of Working Life Survey. One major problem is that although the interview data may allow for the monitoring of absenteeism rates due to illness in various branches of economic activity, they do not contain medical diagnoses. Private-sector absenteeism rates in the Netherlands have in any case been relatively stable and low over the years, at around 5 per cent. In the public sector the figures have been a few per cent higher. Reporting on work-related disorders may not be comparable with the countries where sickness insurance and occupational accident insurance constitute separate insurances. One source for assessing the role of mental problems in absenteeism is the reports of occupational health physicians. Half of the reports concern musculoskeletal diagnoses and a quarter psychological disorders. Registering is most likely not systematic, which limits the representativeness and validity of the information. In any event, around 50 per cent of the reports concern musculoskeletal diagnoses and a quarter mental disorders. Work is in progress to combine the absenteeism data compiled by the National Bureau of Statistics and by the Social Security System; a publication concerning 2004 is foreseen for 2005. Research using self-reported data and validated questionnaires indicates that mental ill health is responsible for a considerable amount of sickness absenteeism. A clear conclusion on the role of mental disorders as causes of sickness absenteeism on the basis of registered diagnostics cannot yet be drawn.

7.5 Mental disorders and work disability pensions

As was the case with the absenteeism data, one can state as the overall impression that mental disorders have an increasing role in causing work disability as judged from the statistics on work disability pensions. But again, statistics available from the four countries need further and more detailed explanations to be understood.

According to the Finnish statistics on disability pension schemes in 1981–2002 the total number of recipients of disability pensions began to grow in the mid-1980's and peaked in the mid-1990's at about 294 000. Thereafter, the total number has gradually decreased by about 14 per cent, having been in 2002 almost at the same level as in the beginning of the 1980's. The increase in the number of recipients between 1986–1997 was almost entirely caused by so-called individual early retirement pensions, which were launched in 1986 for the private sector and in 1989 for the public sector. This pension requires a permanent reduction of one's working capacity resulting from an illness and taking into account the work demands and the length of working life participation. Originally, people aged 55 years or over were eligible. In 1994 the minimum age was raised to 58 years, and in 2000 further to 60 years. At its highest, the number of recipients of this pension reached 60 000. For most of them the cause of disability behind the pension was a musculo-skeletal disorder. The individual early retirement pension is to be phased out in accordance with more recent revisions of the pension legislation.

Although the number of disability pensions is at about the same level as two decades ago, the morbidity behind the disability seems quite different. From 31 per cent ten years previously, the share of mental disorders as the cause of disability rose to 41 per cent in 2002. The share of musculo-skeletal disorders has decreased from 31 to 25 per cent, and the share of cardiovascular diseases from 14 to 9 per cent. In 2002, 32 per cent of all newly granted disability pensions were due to mental disorders, 30 per cent to musculoskeletal diseases, and 9 per cent to cardiovascular diseases.

In the Finnish data, two things call for attention: first, in the latter part of the 1990's, the WHO ICD 10 replaced the ICD 9 and DSM-R used earlier as the diagnostic base of mental disorders. Second, the national basic pension became employment pension deductible in 1996. This caused a gap in the compiling of joint disability pension statistics, so statistics for 1996 and possibly for 1997 may be less comparable with both earlier and later figures. The pri-

vate sector disability pension statistics for 1998–2003 suggest that the main age group in which there was an increase in new disability pensions due to mental health is the oldest one of 55–64 years, and that the increase was seen both for men and women. Furthermore, all other disease categories showed an increase as well (except for cardiovascular diseases in the case of women).

In Germany work disability pensions due to mental disorders showed a marked trend in contrast to disability pensions due to other diseases. The number of all newly granted disability pensions declined from 193 030 in 1986 to 160 438 in 2001. One has to note again that ICD 9 (codes 290–319, both psychotic and neurotic disorders) was used in these statistics and they only concern the "old" federal states. By contrast, the number of pensions due to mental disorders doubled in the same period, rising from 22 000 to 44 000. Similar trends could be observed for both genders. The proportion of mental disorders as a cause of disability pensions also increased. Whereas e.g. in 1986 only 11% of newly granted disability pensions were based on a diagnosis of mental disorders the percentage rose to 28% in 2001. This trend is obviously gender specific. Starting at about the same amount, the share of mental disorders grew faster and to a higher level among women. In 2001 more than one third of all work disability pensions newly granted to women were due to mental disorders.

The most important *change* in the health characteristics of the Dutch workforce probably concerns the inflow of employees into the disability system, i.e. the number and characteristics of persons granted a new disability pensions. The number of new disability pension recipients increased from 79 000 in 1994 to 118 000 in 2001, but then started to decline, reaching 108 000 in 2002 and 85 060 in 2003. For a long time it was estimated that the total number of people receiving disability benefits would pass 1 million in 2003, which did not happen. At the same time the number of persons in the workforce has varied. However, the relative *risk* of becoming disabled also shows a trend from 1993 onwards: it was 1.18 per 1 000 insured employees in 1994, 1.70 in 2001, and 1.52 in 2002. The main reasons for being disabled for work were mental disorders. The figures given also indicate that the percentage of disability inflow due to mental disorders was increasing. A transition of diagnostics from ICD 10 to the newly developed CAS codes in the mid-1990's may have blurred the statistics. When the CAS system was adopted, many causes of disability could not be classified during the first few years. However, a rise in mental diagnoses as a cause of new disability cases is evident after this transition period.

