BEITRÄGE ZUR SOZIALEN SICHERHEIT

Disability benefits due to mental health problems

An Overview of Figures and Measures in six Countries

Research report no. 7/05

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DISABILITY BENEFITS DUE TO MENTAL HEALTH PROBLEMS

An Overview of Figures and Measures in Six Countries

September 2004

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Foreword by the Federal Social Insurance Office

One of the greatest challenges faced by the Federal Invalidity Insurance system (IV) is the over-proportional rise in the number of people receiving benefits due to mental and psychological problems. Currently, mental illness is the main cause of invalidity for four out of ten new IV benefit recipients.

Switzerland is not the only country to be affected by this development. In its 2003 report *Transforming disability into ability*, the OECD states that "mental and psychological problems are responsible for between one-quarter and one-third of the disability recipiency levels, and for a considerable portion of the increase of these levels" (p. 10).

The 5th revision of the Federal Law on Invalidity Insurance (IVG) envisages the introduction of measures for a more effective treatment of mental/psychological illnesses, as well as skeletal disorders and impairment to the organs of locomotion, which are often stress-related. Since other countries are also faced with the same problem, the Federal Social Insurance Office commissioned a report to identify and systematise other countries' experiences with the early detection, clarification and reintegration of people with mental and psychological problems.

As the present survey shows, discussions are under way in several countries on a range of measures. Some have already been developed for implementation at different points during the disablement process – from prevention to (professional) re-integration. The majority of these instruments provide recommendations to those working in the field of invalidity insurance. However, the systematic application and evaluation of these instruments could still be improved.

Bruno Nydegger Lory
Competence Centre for Basic Principles
Research and Development

PREFACE

This cross-national analysis of disability benefit and pension statistics as well as measures to prevent disability was highly dependent on the interest and support of several persons and institutions.

We highly appreciate the interest and active support from the social insurance agencies in the countries included in this study.

Also various experts from social security bodies, social research and in disability management contributed substantially to the success of this exploration. They were willing to inform us about policies, pilots or procedures to tackle the problems associated with disability due to mental health problems.

Finally, we in particular wish to thank the statisticians and researchers at the social insurance agencies, who were willing to support the project and – even under heavy time constraints – provided the data and answers to our additional questions. This study would not have been carried out without the active help of these experts:

- Mrs. Annemarie Halin and Mrs. Petra van den Eynde, Rijksinstituut voor Ziekte- en Invaliditeitsverzekering RIZIV, Brussels.
- Mrs. Rita Kloosterman and Mrs. Joanna Kuznier, Canada Pension Plan Disability Policy, Social Development Canada, Ottawa.
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- Mr. Edgar Kruse and Mr. Thomas Bütefisch, Verband Deutscher Rentenversicherungsträger VDR, Frankfurt.
- Mr. Bruno Nydegger Lory and Mr. Francois Donini, Bundesamt für Sozialversicherung BSV, Bern.

Leiden, The Netherlands
September 2004

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SUMMARY

In order to obtain a better insight into the features of the growth and measures to face the disability pension problem, the Swiss Federal Office for Social Security (Bundesamt für Sozialversicherung, BSV) requested the AS*tri* Research and Consultancy Group to make a comparative cross-national exploration of disability due to mental health problems.

The study comprised two parts and has been carried out Spring 2004.
The *quantitative* part aimed to asses in how far disability benefit receipt due to mental health problems is similar across the countries covered with regard to size, trends, diagnostic patterns and risk groups. The countries included are those four countries, which already participated in the earlier study (Belgium, Germany, the Netherlands and Sweden) as well as Switzerland and Canada. These countries are quite comparable, as they are modern countries with well developed social security systems. Although some major features of their income replacement arrangements differ (e.g. follow up benefit or pension after exhaustion of sickness benefit payment,) they have many similarities in the outcomes of their systems.

In the *qualitative* part the study focused on the 'repertoire' of measures that have been introduced or are pending in various countries, which aim to prevent and reduce disability (benefit receipt) due to mental health problems. This part of the project was not restricted to the six countries mentioned before but also covered other (EU) countries.

The sources used in the quantitative study are basic figures from official statistics and overviews produced by social security agencies in the countries included. They regard (eligible) disability in employed persons (in Switzerland: inhabitants) in the period 1993-2002. The major outcomes of the quantitative comparisons have been summarized in some benchmark overviews:

Disability recipients (stock) per 1000 insured	
High	The Netherlands
Medium	Belgium, Germany, Sweden
Low	Canada, Switzerland

Growth in disability benefit recipients in 10 years	
High	Switzerland
Medium	Belgium and Sweden
Low	Canada, Germany, the Netherlands

New disability recipients (influx) per 1000 insured	
High	The Netherlands and Sweden
Medium	Belgium, Germany and Switzerland
Low	Canada

Completions (outflow) per 1000 beneficiaries	
High	Belgium
Medium	Canada, the Netherlands and Switzerland
Low	Germany

New recipients due to mental health problems per 1000 insured	
High	Switzerland
Medium	Belgium, Germany, the Netherlands and Sweden
Low	Canada

Stock of recipients due to mental health problems per 1000 insured	
High	The Netherlands, Sweden
Medium	Belgium, Switzerland
Low	Canada, Germany

The ‘quick scan’ of measures which aim to prevent or restrict short and long term disability due to mental health problems, also concentrated on persons in employment as the target group. So the measures discussed focus on persons in employment, who are vulnerable to mental health problems, and show sickness absence or disability. Medical interventions fell outside the scope of the inquiry.

The measures explored can be divided into three categories:

1. *Early identification methods*. They consists of measures for screening of persons at risk of long term work incapacity (UK) and identification of employees with mental health problems (Netherlands).

2. *Employment related interventions* (be it on individual level, company level or sectoral level). Here a wide range of initiatives, instruments and policies have been found, which include: work resumption guidelines in case of mental health problems (Netherlands), pilot project on job retention and mental health (UK), initiatives raising awareness to tackle psychosocial risks (Europe), prevention strategies for coping with anxiety, depression and stress related disorders (Europe), and the use of 'occupational health and safety covenants' (Netherlands).

3. *Social security related measures*. In this category four types of measures are presented: specific criteria for evaluation of psychosomatic syndromes (Denmark), early assessment of persons with Chronic Fatigue Syndrome (Belgium), disability evaluation in persons with mental disorders (Germany) and attempts to have stress acknowledged as an occupational disease (various countries).

The focus on the enterprise and working environment (second category) has many roots. Firstly, work may be part of the causes of mental health problems: working conditions like negative management style or low social support may lead to mental health problems, depressive episodes etc. Further, these problems may cause high costs of sickness absence. On the other hand the enterprise also may create conditions for preventionaction: existing occupational health and safety structure in the work place facilitate the provision of (e.g.) mental health promotion activities.
So it is not surprising that the majority of strategies, policies, pilot projects and studies explore or promotes measures to be applied in the province of employment.

The second province of measures can be located in the social insurance sector. Here both the preventive approach is chosen (e.g. screening, before benefit claims are send in) and 'secundary prevention' measures, when the person already is on (short term) benefit receipt. Further, the disability assessment process and its quality is subject to revision in some countries, as sickness and disability benefit administrators 'struggle' with operating the scheme for this category of clients.

Notwithstanding the limitations of the sources examined it may be concluded that several approaches receive attention, whereas many still are 'under development'. Evaluation studies, which assess the impact and implementation of measures that seem successful, especially in the field of employment, still are quite rare.

ZUSAMMENFASSUNG

Das schweizerische Bundesamt für Sozialversicherung BSV hat die AS*tri* Research and Consultancy Group mit einer länderübergreifenden Vergleichsstudie über Invalidität infolge psychischer Beeinträchtigungen beauftragt. Der Vergleich soll einen besseren Einblick und damit eine bessere Kenntnis über die Charakteristik und Funktionsweise der wachsenden Invalidenrentenproblematik und somit geeigneter Gegenmassnahmen bieten.

Die Studie setzt sich aus zwei Teilen zusammen und wurde im Frühling 2004 durchgeführt. Der *quantitative* Teil zielt darauf ab festzustellen, inwiefern sich Invalidenrenten infolge psychischer Probleme in den miteinbezogenen Ländern bezüglich Umfang, Trends, Diagnosemuster und Risikogruppen gleichen. Bei den Ländern handelt es sich um die vier bereits in einer früheren Studie teilnehmenden Länder Belgien, Deutschland, Holland und Schweden, sowie um die neu miteinbezogenen Länder Schweiz und Kanada. Da es sich bei diesen Ländern um moderne Staaten mit gut entwickelten Sozialsicherungssystemen handelt, sind sie gut vergleichbar. Obwohl bezüglich Erwerbsersatzbestimmungen erhebliche Unterschiede bestehen (z. B. Anschlussleistungen oder Renten nach Ablauf der Leistungen aus der Krankentaggeldversicherung), wirken sich die Vorkehrungen ihrer Systeme sehr ähnlich aus.

Der *qualitative* Teil der Studie konzentriert sich auf Massnahmen, die in den verschiedenen Ländern hinsichtlich Prävention und Reduzierung von Invalidität (Rentenbezug) infolge psychischer Probleme eingeführt wurden bzw. zur Einführung vorgesehen sind. Dieser Teil des Projekts beschränkt sich nicht allein auf die sechs erwähnten Länder, sondern zieht auch andere (EU)-Länder mit ein.