Also in Sweden, the granting of disability pensions has fluctuated substantially over the last decades. Obviously, the background to these fluctuations relates to changing criteria for awarding disability pensions, leading also to changes in the proportions of different diagnoses behind the granting. The most obvious shift is the increase for both women and men in the proportion of mental disorders since the early 1990's until now.

With respect to the change in the role of various medical diagnoses in the statistics, it is interesting to note the attitudes of persons on sick leave with regard to the award of a disability pension. A study by the National Social Insurance Board (National Social Insurance Board 2002) indicated that it is mainly individuals with musculoskeletal disorders who would like to be on disability benefit. Significantly fewer of those with mental disorders expressed a similar wish. This stands in contrast to the fact that actual disability pensions are increasingly being awarded to individuals with mental disorders (National Board of Social Insurance 2002). Similarly to sickness absenteeism, there are clear gender differences in the diagnosis profile of disability pensions. The share of cardiovascular diseases is larger among men, while the share of musculoskeletal diseases is larger among women. Mental disorders represent a slightly larger share among men, which is a different pattern compared to the situation with regard to sickness absence where the share of mental disorders is bigger among women. One explanation is that men are more likely than women to be awarded a disability pension due to severe forms of mental disorders such as schizophrenia, schizotypical and delusional disorders or mental and behavioural disorders following psychoactive substance abuse. Mood and anxiety disorders represent the largest share of mental diagnoses, which has also increased over the last few years, from 58 per cent in 1995 to 64 per cent in 2001. Similar to the diagnosis pattern in sickness absence, women's share of affective and neurotic disorders is larger than men's.

Recently, figures on newly granted disability pensions were compared among four EU countries. This comparison was part of a starting document on 'psychological disability' for a committee that was installed to advise the Ministry of Social Affairs and Employment and the Ministry of Health in the Netherlands on measures to be taken to reduce the – until recently – rising number of workers who reported sick and were diagnosed as disabled, particularly those with psychological disorders. Disability figures in the Netherlands were compared with those in Sweden, Germany and Belgium (Veerman et al., 2001). The overall inflow into the disability system turned out to be high in The Netherlands (year: 1998), especially where disability was due to psychologi-

cal disorders (NL: 5.2/1 000 insured; B: 2.2/1 000 insured; G: 1.7/1 000 insured; S: 1.5/1 000 insured). In the Netherlands, the risk of being diagnosed as disabled due to psychological disorders was particularly high for working women in the age range of 25–34 years. The gender difference is apparently limited in Sweden (see above).

7.6 Explanations for the trends observed

The reports all indicate that mental health issues and their role in social protection provisions have undergone heavy debate.

The explanations offered as to why mental health issues at work, in absenteeism and in work disability have come to the forefront are many and point to several societal levels: macro-economy, business life, funding and costs of social protection, working life rules, regulations and practices, the need to combine working and non-working lives, public health, occupational health and health services, coordination of all stakeholder activities involved in the prevention of disability such as occupational health services, employment services, social insurance services and various rehabilitation measures. We shall present a short overview of the issues that seem to fail at various levels. For detailed discussions, the reader is referred to the separate country reports.

7.6.1 Macro-economy, business life, funding and cost-containment of social protection

We have learned more and more about the prerequisites and consequences of globalisation since the 1990's. We have found that globalisation can have an effect on the marginalisation of certain types of geographic areas, economic activities and sectors, and certain groups of people and individuals. At the same time, the workforce is ageing in European countries. Of the four countries the Netherlands and Sweden have been better a managing the employability of their workforce. In Germany and Finland unemployment has remained at a high level, Germany especially being faced by the challenges of the East-West unification. Productivity demands increase all the time, and an idea of high productivity has been also introduced to the public sector at the same time as it has been slimmed rigorously. At the same time all social protection sectors have been trimmed to create efficient incentive systems; to make working pay and staying on so-called passive social protection benefits

less attractive. Nice-sounding phrases such as flexible working hours and flexible work arrangements to meet the various social needs of employees at various life phases may not always benefit the non-working life of employees.

At the same time, skills and competence demands have continued to increase. New and more complicated work tasks that require the kind of technological, social and lingual skills that professional education does not readily provide are replacing simpler tasks. Employment security has also been decreased in Finland and elsewhere. In the event of unemployment, people are assumed to show high activity, competence and skills in order to acquire new employment in the competitive open market. It is no wonder that people with a decreased working capacity, with chronic conditions, poor education and limited skills have a high risk of marginalisation. People suffering from mental disorders may be even worse off: in need of long-term care but not actively seeking it (e.g. Duodecim 2004; Leigh-Doyle and Mulvihill 2004). Lost energy and lowered self-esteem will also lessen chances to of reintegration or re-employment. In summary, one can say that the high demands of working life that can create a *push effect* away from employment may cause mental suffering and particularly impact people who are mentally vulnerable. These types of developments are far from the ideal society inclusive of all.

7.6.2 Working conditions and work organisation

There is rather extensive evidence that poor working conditions, whether physical, psychological or social, combined with too high or too low demands and poor decision latitude are burdening, and cause stress, anxiety and other suffering. These are also caused or worsened by unfair treatment, bullying or harassment by co-workers and superiors. Some people even face a high level of isolation or violence in their work (for references and discussion, see e.g. Chapter 8). Additionally, people may not be willing to reveal suffering or vulnerability which may worsen their treatment outlook or stigmatise them.

As said in the beginning mental disorders typically are multifactorial in origin, and not only physical, psychological, social and genetic but also often economic issues form a part of the aetiology. Burdens of work may in many ways cause or worsen the misfit between an individual, his or her work and work environment. The effect may well be that the person seeks help of or is referred to medical services instead of resolving the workplace generated problems at source.

There is evidence that people with chronic conditions have a higher risk of marginalisation. This holds true especially for people with a psychiatric condition, which may cause longer treatment or longer absence. Although from the society's viewpoint it is clear that it would be more expedient and cost-effective to resume or maintain the employment and skills of a person with chronic conditions, the everyday rules of working life, whether in the private or public sector, may work in just the opposite direction, pushing people out of working life.

7.6.3 Publicity, public health, occupational health and health services

There seems to be a gradual change towards better acceptance and inclusiveness of mental issues in various aspects of life. Yet there is still mystification of the human psyche and of psychological reactions, mental suffering and mental disorders, albeit that public acceptance has increased greatly during the last ten years. It is evident that every opportunity should be taken to integrate mental issues in ordinary life. This would mean similar scrutinity in public development as currently is done for equity issues. Mental health is not a separate issue but a part of everything else, which should be noted accordingly. This is of crucial relevance for public health issues in all of the four countries surveyed. In the political discussion, there is recognition that mental ill health is a matter of great concern, but in practical terms relatively little progress takes place. In Sweden where reducing sickness absenteeism is high on the political agenda, huge organisational, administrative, research and practical improvement efforts have been done, yet the issue of mental-ill health has still not been extensively discussed. Although absenteeism due to mental disorders has been scrutinised, its implications evidently have not. Rather, it is thought that mental health issues can be managed similarly to any other issue that endangers work ability.

In the Netherlands, employers have to contract occupational health services to manage occupational health issues at workplaces. A practical example described in the Dutch report is that even though occupational health physicians only infrequently register mental disorders as work-related, and do so quite extensively in the case of musculoskeletal disorders, the statistics on work disability pensions show an ever increasing role for mental disorders as a cause of disability pensions. For a more detailed discussion of the management of disability risks, see the Dutch report.

According to epidemiological studies mental disorders are much more common than their share of the use of medical services would suggest (e.g. Swedish Council on Technology Assessment in Health Care 2004; WHO 2004). The WHO publication makes also note of there being a considerable amount of so-called non-cases (people not having a mental disorder) in treatment at the same time as one third of the people in the developed world, including several European countries, had not received any treatment for their severe mental disorder during the past 12 months.

7.6.4 Coordination of all stakeholder activities involved in the prevention of disability, including occupational health services, employment services, social insurance services and various rehabilitation measures

In the European context there are many stakeholders at the local level who have not only a responsibility but motives and incentives to participate in the prevention of marginalisation, disability and in improving the reintegration and work resumption processes. How much of the responsibility lies with public authorities and how much with private actors varies from one country to another. However, it is evident that there are many actors that need to work together: the employee him- or herself, employer and employee representative(s), employment agency or labour experts, occupational health experts, other health experts, rehabilitation experts and social services. Of course it is hard to make common interests work well in this type of complex collaboration: typically the incentive systems may not be truly shared; there may be no mechanisms in place for obtaining the needed funding and for sharing responsibilities; employment opportunities may not be available; or there may be no economic incentives for the employer to take responsibility for the employment efforts. Most likely, persons who have been displaced from their workplace, who have experienced bullying or burnout, or who suffer from mental symptoms may need services or approaches that are not available. A person suffering from depression typically needs care for a lengthy period. Timely availability of the services may not be guaranteed, absenteeism may lengthen, and rehabilitation services may not come in time or be available at all. Further, re-employment efforts may fail for many reasons. We evidently need both research and development actions to make the system to work in the interest and for the benefit of people with mental ill health.

7.7 What is carried out or is being planned to manage promotion of mental health and prevention of mental ill health?

Just like in the whole Western world, mental health promotion and prevention of mental ill health have gained a lot of attention in the four countries. There appear to be activities at various levels: at the political level, at the enterprise level and at the service level. However, all four countries are still far from integrating mental health promotion in all health related issues, or mental health promotion in all labour issues. In the Netherlands, there has been major emphasis on the prevention of work disability and hence increased employer responsibility for sickness absenteeism and the re-integration process, the latter with the cooperation of the employees concerned. Sectoral health and safety committees have also been set up to adjust actions to sectoral needs, with a strong emphasis on prevention. The so-called Donner Committee 1 has tackled the issue of absenteeism and work disability due to mental ill health. There have also been active research efforts in this area. In Germany, the main emphasis has been on developing the system of workplace health promotion, mental health services, and competences of various health professionals. There are also various workplace initiatives focusing on many aspects of health and mental health promotion. In Sweden the main issue has been political: halving the sickness absenteeism rate between 2002 and 2008. A huge amount of development work has been done, statistics have been improved, employer responsibilities have expanded, and collaboration between labour inspection and social insurance offices has increased. The National Social Insurance Board and the local office network will be merged in 2005.

Finland has relied greatly on governmental development and public health programmes, which typically are directed by a broad leadership representing ministries and other sectoral actors. They have addressed such topics as ageing workers, well-being at work and, more recently, attractiveness of working life. Finland and Sweden share a rather intense discussion on mental health services and their integration with other health services.

It is recommended that the readers consult the original country reports or their authors for additional details.

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Chapter 8. How to manage the mental health challenge in our societies?