Die im *quantitativen* Teil verwendeten Quellen stammen aus dem Zahlenmaterial offizieller Statistiken und aus Übersichten von Sozialversicherungseinrichtungen aus den miteinbezogenen Ländern. Sie beziehen sich auf (rentenbezugsberechtigte) Behinderung bei Arbeitnehmenden (in der Schweiz: aktive Bevölkerung) in der Zeit von 1993 – 2002. Die wichtigsten Ergebnisse der quantitativen Vergleiche sind in Benchmark-Übersichten zusammengefasst:

Invalidenrentenbezüger (Bestand) pro 1000 Versicherten	
Hoch	Holland
Mittel	Belgien, Deutschland, Schweden
Tief	Kanada, Schweiz

Zunahme des Anteils der Invalidenrentenbezüger über 10 Jahre	
Hoch	Schweiz
Mittel	Belgien und Schweden
Tief	Kanada, Deutschland, Holland

Neuberentungen (Zugänge) pro 1000 Versicherte	
Hoch	Holland und Schweden
Mittel	Belgien, Deutschland und die Schweiz
Tief	Kanada

Aufhebungen (Abgänge) pro 1000 Bezüger	
Hoch	Belgien
Mittel	Kanada, Holland und die Schweiz
Tief	Deutschland

Neuberentungen infolge psychischer Beeinträchtigungen pro 1000 Versicherte	
Hoch	Schweiz
Mittel	Belgien, Deutschland, Holland und Schweden
Tief	Kanada

Rentenbezügerbestand infolge psychischer Beeinträchtigungen pro 1000 Versicherte	
Hoch	Holland, Schweden
Mittel	Belgien, Schweiz
Tief	Kanada, Deutschland

Die kurze Übersicht über Massnahmen zur Prävention und Eindämmung der Zunahme von vorübergehender und dauernder Invalidität infolge psychischer Beeinträchtigungen bezog sich auch auf Personen im Anstellungsverhältnis als Zielgruppe. Es handelt sich dabei also um Massnahmen, die auf unselbständige Erwerbstätige mit einem Risiko für psychische Beschwerden abzielen und die krankheits- bzw. invaliditätsbedingte Absenzen aufweisen. Medizinische Interventionen wurden in den Erhebungen nicht mitberücksichtigt.

Die in die Betrachtungen miteinbezogenen Massnahmen können in drei Kategorien unterteilt werden:

1. *Früherkennung:* Ziel ist, potentiell von dauernder Erwerbsunfähigkeit Betroffene (UK) und Angestellte mit psychischen Störungen (Holland) möglichst frühzeitig zu erkennen.

2. *Arbeitsbezogene Interventionen:* (mit Ansatz auf Einzelpersonen-, Firmen- oder Branchenebene). In diesem Bereich konnten vielfältige Initiativen, Instrumentarien und Massnahmenprogramme festgestellt werden, unter anderem: Wiedereingliederungsrichtlinien bei längeren Absenzen infolge psychischer Erkrankungen (Holland), Pilotprojekt bezüglich Arbeitsstellenerhaltung und psychischer Gesundheit (UK), Bewusstseinsförderungsinitiativen zur Angehung von psychosozialen Risiken (Europa), Präventionsstrategien zum Umgang mit Ängsten, Depressionen und stressbezogenen Krankheiten (Europa) sowie die Anwendung von Verträgen für Sicherheit und Gesundheitsschutz am Arbeitsplatz (Holland).

3. *Sozialversicherungsrelevante Massnahmen*: In dieser Kategorie werden vier Massnahmetypen aufgezeigt: Spezifische Kriterien zur Evaluation von psychosomatischen Syndromen (Dänemark), Früherkennung von Personen mit chronischer Schlafstörung (Belgien), Beurteilung der Invalidität bei Personen mit psychischen Leiden (Deutschland) und Bestrebungen, Stress als Berufskrankheit anzuerkennen (verschiedene Länder).

Dass man sich auch auf das Firmen- und Arbeitsumfeld (zweite Kategorie) konzentriert, hat vielerlei Ursachen. Zum einen kann die Arbeit ein Teil der Ursachen für psychische Gesundheitsprobleme ausmachen: ungünstige Arbeitsbedingungen, wie schlechter Managementstil oder geringer Halt im sozialen Umfeld, können psychische Gesundheitsprobleme, depressive Phasen usw. hervorrufen. Des Weiteren fallen durch die dadurch verursachten krankheitsbedingten Absenzen hohe Kosten an. Firmen können dieser Entwicklung durch Vorsorgemassnahmen und entsprechende Arbeitsbedingungen entgegen wirken: Bestehende Strukturen für Gesundheitsschutz und Sicherheit am Arbeitsplatz erleichtern bspw. die Einführung von Förderungsmassnahmen hinsichtlich psychischer Gesundheit. Dementsprechend erstaunt es nicht, dass sich die meisten Strategien, Programme, Pilotprojekte und Studien auf Massnahmen im Arbeitsbereich konzentrieren bzw. diese untersuchen oder fördern.

Der zweite Massnahmenstrang liegt im Sozialversicherungsbereich. In diesem Bereich kommen sowohl eine präventive Annäherung (z. B. Monitoring vor der Geltendmachung von Ansprüchen) als auch "sekundäre Vorsorgemassnahmen" (wenn bereits über eine kurze Dauer Renten bezogen werden) zum Zug. Ferner wird in einigen Ländern das Beurteilungsverfahren bei Invalidität und dessen Qualität einer Revision unterzogen, da die für die Ausrichtung einer Rente zuständigen Personen bei den entsprechenden Ver-

sicherungen erhebliche Mühe bekunden, Fälle aus der Kategorie der psychischen Beeinträchtigungen zu beurteilen.

Lässt man die Einschränkungen der untersuchten Quellen einmal ausser Acht, kann aus den Erhebungen geschlossen werden, dass verschiedene Ansätze Beachtung finden, wenn auch viele noch "in den Kinderschuhen" stecken. So sind Evaluationen zur Beurteilung von Ergebnissen und Auswirkungen von anscheinend erfolgreich eingeführten Massnahmen, besonders im Arbeitsumfeld, immer noch selten.

RÉSUMÉ

Afin de mieux percevoir l'évolution et de connaître les mesures prises pour répondre au problème des pensions d'invalidité, l'Office fédéral des assurances sociales (OFAS) a confié à l'AS*tri* Research and Consultancy Group le mandat de mener une étude comparative sur l'invalidité résultant de problèmes de santé psychique dans plusieurs pays.

L'étude, réalisée au printemps 2004, se divise en deux parties.
Une partie *quantitative* étudie les différences dans l'octroi de prestations d'invalidité pour cause de problèmes de santé psychique entre les pays considérés, en ce qui concerne le nombre de bénéficiaires, les tendances, les diagnostics types et les groupes à risque. Les quatre pays ayant précédemment participé à un tel projet (l'Allemagne, la Belgique, les Pays-Bas et la Suède), ainsi que le Canada et la Suisse sont les pays pris en compte dans la présente étude. Ils sont comparables, car ils possèdent un système de sécurité sociale très développé et sont des pays avancés. Si ces systèmes peuvent être très différents en matière de remplacement du revenu (par exemple des prestations sont prévues après la fin du paiement des pensions ou des prestations maladie), ils sont en grande partie similaires pour ce qui est de leur résultat.

Une partie *qualitative* présente les différentes mesures qui ont été introduites ou sont sur le point de l'être dans plusieurs pays dans le but de prévenir et de limiter l'invalidité (l'octroi de prestations) résultant de problèmes de santé psychique. Cette partie du projet ne se limite pas aux six pays mentionnés ci-dessus mais porte également sur d'autres pays (de l'Union européenne).

Les principaux chiffres des statistiques officielles et les études réalisées par les organismes de sécurité sociale des pays considérés ont servi de sources pour la partie quantitative du projet. Ils se réfèrent à l'invalidité (admissible) des membres de la population active (en Suisse: tous les habitants) et concernent la période qui va de 1993 à 2002. Les principaux résultats des comparaisons quantitatives ont été résumés sous forme de tableaux regroupant les pays par catégories:

Bénéficiaires de prestations d'invalidité (effectif) pour 1000 assurés	
Elevé	Pays-Bas
Moyen	Allemagne, Belgique, Suède
Faible	Canada, Suisse

Augmentation du nombre de bénéficiaires sur dix ans	
Elevé	Suisse
Moyen	Belgique, Suède
Faible	Allemagne, Canada, Pays-Bas

Nouveaux bénéficiaires (entrées) pour 1000 assurés	
Elevé	Pays-Bas, Suède
Moyen	Allemagne, Belgique, Suisse
Faible	Canada

Fins de prestations (sorties) pour 1000 bénéficiaires	
Elevé	Belgique
Moyen	Canada, Pays-Bas, Suisse
Faible	Allemagne

Nouveaux bénéficiaires pour cause de problèmes de santé psychique pour 1000 assurés	
Elevé	Suisse
Moyen	Allemagne, Belgique, Pays-Bas, Suède
Faible	Canada

Nombre de bénéficiaires pour cause de problèmes de santé psychique pour 1000 assurés	
Elevé	Pays-Bas, Suède
Moyen	Belgique, Suisse
Faible	Allemagne, Canada

Le bref aperçu des mesures visant à prévenir et à limiter à court ou à long termes l'invalidité pour cause de problèmes de santé psychique est centré sur les personnes exerçant une activité lucrative qui peuvent avoir des problèmes de santé psychique et sont régulièrement en absence maladie ou invalidité. Les interventions médicales n'entraient pas dans le champ d'investigation de la présente étude.

Les mesures exposées dans l'étude peuvent être divisées en trois catégories:

1. *Méthodes de dépistage précoce*. Ces mesures permettent d'identifier les personnes qui risquent de se retrouver en situation d'incapacité de travail à long terme (UK) et les employés souffrant de problèmes de santé psychique (Pays-Bas).