"Mental health problems do not just affect the individual. They impact the entire community. They can impose a heavy burden in terms of social exclusion, stigmatisation, and economic costs for people with mental difficulties and their families." (ILO 2000) This statement by the International Labour Organisation summarises what has been pointed out also in this publication for its example countries. The high risks for mental disorder, the increasing number of people at risk, and the costs to societies are well known by now. Under the projects of the European Union dealing with mental health promotion, more than 10 international meetings or conferences have been organised to promote the case of mental health promotion and prevention of mental ill-health (European Commission. Health and Consumer Protection 2004).

Numerous studies report on concerns about mental health issues, but conclusions on causation, and even more importantly, on prevention, remain ambiguous. There is an increasing amount of evidence on the effectiveness of health promotive and preventive interventions. Yet few long-term cost-effectiveness studies in real health systems or in real life contexts, such as workplaces, are available. This is probably due to two aspects. First, the term mental disorders comprises a number of diseases of a complex nature, and second, these diseases are in a complex way related to the living conditions and life situations of individuals and communities. The complexity may in some cases make it difficult if not impossible to collect evidence in the strictest medical sense. In addition, physical, mental, social and behavioural health problems may interact to amplify each other's effects on behaviour and well-being, making it more difficult to cope with such demanding life situations as unemployment, lack of income, poor skill and education, stressful working life conditions, discrimination and human rights violations (Desjarlais et al. 1995). Mental health, then, is affected by individual factors and experiences, by social interaction, by societal structures and resources, and by cultural values. It is influenced by experiences in everyday life, in families as well as at school, in the street as well as at work (Lehtinen et al. 1997). The overall picture is made more complicated and progress is slowed down by the isolation – academic, political and organisational – of mental health issues from other life events.

A special policy paper (European Commission. Health and Consumer Protection 2003a) was prepared in connection with an EU funded project on Mental health promotion and prevention strategies for coping with anxiety, depression

and stress related disorders in Europe. It took up 10 key recommendations that concerned stigmatisation due to mental illness, integration of programmes at the national, regional and local levels, to improve effectiveness, needs for training in life skills, focussing interventions on high risk life events, and basing of interventions on best available evidence. Children, adolescents and young people, adults in working age and older people all need an individual approach to intervention. The final two recommendations concerned multi-disciplinary and multi-sectoral approaches to enhance effectiveness and to ensure that the civil and human rights of people with mental illness are respected.

One has to bear in mind that many macro-level conditions and circumstances, such as economic factors, societal developments, and cultures and their development, create a basis for living and opportunities of life for human beings. In two of its recent publications, the WHO analyses the effectiveness of prevention and health promotion from the macro level (WHO 2004a, 2004b). In this overview we shall, however, focus only on the level of interactions that relate to daily activities of social insurance, which means a micro-level approach concerning people in working life or belonging to the workforce.

One has also take full note of the fact that in analysing the effects of any intervention, at any level, whether they concern health promotion, prevention of disease or their consequences, social interventions, or something else, we must balance their capability of producing the intended good against their potential for harm, and also consider the cost at which safe effectiveness is achievable. The statistical data from the four European countries overviewed in this publication indicate that seen from the social protection side, the role of mental ill-health in causing absenteeism from work is increasing. This is happening despite the fact that mental health issues are today known better than ever, that they are more widely accepted, and that the health services are better equipped with screening, diagnostic, treatment and rehabilitation tools than ever before, at least in Europe. Another aspect seems to be that the prevalence or incidence of mental disorders is not necessarily increasing, at least not those of more severe disease states.

Absenteeism from work concerns people of working age, from people perhaps slightly less than 20 years old to those a little under 70 years. The overarching idea in the European economic and social development has been to increase the working life participation of all people in this age group. It appears likely

that the increased absenteeism mainly concerns persons whose mental ill-health diagnoses, made for sickness and pension insurance purposes, are typically not very severe. Various hypotheses have been put forward why this type of morbidity has been increasing as a factor causing absenteeism. Typically, psychosocial and physical conditions in working life, line management styles, increased productivity demands, and a poor match of the worker's competences, skills, wishes and values with his or her working tasks, work organisation and working rules, or a mismatch between work and social life (family life or other), are mainly behind the misfit seen in certain employee segments. Provided these hypotheses are accepted, it could be argued that these competence, organisational and leadership problems should be removed or relieved at workplaces and in working life. Occupational health and medical services should have a maximal expert role, as appropriate, in the management of these problems, yet the problems evidently are not medical. Social security may, of course, be involved to some extent in processes that relate to rehabilitation, reintegration or resumption of work.

In this chapter we present a short summary of current views about the prevention of mental disorders and promotion of mental health. We shall also present conclusions about how the prevention and promotion actions could be related to social security provisions.

8.1 Evidence for promoting mental health and preventing mental ill-health

During the last few years, various international bodies, especially the WHO, have been very active in collating available information on mental disorders, their prevention, promotion of mental health, and providing services for mental disorders (World Health Organization 2003a, 2003b, 2004a, 2000b). There seems to be much that can be done, not limited to making available services, rehabilitation and other mechanisms that allow a return to better life control and to work.

The key issue appears to be to make mental health part of every strategy that concerns health or well-being at work and more generally as well. Another issue is that a person with these problems must be empowered to gain all relevant guidance and services to manage their life.