2. *Interventions liées au travail* (au niveau de l'individu, de l'entreprise ou d'un secteur particulier). On trouve dans cette catégorie toute une série d'initiatives, d'instruments et de politiques. Il s'agit par exemple de lignes directrices pour reprendre le travail en cas de problèmes de santé psychique (Pays-Bas), d'un projet pilote pour le maintien de l'emploi en cas de problèmes de santé psychique (UK), d'initiatives de sensibilisation aux risques psychosociaux (Europe), de stratégies de prévention permettant de faire face aux troubles liés à l'anxiété, à la dépression et au stress (Europe) et de l'élaboration de conventions garantissant la santé et la sécurité au travail (« occupational health and safety covenants », Pays-Bas).

3. *Mesures de sécurité sociale*. Quatre types de mesures sont présentées dans cette catégorie: critères spécifiques pour évaluer les syndromes psychosomatiques (Danemark), dépistage précoce des personnes souffrant du syndrome de fatigue chronique (Belgique), évaluation de l'invalidité chez les personnes atteintes de troubles mentaux (Allemagne) et initiatives pour que le stress soit reconnu comme une maladie professionnelle (différents pays).

L'accent a été mis sur l'entreprise et le domaine professionnel (deuxième catégorie) pour plusieurs raisons. D'une part, le travail peut être en partie à l'origine des problèmes de santé psychique; des conditions de travail défavorables comme une mauvaise gestion ou un accompagnement social insuffisant peuvent être la cause de problèmes de santé psychique, d'épisodes dépressifs, etc. De plus, les absences maladie liées à ce type de problèmes coûtent très cher. Mais d'autre part, les entreprises peuvent aussi favoriser l'introduction de mesures de prévention; si l'entreprise met à disposition une structure garantissant la santé et la sécurité au travail, il est plus facile de prendre des dispositions pour promouvoir entre autres la santé psychique.
Il n'est donc pas surprenant que la majorité des stratégies, des politiques, des projets pilotes et des études s'intéressent aux mesures à appliquer dans le cadre professionnel et en préconisent l'application.

Les assurances sociales sont un deuxième domaine où des mesures peuvent être prises. On adopte ici deux approches: la prévention pour le dépistage des problèmes avant qu'une demande de prestations ne soit faite et la « prévention secondaire » si la personne est déjà bénéficiaire (à court terme) d'une prestation. En outre, le processus d'évaluation de l'invalidité et sa qualité sont révisés dans plusieurs pays, car les

responsables de l'octroi des prestations savent difficilement comment appliquer le système à cette catégorie de clients.

En conclusion, malgré les limites des sources prises en compte, différents systèmes ont pu être examinés, même si beaucoup d'entre eux sont encore en phase de développement. Mais il y a à ce jour très peu d'évaluations portant sur l'impact et la mise en œuvre des mesures apparemment efficaces, surtout dans le domaine du travail.

RIASSUNTO

L'Ufficio federale svizzero delle assicurazioni sociali (UFAS) aveva commissionato all'AS*tri* Research and Consultancy Group uno studio comparativo sull'invalidità dovuta ad infermità psichica basato sui dati di diversi Paesi. Il confronto aveva lo scopo di ampliare e migliorare la conoscenza delle caratteristiche e della dinamica dell'aumento del numero delle rendite d'invalidità proponendo al contempo contromisure adeguate.

Lo studio, eseguito nella primavera del 2004, consta di due analisi: una *quantitativa* ed una *qualitativa.* Obiettivo dell'analisi *quantitativa* era di valutare le analogie delle rendite concesse per invalidità psichica nei Paesi considerati in relazione a volume, tendenze, diagnosi e categorie di rischio. Per il confronto sono stati scelti Stati moderni con sistemi di sicurezza sociale evoluti: quattro Paesi già oggetto di uno studio precedente (Belgio, Germania, Olanda e Svezia) più la Svizzera e il Canada. Nonostante le disposizioni dei diversi sistemi in materia d'indennità di perdita di guadagno presentino notevoli differenze (p. es. in relazione a sussidi o rendite versati alla scadenza delle prestazioni d'indennità giornaliera dell'assicurazione malattie), gli effetti dei provvedimenti proposti sono molto simili.

L'analisi *qualitativa* prende in esame i provvedimenti introdotti o previsti nei Paesi interessati al fine di prevenire e ridurre l'invalidità (nel senso del versamento di rendite). Questa parte del progetto non è limitata ai sei Paesi citati, ma è estesa ad altri Stati (membri dell'UE).

I dati utilizzati nell'analisi *quantitativa* – riferiti alle rendite d'invalidità dei salariati (per la Svizzera: degli assicurati in età lavorativa) – sono tratti da statistiche ufficiali e panoramiche di istituzioni delle assicurazioni sociali dei Paesi considerati relative al periodo compreso tra il 1993 e il 2002. I principali risultati dei confronti quantitativi sono riassunti in tabelle comparative (i tassi sono calcolati in per mille in funzione del numero di assicurati).

Tasso di beneficiari di rendite d'invalidità	
Elevato	Olanda
Medio	Belgio, Germania, Svezia
Basso	Canada, Svizzera

Crescita del tasso di beneficiari di rendite d'invalidità sull'arco dei 10 anni considerati	
Forte	Svizzera
Media	Belgio e Svezia
Debole	Canada, Germania, Olanda

Tasso di beneficiari di nuove rendite d'invalidità	
Elevato	Olanda e Svezia
Medio	Belgio, Germania e Svizzera
Basso	Canada

Tasso di rendite estinte o soppresse	
Elevato	Belgio
Medio	Canada, Olanda e Svizzera
Basso	Germania

Tasso di beneficiari di nuove rendite d'invalidità dovute ad infermità psichica	
Elevato	Svizzera
Medio	Belgio, Germania, Olanda e Svezia
Basso	Canada

Tasso di beneficiari di rendite d'invalidità dovute ad infermità psichica	
Elevato	Olanda, Svezia
Medio	Belgio, Svizzera
Basso	Canada, Germania

La breve panoramica dei provvedimenti finalizzati a prevenire i casi d'invalidità, durevole o passeggera, dovuta a disturbi psichici ovvero contenere l'aumento del loro numero è riferita anche ai salariati e contempla dunque provvedimenti destinati ai lavoratori dipendenti a rischio che hanno già fatto registrare assenze dovute a malattia o invalidità. Nelle rilevazioni non si è tenuto conto dei provvedimenti medici.

I provvedimenti considerati possono essere divisi in tre categorie:

1. *Individuazione tempestiva:* lo scopo è di individuare il più presto possibile le persone potenzialmente minacciate da incapacità al guadagno durevole (Gran Bretagna) e i salariati affetti da disturbi psichici (Olanda).

2. *Interventi in ambito lavorativo* (approccio individuale, aziendale o settoriale). In questa categoria si registrano molteplici iniziative, strumenti e programmi, in particolare: direttive per la reintegrazione in caso di assenza prolungata dovuta a disturbi psichici (Olanda), un progetto pilota per il mantenimento del posto di lavoro e la salute psichica (Gran Bretagna), iniziative per il promovimento della consapevolezza contro i rischi psicosociali (Europa), strategie preventive volte a combattere paure, depressioni e malattie dovute allo stress (Europa) e l'applicazione di accordi per la sicurezza e la protezione della salute sul posto di lavoro (Olanda).

3. *Provvedimenti rilevanti per le assicurazioni sociali*. In questa categoria si rilevano quattro tipi di provvedimento: elaborazione di criteri specifici per la valutazione dei disturbi psicosomatici (Danimarca), individuazione tempestiva delle persone affette da disturbi del sonno cronici (Belgio), valutazione dell'invalidità delle persone affette da disturbi psichici (Germania) e iniziative finalizzate al riconoscimento dello stress come malattia professionale (diversi Paesi).

L'ambiente di lavoro nelle aziende (seconda categoria) è stato scelto come oggetto dello studio per diverse ragioni. In primo luogo perché può essere in parte causa di problemi psichici: difficili condizioni lavorative, cattiva gestione e scarsa integrazione possono essere all'origine di disturbi psichici, depressioni ecc. Inoltre, le assenze per malattia che ne conseguono causano costi elevati. Le aziende possono prevenire situazioni di questo genere adeguando le condizioni di lavoro con appositi provvedimenti. La presenza di strutture per la protezione della salute e per la sicurezza sul lavoro, per esempio, agevola l'attuazione di provvedimenti per il promovimento della salute psichica. Non sorprende quindi che molto spesso strategie, programmi, progetti pilota e studi analizzino e promuovano provvedimenti destinati al settore lavorativo.

La seconda categoria di provvedimenti concerne le assicurazioni sociali. In questo settore sono praticate sia la prevenzione primaria (destinata a chi non ha ancora chiesto prestazioni, si pensi p. es. al monitoraggio) che la prevenzione secondaria (destinata a chi, per breve tempo, ha già beneficiato di una rendita). Inoltre, in alcuni Paesi si sta procedendo ad una revisione della procedura di valutazione dell'invalidità (inclusi i requisiti qualitativi) in quanto le persone responsabili della concessione delle rendite presso le competenti istituzioni assicurative hanno notevoli difficoltà a valutare i casi d'infermità psichica.

Nonostante i limiti delle fonti considerate, dall'analisi delle rilevazioni emergono diversi approcci, anche se in molti casi si è ancora ai primi passi. Soprattutto in relazione all'ambiente lavorativo sono ancora rare, per esempio, valutazioni dei risultati ed analisi degli effetti che documentino il successo dei provvedimenti introdotti.