As the current publication is focused on the social security consequences of mental ill-health, our main interest here concerns the potential ways in which these phenomena can be prevented. Evidently the main thrust should be to integrate mental health as a natural component of any health relevant policy, strategy or action. This is the approach advocated also by the above mentioned two WHO publications (WHO 2004a, 2004b). These two summary publications primarily examine the evidence concerning the primary prevention of and protection against the risks of mental disorders. The report titled Promoting Mental Health. Concepts. Emerging evidence. Practice (WHO 2004a) proposes actions at many levels and facets where it finds evidence available. These include issues related to social and economic determinants, special population groups, and various sectors and settings of society. The other WHO publication, "Prevention of mental disorders. Effective intervention and policy options (WHO 2004b)", is more specifically focused on what is known about the risks and protective factors concerning mental health, what macrostrategies improve quality of life and mental health, what can be achieved through reducing stressors and enhancing resilience, and finally, what is known about interventions aiming at preventing mental disorders. Specifically in regards to work stress, the document proposes interventions directed both at reducing stressors and at increasing the coping capacity of employees. The document also recommends various interventions for persons at risk of unemployment or having become unemployed: both formal social security intervention, welfare assistance and interventions that aim at improving the capabilities of the person to achieve re-employment. Finally, some interactions are deemed efficient for adults affected by depression and anxiety disorders.

The above-mentioned EU-funded project on Mental health promotion and prevention strategies for coping with anxiety, depression and stress related disorders in Europe, also had a special sub-project on adults in working life (European Commission. Health and Consumer Protection 2003b). The researchers analysed the availability of good practices in promotion of mental health at work in 15 EU Member States. Of the 54 activities identified, the researchers selected 20 that met the set criteria for good practice. These 20 models are described in some detail in the report (European Commission. Health and Consumer Protection 2003b). The project concerned the prevention of stress and other mental disorders in women, self-management of work stress, assessment of burnout, empowerment-culture in improving work life, life-long learning for coping in elderly care, multiplying role models in workplace health promotion, prevention of anxiety disorder and depression relapses, detection of physical and psychological stressors, self-competence and

self-responsibility as means to counteract work stress and improve job satisfaction, and career development in increasing self-esteem and knowledge of a company's operations. Further, the models concerned health promotion in preschool services, preparing for retirement, stress prevention among teachers, prevention of psychological and physical stressors in small and medium enterprises, training for shop floor employees to manage work demands, counselling and consulting for early detection of mental health risks, stress management for health care workers, manager education for organisational health, and teaching of section managers in cognitive behavioural skills. In its report, the research group stresses the importance of stated policies, leadership, integration of mental health issues in workplace, health and safety programmes, and paying adequate attention to the co-morbidity of physical and mental disorders also in preventive interventions.

8.2 Sickness absenteeism and work-related stress

Wherever sickness absenteeism records are kept, it is uniformly observed that there is always variation over time in general absenteeism rates as well as variation in cause-specific absenteeism rates. The reasons are many, often operating at the same time: behavioural and cultural trends, the relative role of being sick *vis-à-vis* other optional states: being at work, being absent due to other reasons, being unemployed, or even being out of the workforce voluntarily (e.g. at home or in further education). Administrative and legislative rules, economic incentives, and weighing the values of various options all affect people's actual behaviour. One consistent observation is that sickness absenteeism rates decline during an economic recession. There are various assumed reasons behind this phenomenon (Hemmingsson 2004). One is that according to the so-called outflow hypothesis, persons who have limited capacity for work or other vocational limitations are forced out of work during a recession phase, primarily to unemployment but possibly also out of the workforce entirely. This evidently will decrease the share of people at risk of absenteeism among the employed. According to the so-called inflow hypothesis, people with limitations of working or other capacities can become reemployed during a phase of high economic growth.

A great deal is known about absenteeism and working conditions from descriptive follow-up studies (e.g. Marmot et al. 1995; Gründemann and van Vuuren 1997; Kivimäki et al. 2000; Vahtera et al. 2000). The assumed reasons for absenteeism include poor line management, poor decision latitude, poor

psychosocial and physical working condition, unfair treatment by management and co-workers and high work demands, whether mental or physical. A search of the Cochrane Collaboration (www.cochrane. org) and the Campbell Collaboration (www.campbellcollaboration.org) data bases indicates that very few systematic reviews are available on interventions that enhance return to work or diminish absenteeism (Krause et al. 1998). On the other hand, it is a well known that many workplace interventions, whether directed toward individual health or well-being, lifestyle issues, physical or social working conditions, skill or competence, all have a potential to reduce absenteeism. One explanation for this trend seems to be that all of these interventions both improve workplace commitment and motivation and strengthen belief in the common interests and trust of the employers and employees.

Desciptive studies also indicate that work can cause stress and that a high level of experienced work stress is related to increased absenteeism (Levi et al. 1999). While no systematic reviews on the prevention of stress and its consequences seem to be available at this point through the Cochrane databases, the other literature is extensive. In 1996, Murphy published an extensive overview of published literature on stress management interventions. Of the 64 reviewed publications, 34 were deemed properly conducted with randomised controls and 15 properly conducted but without randomisation. The health outcome measures varied, and job/organisational outcomes were included only in 40 per cent of the studies. The interventions ranged from muscle relaxation, meditation and biofeedback to various combinations. Thirty of the studies used combined stress management interventions, producing consistent and significant results on various outcome measures. The rating of the whole literature (based on the categories conclusive, acceptable, indicative, suggestive, weak) was deemed as indicative, and the rating of the combined muscle relaxation and cognitive-behavioural skills management techniques as acceptable. More recently, the British Government has put forward a white paper titled Saving Lives: Our Healthier Nation (1999), which puts a strong emphasis on horizontality and verticality of health promotion programmes to encompass various actors and various action levels of the society. The British Health and Safety Executive has also put forward management standards for work-related stress (Health and Safety Executive 2004) which are supported by a study on good practices implemented in the UK (Jordan et al. 2003). We must also note that the report on the evidence of health promotion effectiveness issued by the International Union for Health Promotion and Education prepared for the European Commission (IUHPE 2000) strongly emphasises the already available evidence for effectiveness of mental health promotion and

workplace health promotion. In 2002, the Directorate General Employment and Social Affairs published an executive summary on Guidance on work-related stress (European Commission. Employment and Social Affairs 2002). The message was clear: enough is known about work-related stress and its prevention. Actions should be taken with the help of the available knowledge to prevent harmful effects of stress. This has also been emphasised by Professor Lennart Levi in his numerous publications (e.g. Levi 2002).