1 BACKGROUND, AIM AND METHODOLOGY

1.1 Background

On request of a Dutch State Committee[1] (Donner 1) the AS*tri* Research & Consultancy Group made an evaluative study in 2000 of the 'body of knowledge' in the Netherlands regarding trends, causes and interventions on short and long term work incapacity due to mental health problems. The report on this project also comprised a cross-national exploration into disability benefit statistics. It had a 'benchmarking' aim: to assess the 'international position' of the Netherlands regarding disability benefit receipt due to mental disorders, as reflected in social security statistics from four countries. The study compared data on trends and characteristics of disability benefit/pension recipients in Belgium, Germany, Sweden and the Netherlands. The social security institutions that participated in this quantitative study were RIZIV (Belgium), VDR (Germany), Riksförsäkringsverket (Sweden) and LISV (Netherlands)[2].

The study evoked quite some attention as it gave a systematic insight into the specific 'national' features of disability pension/benefit recipient due to mental health problems. Also in Switzerland the growth of the number of disability pension recipients receives more and more attention. One of the many actions taken last year was a short cross-national 'quick scan', also performed by AS*tri*, which explored instruments and experiences with early detection of clients with disability due to mental disorders[3].

In order to obtain a better insight into the features of the disability pension problem the Swiss Federal Office for Social Security (Bundesamt für Sozialversicherung, BSV) recently requested AS*tri* to make an update of the cross-national comparison of disability rates, now also including Swiss data and those from more countries (when interested). We further should include a qualitative part into the study namely a 'quick scan' of measures taken to restrict and prevent disability due to mental health problems.

1 The Committee advised the Dutch government on policies to reduce sickness absence and disability due to mental health problems.
2 Cf. Prins, 2000.
3 Cf. van Kolck & Prins, 2003.

1.2 Aim of the exploration

The *quantitative* part of the study aims to asses in how far disability benefit receipt due to mental health problems is similar across the countries covered, with regard to size, trends, diagnostic patterns and risk groups. Where possible the comparisons will also regard the backgrounds of differences, in particular those related to changes in legal framework (e.g. disability criteria, population of insured) or administration (e.g. assessment methodology).

So the quantitative part of the project will focus on two topics:

a. *Developments* in the phenomenon: new entries ('entrants'), stock ('stayers') and completions ('leavers') in the disability benefit programme as to basic demographic characteristics (gender, age groups) and main diagnostic groups;
b. *Characteristics* of the category of disabled with mental disorders as to demographic aspects (gender, age), and – if available – underlying sub-diagnoses, as well as reasons for completion of disability pension/benefit payment.

In the *qualitative* part the study will focus on the 'repertoire' of measures that have been introduced or are pending to prevent and reduce disability (benefit receipt) due to mental health problems. Consequently, the inventory may cover a wide range of measures, e.g.:

- preventive measures;
- early identification (e.g. high risk groups);
- diagnostic and evaluative instruments (e.g. disability assessment);
- return to work and vocational rehabilitation measures.

This exploration focuses on the countries included in the study but will present some interesting initiatives in other countries or from international organizations. The qualitative part, however, has the character of a 'quick scan', exploring the repertoire of measures taken or in preparation, without pretending completeness and without sound evaluation of the empirical support for methodological basis of the measures. When available, information on evaluations as to implementation or impact of measures will be summarized.

The overview primarily should give insight into ongoing initiatives and experiences, which may provide suggestions for those designing measures to tackle the problem in their country.

1.3 Countries included in the study

The countries included in the study are those four countries, which already participated in the earlier study (Belgium, Germany, the Netherlands and Sweden) as well as Switzerland and Canada. These countries are quite comparable, as they are modern countries with well developed social security systems. Although some major features of their income replacement arrangements differ (e.g. follow up benefit after exhaustion of sickness benefit payment, or pension) they have many similarities in the outcomes of their systems.

Belgium

In Belgium the growth in disability benefit recipiency declined in recent years. Between 1980-1985 the growth in disability benefit recipiency was 10%, it declined to 6% between 1985-1990, to 4% between 1990-1995 and to 1% between 1995-1999 (Transforming, 2003). Statistics from the RIZIV annual report 2002 further show that the proportion of mental illness in the stock of recipients is between one quarter and one third, increasing from 28% in 1997 to 30% in 2001.

Canada

Disability benefit recipiency rates have grown since 1990. Mental disorders have become a leading cause of disability among workers, accounting for nearly one in four persons now receiving a public disability pension due to mental illness. The absolute growth of disability benefit recipients due to mental disorders has increased from 21,830 in 1990 to 63,171 in 2000 (Parliamentary Research Branch, 2002). Among younger workers mental disorders are the predominant cause of disability (Worksite News, 2003). OECD data show the proportion of mental illness in the stock of recipients of disability benefit increased from 11% in 1990, to 21% in 1999 (Transforming, 2003).

Germany

The growth in disability benefit recipiency declined in the period 1985-1990. Between 1990 and 1995 there was a large increase, but this growth slowed down in recent years. Mental and psychological problems account for about one quarter of the inflow of disability benefit recipients. The proportion of mental illness in the newly granted disability benefits increased over the last years, from 17% in 1990 to 28% in 1999 (Transforming, 2003).

The Netherlands
In the Netherlands the number of recipients of full or partial disability benefits increased to 921,000 in 1993. Reforms in disability criteria and in the way benefits were calculated reduced the number of new awards. Moreover, part of the beneficiaries has been re-examined in the light of new, more stringent definitions and assessment guidelines. This led to a drop in the number of beneficiaries to 855,000 in 1996. From then on the numbers started growing again (Gould & Laitinen-Kuikka, 2003), but since 2002 the rates for newly granted and stock of disability benefits are declining again. The proportion of mental illness in the newly granted disability benefits rose from 30% in 1990 to 33% in 1999 (Transforming, 2003).

Sweden
Early in the 1990s, the granting of new disability pensions rose to record heights. After 1993 the number of new disability pensions decreased (Mansson, 1997), which is associated with less long-term sickness absence, tightened regulations and a more restrictive application. In recent years, the number of new disability pensions once again is rising, and the average age of a new permanent disability pensioner has fallen from about 55 at the end of the 1980s to just over 50 years today (The Social Insurance Institution). Mental disorders show to predominate in younger age groups and there is a slight difference between men and women (Prinz, 2003). The proportion of mental illness in the newly granted disability benefits increased over the last decade, from 16% in 1990 to 24% in 1999 (Transforming, 2003).

Switzerland
Until 1985, the situation in Switzerland was extremely favorable, with very few people on disability benefits. Since that year disability benefits started to rise. Recently the increase in the number of disability benefit recipients showed to be greater than in most other Western European countries. Their number has increased from around 100,000 (1980) to about 200,000 in 2000 (Prinz, 2003).
OECD data show that mental illness is a major diagnostic group in this country. The proportion of mental illness in the stock of recipients of disability benefit was around one third (34%) and 39% in 1999. The proportion of mental illness in the newly granted disability benefits was around one third (34%) in 1999.

1.4 Sources and restrictions

Apart from interesting differences in programme features, there also were pragmatic reasons for including these countries in the study: the administrators showed to be able to provide statistics which are quite validly comparable.

Social security statistics in general inform about various aspects of benefit claimants, decisions, benefit payments, completions, diagnoses, costs, etc. These sources, however, also have limitations, as they differ cross-nationally regarding their scope and level of details. Disability benefit statistics should not be considered as sound health status indicators. They only partially describe the prevalence of mental disorders or psychiatric morbidity in a population, as definitions, eligibility criteria, diagnostic or reporting habits in social security affect the figures considerably.
On the other hand, these sources of bias do not exclude opportunities to assess, in a comparative way, levels, trends and risk groups. They also give an insight into the way social security in each country is dealing with clients with mental disorders, as is reflected in acceptation of claims, duration of benefit payment, as well as reasons and number of completions of benefit payment.

The sources used here are basic figures from official statistics and overviews produced by social security agencies in the countries included. They regard (eligible) disability in employed persons, in the period 1993-2002. Due to differences in disability regulations the populations covered are not fully identical. All countries cover employed persons, for Sweden and Canada self-employed also have been included whereas the Swiss data include disability pensions to all residents. When necessary – figures have been corrected to cover only persons in working age (15-65 years). Dutch, Swedish and Swiss figures also include disability due to occupational injuries and diseases, whereas statistics from the other three countries do not include disability due to these risks. The data from Canada consist of the data from the Canada Pension Plan, the public disability program in Canada.[4] The consequences of these restrictions will be taken into account when interpreting the outcomes. Statistics on rehabilitation and reintegration have not been covered in the study.

1.5 Structure of the report

The quantitative part of the study is reported in Chapter 2 and 3. The second chapter describes similarities and differences between the countries as to general disability benefit recipiency rates (disregarding diagnoses). Chapter 3 is devoted to disability benefits related to the category of mental health diagnoses. We compare the countries as to stock and influx in the scheme due to mental health disorders. Chapter 4 reports on the qualitative part of the exploration. It gives an overview of the outcomes of our 'quick scan' of measures and initiatives to manage sickness

[4] The Canada Pension Plan dos not include province of Quebec, which has its own separate but similar pension plan. The data from Canada does not include data from the other disability income programmes in Canada such as social assistance (welfare), workers' compensation, veterans pensions and private disability insurance.

absence and disability in enterprises and in social security. Chapter 5 summarizes and discusses our findings from the quantitative and qualitative sub projects. This chapter also includes a benchmarking presentation of the six countries.

2 FEATURES OF DISABILITY BENEFIT DEPENDENCY

2.1 An introduction

Disability benefit recipiency rates are high in many countries. During the 1990s, the recipiency rates for disability benefits increased in most countries. In some countries, however, the growth slowed down in recent years, partly due to reforms in benefit programmes, but in others the rates are still increasing. Outflow from disability benefits is very low, despite considerable cross-national differences in regulations on reviewing entitlements, availability of partial benefits, work incentives, etc. In average only about 1% of recipients of disability benefits leaves the roll each year due to recovery or work resumption (Gould & Laitinen-Kuikka, 2003).

Also developments in diagnostic patterns give rise to major concern in many countries. Some studies showed that in most countries mental and psychological problems account for about one quarter or one-third of the inflow of disability benefit recipients. Further it seems the younger the recipients, the higher the share of persons with mental health restrictions. One of the background of the increase of mental health problems is sought into changes in working conditions. An ILO study concluded that the incidence of mental health problems among workers was increasing sharply. One out of ten workers reports to be suffering from depression, anxiety, stress or burnout, which in some cases led to hospitalization and unemployment (Gabriel & Liimatainen, 2000). Secondly, the Third European Survey on Working Conditions found that almost one quarter of employees report overall fatigue, more than one quarter report stress, furthermore 15% of the employees report headaches, 11% report irritability, 8% report sleeping problems and 7% report anxiety (Paoli & Merllié, 2001).

Our study will not be able to evaluate the relationship of mental health problems, as manifested in disability benefit, to working conditions and health complaints. This introductory chapter firstly compares the use of the disability benefit programmes in the countries under study, disregarding the diagnosis. A comparison is made of trends in the number of persons entering, staying and leaving the benefit schemes as well as the role of socio-demographic characteristics of the insured populations. First of all the growth rates of the number of disability benefit recipients will be described for the past ten years. In addition a deeper insight into the use of the programmes is made by analyzing for the most recent year of observation (2002) the stock of recipients, followed by the entrants and the completions.

2.2 Disability benefit programmes: trends in stock, influx and outflow

Number of disability benefit recipients is rising in four countries

In four countries the (absolute) number of disability benefit recipients has been rising, namely in Belgium, the Netherlands, Sweden and Switzerland. The growth rate was largest in Switzerland, followed by Sweden and Belgium. Further it can be noted that initially the number of disability recipients also was rising in Canada and Germany, but in the last 4-5 years the number of disability recipients was stable or dropped slightly.

Table 2.1 Growth rates in number of disability recipients (1993-2002)[5]

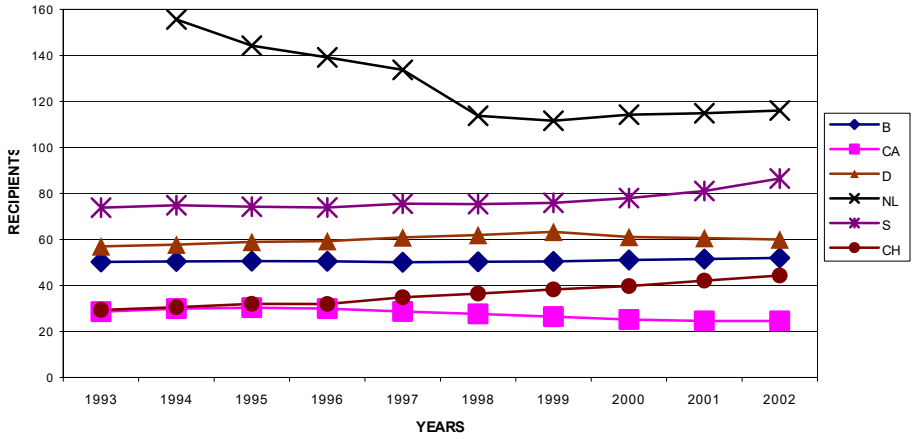
Year	B	CA	D	NL	S	CH
1994	0,9%	6,7%	0,7%	-3,6%	2,1%	5,5%
1995	1,1%	2,8%	0,6%	-4,6%	-0,5%	4,5%
1996	1,0%	-0,6%	-0,8%	-0,7%	-0,2%	4,6%
1997	1,2%	-1,6%	3,0%	0,6%	2,4%	4,4%
1998	2,2%	-0,8%	0,8%	3,9%	0,0%	4,9%
1999	1,6%	-1,8%	0,2%	2,1%	1,0%	5,3%
2000	3,1%	-1,8%	-2,4%	3,3%	3,2%	4,7%
2001	2,4%	-0,8%	0,2%	3,0%	4,4%	7,9%
2002	2,7%	0,0%	-1,7%	1,3%	7,3%	6,3%
Total[6]	17,5%	2,0%	0,5%	5,1%	21,2%	59,4%

Prevalence rates are rising in Sweden, Switzerland and for Dutch females

When we take into account the size of the population of insured, Germany and Canada still show a moderate decline over the last years (Figure 2.1). Belgium now shows a stable pattern, whereas in Sweden and Switzerland prevalence rates are slightly rising over the last years. In the Netherlands, after a large drop until 1999, the rates for males are still slightly declining, where as the rates of females are rising.

[5] B: Belgium; CA: Canada; D: Germany; NL: The Netherlands; S: Sweden; CH: Switzerland.
[6] Total growth in 10 years.

Figure 2.1 Number of disability recipients per 1.000 insured (1993-2002)



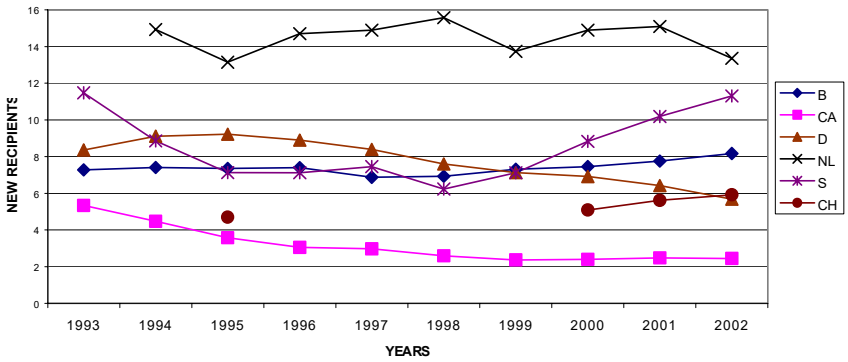
Furthermore, Figure 2.1 demonstrates the large and stable differences in prevalence rates between the countries: the Netherlands show the highest rates, which are up to 4 times higher than in the country with low rates (Canada). Canada and Switzerland show the lowest prevalence rates.

Incidence rates rise in Switzerland, Belgium and Sweden

The previous rates showed the stock of recipients. This is the result of two processes: the influx ('entrants') and outflow ('leavers') of the benefit scheme.

Figure 2.2 shows that the number of new disability recipients per 1.000 insured is declining in Germany (steeply) and Canada (slightly). The past five years incidence rates are (slightly) rising in Switzerland and Belgium and steeply increasing in Sweden. In the Netherlands the incidence rates have fluctuated considerably, since two years they are steeply dropping. Notwithstanding, the Dutch figures demonstrate the highest influx rates, whereas the lowest again are found in Canada (about 1/6 of the Dutch levels). In all countries incidence rates for males and females show a similar pattern.

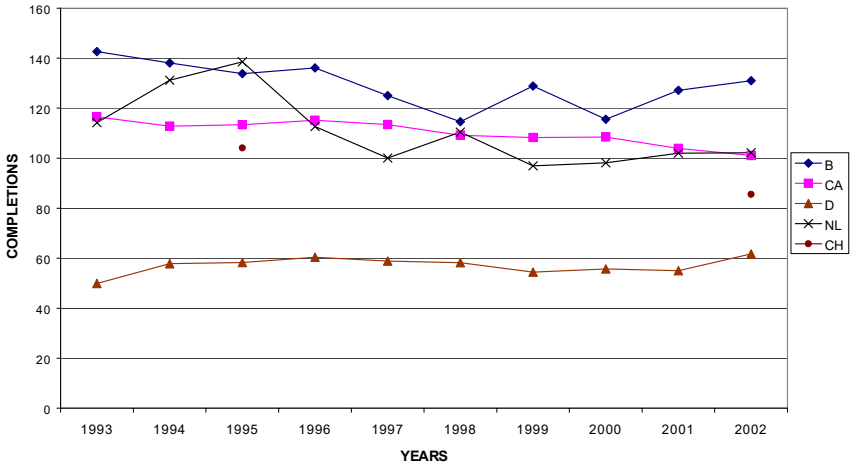
Figure 2.2 Number of new disability recipients per 1.000 insured (1993-2002)



In three countries the number of completions is increasing

The annual stock of disability benefit recipients also is affected by the number of persons leaving the scheme. For the five countries where data were available Figure 2.3 shows the number of completions (per 1.000 recipients) is quite stable in Germany, (slightly) decreasing in Canada and Switzerland and fluctuating in Belgium and the Netherlands. The German programme shows systematically the lowest out-flow rates and Belgium constantly the highest. In most countries males and females show a similar pattern, but in Belgium and the Netherlands the trends in completions for females display large fluctuations over time.

Figure 2.3 Number of completions per 1.000 recipients (1993-2002)[7]



7 No numbers are available for completions in Sweden.

2.3 Insured and disability benefit recipients in 2002

In this section the stock of disability recipients, new recipients and completions will be analyzed further. But first the insured populations in the different countries will be compared with regard to gender and age structure, as these demographic factors partly determine the use of the benefit scheme.