8.3 Who are the target groups needing interventions?

There is an ongoing scientific debate on the most efficient ways of prevention. The common high risk approach aims at the allocation of preventive activities to the individuals known to be at the highest risk for a specific disease. In contrast, the population approach advocated by G. Rose (1985, 1992) proposes that the most efficient prevention can be reached by targeting a high number of people, i.e. the general population.

The above mentioned WHO publications bring additional aspects to this discussion. The summary publication, Prevention of mental disorders. Effective intervention and policy options (Mrazek and Haggerty 1994: 22–24; WHO 2004b), proposes a different classification: universal prevention targets such as the general public or a whole population group that has not been identified on the basis of increased risk. Selective prevention targets individuals or subgroups of the population whose risk of developing a mental disorder is higher than average, as evidenced by biological, psychological or social risk factors. Indicated prevention targets high-risk people who are identified as having a predisposition for a mental disorder but who do not meet the diagnostic criteria. This three class classification is used in the document as one set of criteria in assessing evidence on preventive interventions.

Of course, relating the targeting issue to the real events behind sickness absenteeism or disability pension applications is demanding. In everyday life situations, it is poorly known and difficult to address scientifically what really lies behind a mental diagnosis leading to absence from work. In summary, more information is needed and efforts to review systematically what is known about the factors influencing mental disorders should be encouraged. Since there seems to be much experience that is not being submitted to the scientific literature, international and regional cooperation is necessary for the transfer and evaluation of such information and experiences.

8.4 What in the evidence for evidence based intervention?

The two above mentioned WHO publications take a rather inclusive view on what can be considered as evidence (WHO 2004a, 2004b). The approach is clearly different from the strict demands of the Cochrane collaboration where randomised controlled trials (RCT) are the gold standard. The WHO documents make a note on the advantages and disadvantages of RCTs. They are specifically appropriate for studying causal influences at an individual level using interventions in a highly controlled context. However, many preventive and health promotive interventions address whole classes, schools, companies, communities or even populations. In these circumstances, randomisation is hard to achieve. Therefore, the documents recommend that other study designs such as quasi-experimental studies and time-series designs, should be considered as producing useful evidence. The report also underlines that qualitative research also may be necessary to develop insight into facilitating factors and barriers (WHO 2004b). The other publication (WHO 2004a) stresses that health promotion is social action. "The principle of prudence recognizes that all evidence has weaknesses that we can never know enough to act with certainty, but that we can in many cases be sure enough of the quality of the existing evidence to make recommendation for action". The report, quoting Tang et al. (2003), proposes that the strength of evidence could be classified according to four types:

- Type A: What works is known, how it works is known, and the repeatability is universal.
- Type B: What works is known, how it works is known, but the repeatability is limited.
- Type C: What works is known, repeatability is universal, but how it works is unknown.
- Type D: What works is known, how it works is not, and repeatability is also limited.

The report also states that health promotion research operates in an environment where numerous cultural, social, economic, and political factors interact. It is unlikely that the effectiveness of a health promotion intervention can be guaranteed beforehand; hence, evaluation research needs to be combined with health promotion practice (WHO 2004a).

The above-mentioned sub-project of the EU-funded project on Mental health promotion and prevention strategies for coping with anxiety, depression and stress related disorders in Europe (European Commission. Health and Con-

sumer Protection 2003b) used the following criteria in selecting 20 good practice models: such a model should include early detection (early warning sign); it should involve the participants in the whole project management; it should be integrated in the management philosophy; it should include different levels of intervention, i.e. the individual, the social environment and the working conditions; it should focus on mental health promotion in relation to prevention of anxiety and depression but also to other phenomena such as stress, bullying, moral harassment, burnout etc.; and it should cover different levels: promotion, primary prevention and secondary prevention. It should also be designed and implemented by a multi-professional team, apply a multifaceted target group, include various actions (e.g. training, counselling, surveys), and be proven effective. The set of criteria naturally goes far beyond scientific evidence to the philosophy of health promotion in general; Yet at the same time, this kind of purism may be assumed to strengthen the success of the approaches.

To summarise, what was said above may well be in line with what the social security sector needs in terms of proper approaches to analysing the reasons for variations in absenteeism rates due to various reasons or in terms of actions to prevent them. At any rate, this may be true of less severe conditions in which actual medical, often expensive interventions are not justified.

8.5 Primary intervention versus care, rehabilitation and re-integration

In the above, we have focused primarily on prevention and health promotion actions to prevent absenteeism or early retirement due to mental ill-health. The text was written based on the assumption that trends over time are mainly caused by milder disorder states than severe mental disorders. Social security is also responsible for medical and rehabilitation actions that are necessary for persons who have progressed to a more severe disorder level. Treatments and rehabilitation efforts are typically individually oriented services which demand time and a high level of professionality, and are typically therefore much more expensive. For these efforts, convincing evidence about effectiveness and cost-effectiveness is even more necessary.