Slightly more males than females in most insured populations

Table 2.2 shows the proportion of males and females is highly comparable across the countries. In Sweden and Switzerland the proportion of males and females is almost equally divided, whereas in the other countries the insured population comprises slightly more males than females[8].

Table 2.2 Proportion of male and females in the insured population (2002)[9]

Gender	B	CA	D	NL	S	CH
Male	55%	54%	56%	56%	51%	51%
Female	45%	46%	44%	44%	49%	49%
Total	100%	100%	100%	100%	100%	100%

Insured population and age groups

Table 2.3 shows more differences when we consider age groups. The Netherlands have the largest proportion of young people in the insured populations (18% is younger than 25 years). The proportion of persons in the oldest age groups (55 - 64 years) is relatively small in the Netherlands and in Canada (9% and 10%, respectively), whereas Sweden and Switzerland show the largest proportion of elderly people.

[8] We did not specify whether the relatively low percentage of males is due to the definition of the population of insured in Switzerland. For Sweden, however, the low proportion of males is connected to the) traditionally' high female labour force participation in this country.

[9] Because numbers for the insured population in 2002 are not available for Canada, the numbers of the insured population in 2001 is used as an estimation. This estimation for the insured population 2002 is used throughout this section.

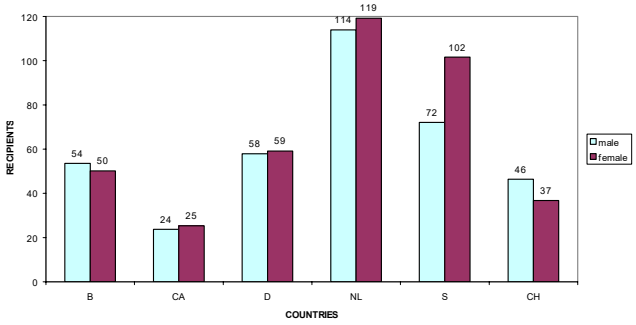
Table 2.3 Insured population by age groups (2002)

Years	B	CA	D	NL	S	CH
16-24 years	10%	14%	11%	18%	16%	13%
25-34 years	29%	23%	21%	26%	21%	22%
35-44 years	28%	29%	30%	26%	22%	26%
45-54 years	21%	24%	24%	21%	21%	22%
55-64 years	12%	10%	13%	9%	20%	17%
Total	100%	100%	100%	100%	100%	100%

Demographic features of recipients

The relationship of gender and disability benefit recipiency is considered in Figure 2.4. It shows females have a higher prevalence rate than males in Sweden and the Netherlands. In Canada and Germany the prevalence rates for males and females are almost equal, whereas in Belgium and Switzerland more males than females (per 1.000 insured) are receiving disability benefits. Consequently, the relationship between gender and benefit dependency does not show an “universal” pattern. The data further show that the outstanding position of the Netherlands is reflected in both gender groups, whereas in particular female insured account for the high rates in Sweden.

Figure 2.4 Disability benefit recipients per 1000 insured by gender (2002)



As can be expected, prevalence rates also vary with age, as younger age groups show lower prevalence rates and the older groups higher rates. This is a general pattern over all countries.

Table 2.4. also allows a more detailed insight into cross-national differences: especially large variations are found in the younger age groups. Whereas in Canada almost no person under 25 years receives a benefit, in Switzerland and the Nether-

lands 5 persons and in Sweden 13 persons (per 1000 insured) in this age group receive benefits. On the other hand about 5 times more persons between 55 - 64 years receive a disability benefit in the Netherlands compared to persons in Switzerland 4 times more than in Canada and 3 times more than in Belgium.

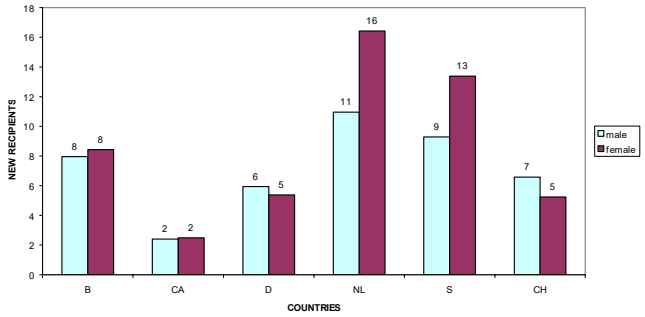
Table 2.4 Disability benefit recipients per 1000 insured by age groups (2002)

Years	B	CA	D	NL	S	CH
16-24 years	3	0	1	5	13	5
25-34 years	13	2	7	38	20	14
35-44 years	38	12	22	79	50	29
45-54 years	89	32	61	169	109	57
55-64 years	155	128	271	546	235	107
Total	52	25	58	116	87	42

Many female recipients in the Netherlands and Sweden

Figure 2.5 presents the incidence rates, the number of new disability recipients per 1000 insured. Lowest influx rates are found in Canada and Switzerland, and highest in the Netherlands and Sweden. In these two countries more females than males enter the benefit scheme. In Switzerland it is the other way around, with more new male recipients than new female recipients. In the other countries the incidence rates for males and females are about the same.

Figure 2.5 New disability benefit recipients per 1000 insured by gender (2002)



Combining the figures on gender and age (cf. Table 2.5) shows a remarkable difference between the countries in the highest age groups: whereas in Germany and Switzerland more males enter the benefit scheme, in Sweden and the Netherlands the females are more depending on a disability benefit.

Further it can be noted that the high rates for the Netherlands are reflected in all age groups, whereas the second highest rates in Sweden particularly are related to the highest age group.

Table 2.5 New disability benefit recipients per 1000 insured by age and gender (2002)

Years	B		CA		D		NL		S		CH	
	M	F	M	F	M	F	M	F	M	F	M	F
16-24 years	3	2	0	0	0	0	2	4	3	3	2	2
25-34 years	5	5	1	1	1	1	7	15	3	4	2	2
35-44 years	8	9	1	2	3	4	11	18	6	11	4	5
45-54 years	13	14	3	4	9	9	17	25	11	17	8	8
55-64 years	11	11	10	10	19	14	22	27	24	30	16	10
Total	8		2		6		13		11		6	

Figure 2.6 and Table 2.6 specify the pattern of completions of disability benefit payment. In all countries more males than females leave the benefit rolls. Another finding regards the role of age in termination of disability benefit dependency: in all countries, except Switzerland, the youngest age group shows the highest number of persons for which benefit payment is stopped. This country shows relatively very low termination rates in the age groups (except the highest), whereas the Belgian system shows the highest termination rate (except in the oldest group).

Figure 2.6 Number of completions per 1000 recipients by gender (2002)

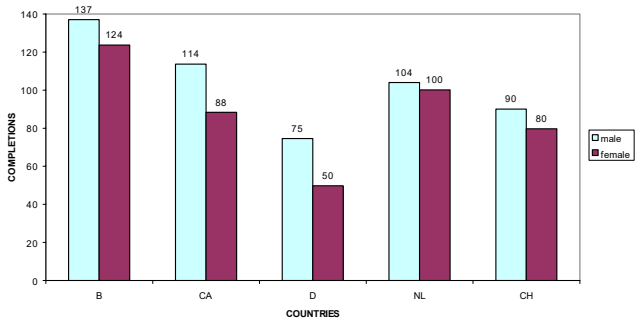


Table 2.6 Number of completions per 1.000 recipients by age (2002)

Years	B	CA	D	NL	CH
16-24 years	391	130	216	243	48
25-34 years	228	59	86	157	45
35-44 years	125	40	67	106	38
45-54 years	75	40	66	61	36
55-64 years	169	155	61	117	149
Total	131	102	64	102	86

* Sweden: no data on reasons for completion of disability pension payment.

Large variations is reasons for completion of benefit payment

Finally, the figures provided by most of the social security administrations also allow an insight into the background of the outflow rates. Table 2.7 describes the reasons noted for leaving the disability benefit scheme. Although the systems do not use identical categories, some remarkable differences can be noted.

Table 2.7 Reasons reported for leaving the disability benefit programme (2002)

Reasons	B	CA	D	NL	S*	CH
Exclusion, refusal	27%	-	-	-	-	-
Completion of temporary benefit	-	-	11%	-	-	-
Transfer to old age pension	32%	59%	61%	36%	-	57%
Work resumption	23%	7%	1%	45%	-	-
Regained capacity	-	1%		-	-	-
Death	18%	30%	22%	11%	-	-
Migration	-	-		-	-	8%
Others	-	4%	5%	9%	-	35%
Total	100%	100%	100%	100%	-	100%

* Sweden: no data on reasons for completion of disability pension payment.

In all countries, except the Netherlands, the major reasons for termination of benefit payment is a demographical one: about 60% of completions are due to reaching the statutory pension age and 11% - 30% of completions are due to mortality. But in the

Belgian and Dutch programme considerable less persons leave the scheme due to (old) age pension reasons (just over 30%), whereas in these countries work resumption (and for Belgium also ‘refusal’) are an important reason for completion of payment. The relative restricted weight of transfer to old age pension ín these two countries has different reasons. In Belgium older workers can, more than in other countries, make use of various early retirement schemes. The low Dutch figures in this category may be related to the relatively younger age of the Dutch recipients. Finally, it can be noted that, with the exception of the Netherlands, the mortality in disability benefit recipients is substantial in Canada, and – be it on a lower level – also in Germany and Belgium.

3 DISABILITY DUE TO MENTAL HEALTH PROBLEMS

This chapter looks deeper into the data that describe disability due to mental health problems. Diagnostic data derived from social security statistics do not allow refined cross-national comparisons, however. Legal, administrative and – in particular – cultural factors are reflected in the national diagnostic patterns. So we only will compare main diagnostic categories, namely recipients with mental disorders, with musculoskeletal disorders and a mixed category ('all other diagnoses'). In most North West European countries the first two account for about 2/3 of all recipients nowadays entering the benefit rolls.

3.1 Demographics aspects of disability due to mental health problems

Mental health problems most prominent in Switzerland

As Figure 3.1 shows there is some variation in the proportion of mental health problems in new recipients. Canada shows the lowest proportions and Switzerland the highest (twice as large as the Canadians). With the exception of Sweden the same gender pattern is found: mental health problems are more prominent in female than in male recipients. In particular in Belgium, Germany and Switzerland the gender differences are substantial.

Figure 3.1 Proportion of new recipients with mental health diagnoses (2002)

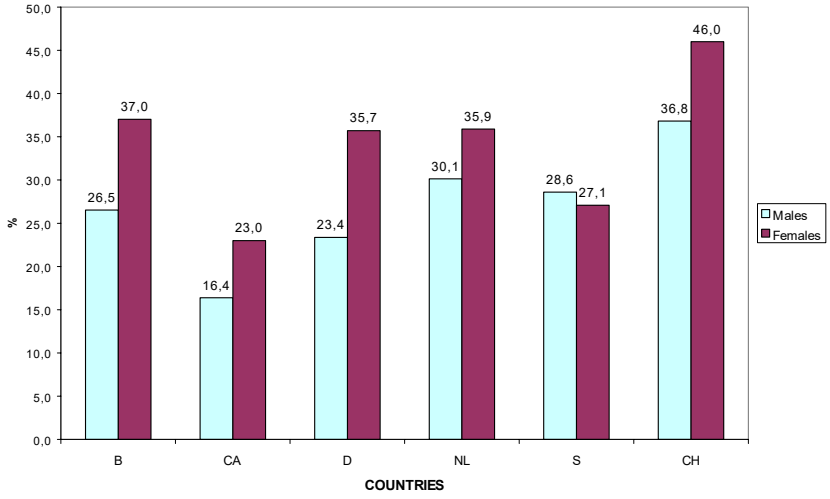
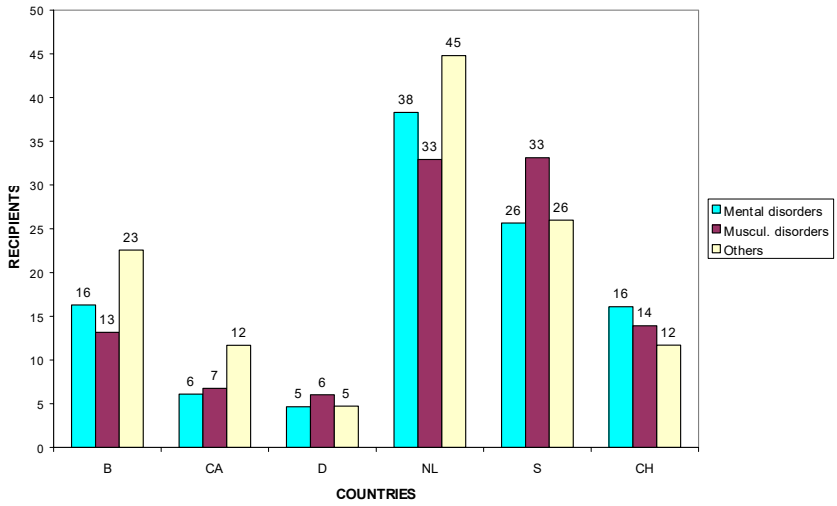
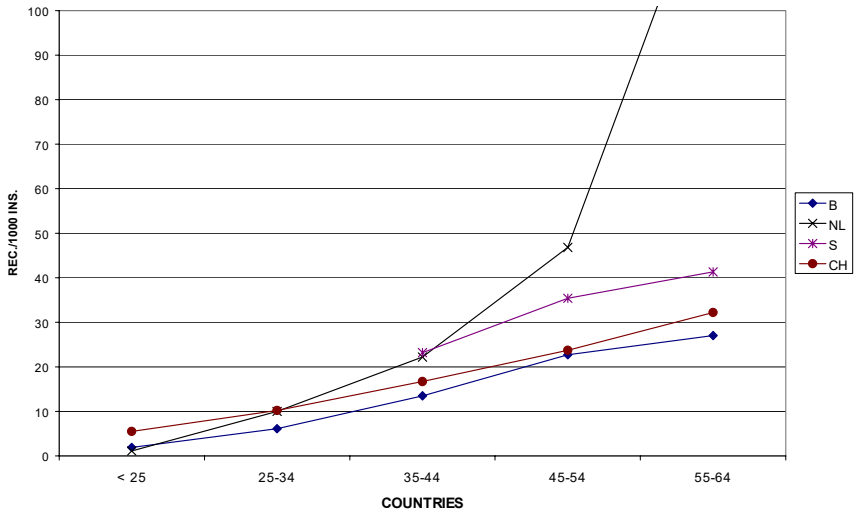


Figure 3.2 Recipients (per 1000 insured) by diagnostic categories (2002)



The diagnostic pattern in persons receiving disability benefits are presented in Figure 3.2. Apart from the familiar pattern that the Netherlands and Sweden show the highest prevalence rates it can be noted, that musculoskeletal disorders still are the largest category in the Swedish and German programme. The Canadian, Belgian and Dutch beneficiaries also show a substantial weight of the 'other diagnoses'.

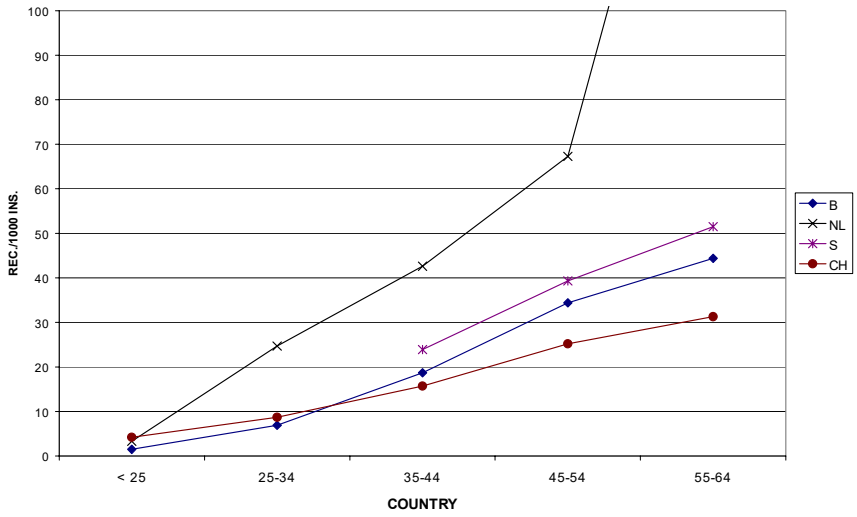
Figure 3.3 Male recipients (per 1000 insured) with mental health diagnosis by age (2002)



Particularly high mental health related disability rates in young Dutch insured

Figures 3.3 and 3.4 show the prevalence of disability due to mental health problems for four countries[10]. For male insured the differences between countries are modest until 34 years, but in higher age groups some countries (Netherlands, Sweden) show considerably more recipients than the other (Belgium and Switzerland). The latter have a highly comparative pattern over all age groups. In the highest age group mental health related diagnoses are in the Netherlands 3 - 5 times more prevalent than in the other countries.

Figure 3.4. Female recipients (per 1000 insured) with mental health diagnoses by age (2002)



Female benefit recipients show a slightly different pattern. Whereas in the youngest age groups Swiss and Belgian prevalence rates are almost the same, in Dutch females aged 25 - 34 years mental health diagnoses are three times more prevalent than in the other countries. These cross-national differences increase with age; in the highest age group Dutch female prevalence rates are 6 times as high as in Swiss female insured and 4 times as high as in Belgian female insured.

[10] For Germany and Canada no data were available, and for Sweden only data for persons aged over 34 years could be included.

3.2 Mental disorders and partial disability benefits

We finally examine whether benefit recipients with mental health diagnoses differ from the entire stock of recipients in the degree that they receive partial benefits. This can only be compared for the Netherlands, Sweden and Switzerland[11].

Table 3.1 Percentage of beneficiaries with mental health diagnoses receiving partial benefits (2002)

	Mental diagnoses		All diagnoses	
	Males	**Females**	**Males**	**Females**
Netherlands	25.4	23.3	37.3	26.8
Switzerland	11.2	18.5	22.9	28.2
Sweden	7.7	14.2	22.2	25.4

Table 3.1. shows that mental health problems are associated with receiving *full* disability benefits. A common pattern is obvious: persons with mental health problems receive substantially less partial disability benefits than in average ('all diagnoses'). Notwithstanding, between the countries substantial differences can be noted: whereas in the Dutch system still about 25% of recipients have a partial benefit, this percentage is just a half or a third in Switzerland and Sweden.

[11] German data are missing and the schemes in other countries only provide benefits in case of full disability.

4 REPERTOIRE OF MEASURES

4.1 Scope of the inquiry

The quantitative comparisons made so far focused on a cross-national comparison of disability benefit recipiency rates, trends and underlying patterns. They describe in a comparative way the benefit dependency of persons in working age, which cease or restrict participation in gainful employment due to health restrictions.

The quick scan of measures which aim to prevent or restrict short and long term disability due to mental health problems, also concentrates on persons in employment as the target group. So the measures discussed here focus on persons in employment, who are vulnerable to mental health problems, and show sickness absence or disability.