However, the evidence base available for treatment and rehabilitation of depression, anxiety and other mental disorders is not extensive. The Cochrane Collaboration has a specific Cochrane depression, anxiety and neurosis group (2004), which produces reviews. These reviews are at the heart of Evidence-

based Medicine and are organised and published by the Cochrane Collaboration. The group has produced reviews on clinical trials with pharmaceuticals, on prevention based on various treatments, and on various other treatment-related issues within the scope of the group. Two general practice level reviews will be described here in some detail. Huibers et al. (2004) reviewed the effectiveness of psychosocial interventions delivered by general practitioners (GP). The study was stimulated by the observation that general practitioners to a large extent are contacted by patients with problems of psychosocial origin. Therefore it was asked whether structured psychosocial interventions can be an appropriate tool for GPs. The reviewers conclude: "In general, there is little available evidence on the use of psychosocial intervention by general practitioners. Of the psychosocial interventions reviewed, problem-solving treatment for depression seemed the most promising tool for GPs, although "a stronger evidence-base is required and the effectiveness in routine practice remains to be demonstrated". Merry et al. (2004) reviewed the evidence for psychological and/or educational interventions for the prevention of depression in children and adolescents. Since depression is considered the fourth most important disease in the estimation of disease burden and strongly linked to social functioning, the attempt was made to assess programmes developed for preventing the onset of depression. The authors conclude: "Although there is insufficient evidence to warrant the introduction of depression prevention programmes currently, results to date indicate that further study would be worthwhile."

Outside the scope of the Cochrane collaboration, some intervention recommendations have been given. Barlow and Lehman (1996) have assessed the evidence on psychosocial treatment for anxiety disorders. Clarkin et al. (1996) and Robinson et al. (1990) have assessed the evidence for depression psychotherapy. Jané-Llopis et al. (2003) have published a meta-analysis of predictors of efficacy of depression prevention programmes, initially concerning 1474 publications and in the end resulting in 69 programmes for analysis. The conclusion of the authors was that prevention programmes to reduce depressive symptoms can lead to an 11% improvement in the intervention groups compared with control groups. The authors recommend that health and mental health care providers should be informed and provided with training in interventions to reduce and prevent depressive symptoms for targeted populations. Also the WHO has produced an initiative on depression in public health (WHO 2004c).

While quite different, these reviews point to some common conclusions:

- Since mental disorders often develop slowly, there is no sharp onset of the disease. It is therefore difficult to differentiate interventions for disease prevention from treatment.
- Intervention studies concerning mental health aspects often are so poorly implemented with respect to the quality of group selection, selection of tools and outcomes and documentation that many of them resist inclusion in systematic reviews.
- Given the great number of mental health related complaints, illness and diseases as well as the variety of possible interventions and treatments by various care-providers, one can say that much is known, but more evidence is still necessary.

Finally, two issues that concern therapies and rehabilitation. One is that due to the huge variation in approaches to therapies, medical rehabilitation and various therapies overlap. On the other hand, it is perhaps worth stressing that from the point of view of society as well as that of social security, outcome measures, such as return to work and continuation in working life should be taken into account much better in any future research activities.

Prevention, treatment and rehabilitation are always a question of money, too. So it seems appropriate to emphasise that prevention and health promotion, especially in the working environment, do pay off, as should in most cases therapies and rehabilitation. Thanks in particular to the reduction of medical costs and reduced absenteeism, the reported "return of investment" values are between 1:2.3 for savings with regard to medical costs and 1:10.1 in respect of savings due to decreased absenteeism (Kreis and Boedeker 2004).

8.6 Incentives for prevention – the scope for various stakeholders

Preventive measures and rehabilitation are decisive – and complex – elements in social protection policies. There are many who have a stake in the management of workforce and return to work: state, municipalities, workplaces, employees, employers, health, occupational health sector, rehabilitation services, adult education providers, employment agent services and funders of various services and benefit systems. Although there is no panacea for a successful implementation, each stakeholder involved in the process of prevention and rehabilitation must be active and motivated and find the right incentives. Such

incentives could be an instrument that improves early detection and prevention of risk factors for mental health, treatment, rehabilitation and resumption of work.

The importance of incentives is obvious in the discussion on societal development. Yet the meaning of the concept is not that clear. One suggestion is that incentives represent the system of economic rewards inherent in the economy. Such a definition also points at a decisive limitation that is implicitly found in the debate concerning the meaning of incentives. It is, with very few exceptions, the economic incentives that are subject to discussion. Limiting incentives to economic rewards may be reasonable, but it should be kept in mind that there are other rewards and penalties, not least of a moral nature, that have an effect on human behaviour. (Sjöberg and Bäckman 2001). Without defining the specific measures for preventing mental disorders, or the specific incentives for an actor to implement these measures, it is clear that the incentives for preventing mental disorders differ between stakeholders. The state's interests generally do not coincide with those of the employer, the employees have their own specific motives as do health care institutions, and so on.

In an environment of high employment, working life carries strong health implications for society in general and, hence, the employer's commitments are decisive. Activating the employer to create favourable working conditions can be done in several ways. However, the central idea is to involve employers in the financing of sickness absence while enabling them to influence its cost. A widespread model that achieves this is a sick pay covered by the employer for an initial period of the sickness absence. Another model is to let the employer share the financing of sickness benefits paid out of the general system. Further, there are differentiated social contributions that depend on *e.g.* the employees' health status or an employer's special efforts to improve the working environment.

Parallel to creating incentives for the employer are the state's motives. From a budget and cost containing perspective it is attractive for the state to leave the financial responsibility to someone who is close to the field and who is able to efficiently carry out control. Convincing the employer to take on responsibility for prevention measures may be even more attractive for the state. Incentivising the state could also consist of increasing workforce productivity, increasing employment and improving employability, which all should lead to a stronger economy and higher tax revenues.

The incentive structure is also relevant for social insurance institutions, health care services and other organisations that have a role in the process of preventing mental disorders. At the organisation level there must be a mandate, or business concept, including objectives to work towards and resources for realising these objectives. For employees within these organisations – social insurance employees, municipality employees, physicians, health care employees, administrative personnel, etc. – that encounter the individual, the reward system depends on factors such as influence over bureaucratic procedures, decision latitude, feedback on measures, authority over the work situation, training opportunities, personal development, and all in all, a possibility to feel well in working life.

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Chapter 9. Priorities for further research from the viewpoint of social protection

Our study deals with trends in sickness absence and disability pensions due to mental ill health. Although there are diverging trends in the development of the studied countries' social protection systems, the overall picture is that a large variety of mental disorders and complaints are increasingly the cause of sickness absence and disability pensions. The roots of the problem seem to be common; a multitude of interrelated factors that originate from the challenges of today's social and working life.

To meet the challenges, there is a need for increasing awareness of the factors for mental health on all levels of society. It is a matter of setting the agenda, sharing responsibilities and defining who should be doing what. This work involves a broad spectrum of stakeholders including governments and public bodies ranging from state to local level, universities and the research community, social partners, civil society, the business community, international organisations, etc. There is a great need for highlighting national experiences, with attention to specific national features that are decisive for the development, and to carry out comparisons between countries.

One outcome of this study is to propose three overall objectives for carrying forward the discussion:

1. to improve the understanding of the reasons and explanatory factors for sickness absence and disability pensions due to mental disorders;
2. to improve the understanding of the aims, means and effects of rehabilitation activities;
3. to boost and explore the analysis and promotion of preventive measures and strategies from a social protection perspective.

Determinants of sickness absenteeism and disability pensions due to mental disorders

The examples of this study highlight some of the issues to be handled in order to know more of the background to mental ill health. This work can be based on the objective of *improving the understanding of mental disorders from the*

sickness and disability pension perspective. This objective stresses the multitude of factors and the interaction of these factors that lead to mental pressure. Key concepts are misfit, illness, disease and sickness.

At the core of this objective is the focus on new patterns of work and individualisation of work, on physical risks and on psychosocial working environment. Central questions are decision latitude, skill discretion, increasing psychological demands, social support from supervisors and colleagues, conflicts at work, continuous training and education, etc. It is also of interest to extend the studies to take account of the broader social sphere including the homework and distance work interface, risks of urbanisation, the implications of increasing alcohol consumption, drug and pharmaceutical abuse, etc.

Improving the understanding of mental disorders require deepening the study of diagnoses and what different mental disorders imply for the ability to work. Another perspective of this objective is the process behind sickness and disability. There is the role of different actors such as social security officials, physicians, employers and employees. Another topical question is the implications of intense mass media coverage and the driving forces behind the public debate. This involves the question of changing values and the medicalisation of factors behind work misfit and mental strain.

The aims, means and effects of rehabilitation

"Rehabilitation is taken for granted, but we do not know for what purpose, what means to use and what the effects are." This is obviously a cynical view of rehabilitation. Yet it reflects the difficulties that many social protection systems face when it comes to handling sickness absence, promoting work resumption and preventing disability pensions. To carry forward the work the objective is *to improve the understanding of the aims, the means and the effects of rehabilitation activities*.

Organisation and sharing of responsibilities are important aspects of rehabilitation. In today's systems the employer has a key role. Still the conditions for successful rehabilitation can depend on input from other actors such as social protection bodies, health care services, company health care including specialist care and other expert services that act on the workplace level, employment services, etc. The individual's motivation and abilities must also be taken into account.

Rehabilitation of mental disorders raises questions about differences in relation to somatic complaints, ill-health and disorders. Studies demonstrate that access to employment rehabilitation and vocational training is more complicated for persons with psychological problems. These difficulties point to sensitive issues such as discrimination and our view of people with mental troubles. It also highlights the dilemma of medical rehabilitation efforts before initiating employment-oriented activities.

A key challenge for future research is to go beyond the political ambitions and the legal provisions and to look at the actual conditions for realising rehabilitation. Valuable contributions would depend on involving all parties concerned, not least the employer's perspective

Preventive measures

In discussing preventive measures, one must distinguish between levels – state to local, primary and secondary, general to individual, etc. In order to realise the objective of *boosting and exploring the analysis and promotion of preventive measures and strategies from a social protection perspective*, actors on all levels are invited to demonstrate successful strategies and implementation of programmes to prevent exclusion of persons with mental disorders from working life.

The prevention objective is to a large extent centred on the workplace perspective. Studies of best practices should include *e.g.* organisational and individual level interventions, company health care activities, employers' incentives, time and resource management and new patterns of work, training and personal development, etc. Further perspectives to consider include prevention and rehabilitation activities viewed from the standpoint of health care and medical services. Social insurance bodies, employment policy bodies and their partners have key responsibilities not only for ensuring supervision and control but also for such functions as information, evaluation and research.

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