A further restriction regards the type of measures covered: medical interventions fall outside the scope of the inquiry. We did not cover literature on medical, psychological or psychotherapeutic treatment, but restricted to measures focusing on continuation of employment and less dependency on disability benefits. Consequently, our selection regards measures to address sickness absence and disability due to mental health problems.

The measures cover a wide range of health problems in the province of mental disorders and complaints. We further do not restrict to measures where sound evaluative studies are available. That even would not be possible as only since about 10 years attention is paid to the health consequences of psychosocial problems at the work site (e.g. work stress, aggression, bullying). And mental health problems with a weaker or no connection to work (e.g. depression, chronic fatigue syndrome, fybromyalgia) only very recently got some attention in preventive policies. So it will not be surprising that most of the instruments or strategies presented here are in a stage of development or have been implemented without substantial insight in their application or impact.

Policies and measures may be divide into three categories:
1. Early identification;
2. Employment related interventions (be it on individual level, company level or sectoral level);
3. Social security related measures.

4.2 Early identification of vulnerable groups

4.2.1 Screening of persons at risk of long term work incapacity (UK)

On behalf of the Corporate Medical Group in 2003 a report was published which explored methods of “Screening to identify people at risk of long term incapacity to work” (Waddell et al, 2003). Background was the need in the social security administration to identify, at a suitably early moment, clients at risk of becoming long term work incapacitated.

Aim of the study was to develop more focussed and effective interventions to assist persons to come off benefits and return to work. These methods should be able to identify those clients most at risk of long-term work incapacity, and those likely to return to work quickly. The screening methods should be applicable to individual clients in employment and groups of disabled clients (employed, unemployed, inactive). Other criteria were (e.g.): ease of implementation (without reliance on a specialist), reasonable transparency and acceptable level of accuracy.

The paper reports on the conceptual and scientific bases for screening, whether screening can be applied to all medical conditions, the relative value of administrative data (in social security administration) vs. individual clinical and psychological data, and the practicality of screening in a social security agency context.
The review identified a wide range of individual predictors of long term work incapacity, but few had consistent strength of prediction across different studies and contexts. A screening based on socio demographic data could be useful for the social security body but the ´risk markers´ used (e.g. aged over 55) themselves provided limited information about obstacles to return to work.
It further was concluded that adequate prediction becomes possible by the sub-acute stage of work incapacity (at about 3 till 4 weeks), but beyond six months all clients should be regarded as being at risk. The variable findings in different studies suggest that they do not combine into a simple, robust and universal screening tool. The authors conclude that the screening tool is potentially valuable in a social security context, but it needs to be further developed. Therefore, the sign of screening tools should be linked to the development of more effective rehabilitation programmes.

Based on this study the medical service performing assessments (’Corporate Medical Group’) started a pre-piloting project, to identify those new clients on temporary incapacity benefit who are most likely to return to work within the next 6-12 months, or who have the most severe medical conditions. The paper and the ongoing follow up project did not specify for persons work incapacitated due to mental health problems. The analysis identified, however, that the psychosocial factor ‘depression’ is a moderate till strong predictor of chronic pain and disability.

4.2.2 Identification of employees with mental health problems (Netherlands)

In the Netherlands the occupational physician has an important role in supporting the employer in his working conditions policy and sickness absence management. Consequently, validated scales (questionnaires) have been developed for the worker who consults the company physician for an assessment of work incapacity or advice on work resumption. One of the scales used by the company doctor measures mental health problems in general, whereas a specific scale (‘UBOS’) measures ‘burnout’. However, only a minority of occupational physicians shows to use these scales regularly. Also in other countries similar tools for company physicians are being developed (e.g. Germany, UK).

4.3 Employment related interventions

4.3.1 Work resumption guideline in case of mental health problems (Netherlands)

A multidisciplinary[12] (State) Commission gave in 2001 proposals to improve prevention, care, and labour reintegration in case of absence from work due to mental problems. The commission firstly made an inventory of ongoing initiatives. Secondly, it developed a guideline for an integrated approach to persons who become sick listed or disabled due to mental health problems. Explicitly also the issue of "individual labour conflicts" is covered, as a substantial proportion of persons long term sick showed to be involved in a conflict with their employer or supervisor.

The guideline is 'system-oriented' and has an 'activating approach': after a relatively short period of recovery, an exploration of the problems and solutions should be made, in order to stimulate actions from employer and employee for recovery and work resumption (Absence, 2004). Steps in this approach are (summarized):

First week of sickness absence
The employee reports sick (on the first or second day) and is open for telephone contact later that week with his employer or supervisor. The latter then asks whether absence is work related and also, when and under which conditions the worker could resume.

Second week
Again contact by telephone: the employer/supervisor inquires the state of affairs, clarity on causes, progress, asks whether (medical) help has been sought, whether the patient did think about solutions, and what the employer (further) could do. The occupational physician should be involved when the background of sickness absence continues to be unclear.

On or before the fifth week of sickness absence
When absence appears likely to become chronic: the occupational physician should make a 'problem analysis'. It gives an initial insight into the causes and restrictions of the complaints and sickness absence. When needed a follow up investigation should be made (evt. psychiatric investigation). Based on the 'problem analysis' and advise from the occupational physician, the employee and his supervisor make a (written) work resumption plan and carry it out, when needed with support of advisors or care givers.

[12] Members were representatives from medical specialists, psychotherapists, rehabilitation services, general physicians, occupational health services, social insurance administration, employers organizations, labour unions, patient organizations, ministries, scientific centres.

Between sixth and twelfth week
When sickness absence seems to be complex and is continuing, the employer discusses additional steps with the employee and occupational physician. Employer and employee may request an assessment ('second opinion') from the social insurance body (about further wage payment, and availability and offer of suitable work in the firm). Also the availability of 'labour reintegration subsidies' should be explored.

After the twelfth week of sickness absence
The supervisor/employer, employee and occupational physician regularly (every six weeks) have contact on the progress of recovery and on opportunities to resume work. Moments of evaluation of the progress and adaptations in the return to work plan are agreed in written form.

Finally: prevention of future sickness absence
When needed the occupational physician, employee and supervisor discuss how to prevent that the worker will again report sick. Central focus is: what in the work (situation) and the employees work behaviour should be changed, to prevent that the employee becomes work incapacitated again. Also should be assessed whether factors in the working situation also are relevant for the health and functioning of other employees in the same department or firm.

The guideline has been published autumn 2001 and subsequently a public relation campaign started (for employers, employees, health care providers, etc.) as well as a training programme (e.g. for occupational physicians). All were aiming to stimulate the application of the guideline. Initial monitoring indicated that one year after its introduction only a minority of occupational physicians and employers is using the guideline.

Very recently a pilot project has been evaluated in seven (health care and daily care) institutions, which were motivated to address high sickness absence due to mental health problems (positive selection!). Major findings from an interim evaluation showed (cf. van den Heuvel et al., 2004):

a. There was no integral implementation of the guideline: each institution took over those elements in its own programme, that fitted to the needs of the organization;
b. Basic features of the guideline (e.g. simultaneous focus on recovery and work resumption) were included in all programmes;
c. Facilitators for applying the guideline showed to be (selection): support from management, involvement of the worker's supervisors in shaping the programme; supervisors received training, and support from an external consultant (in these pilots: for free);

d. Obstacles (selection) in applying the guideline were implementation is time consuming; identification of mental health problems by supervisors is difficult: they are reluctant to contact the worker with mental health problems; the guideline is considered as very extended.

A conference in June 2004 on initial experiences further indicated, that support of management is crucial for implementation of the guideline; supervisors and occupational physicians hesitate to appeal the employee's own responsibility; and mental health care providers are insufficiently aware of the guideline and the crucial role of employment in the recovery process[13].

4.3.2 Job retention and mental health: review of literature and pilot project (UK)

Within the framework of the New Deal for Disabled Persons (NDDP) a literature review has been made to develop key criteria for an effective job retention pilots. A major conclusion (mainly based on literature from English speaking countries) states there is a large lack of available research and literature on mental heath and job retention (Thomas, et al., 2002). Literature on three models has been evaluated:

a. *Employee assistance programmes* (EAPs): employers provide a counselling benefit, which allow psychologically distressed persons free and confidential access to mental health (e.g. occupational stress intervention while people are still working). These programmes are mainly used in large US and UK organizations;
b. *Social process model:* a 'job retention worker' provides information to the work place about the nature of the disability, interprets workplace policies to workers with disabilities, negotiates with the employer to secure adjustments to the needs of the employee and trains supervisors and relevant others on how to accommodate persons with disabilities;
c. *Case management approach*, which involves a central worker, who facilitates communication between the actors involved (health services, employer, worker, other agencies). The case manager coordinates the treatment with a return to work plan, agreed upon by employer and employee.

The reviewers conclude, that the case management approach is the most effective model. This model further has been tested in the UK (Thomas, et al, 2003). This pilot project, which included only a small number of clients showed the need of:

- early intervention: within 4 weeks there should be access to the case management service;

[13] Personal communication Ilse Hento (Netherlands).

- continuous focus on return to work (how, when, which tasks/job);
- ongoing support;
- access regardless of diagnosis;
- a case manager needs a range of knowledge and skills (e.g.: on mental health, employment issues, empathy towards client, understanding of employer's issues, mediates between employer and employee).

4.3.3 Initiatives raising awareness to tackle psychosocial risks (EU)

Autumn 2002 the European Agency for Safety and Health at Work (Bilbao) provided an overview of models of good practice on the prevention of psychosocial risks at the work place. The policies presented focus on three risks: stress, bullying and violence. Some examples that were presented (Agency, 2002):

Developing a mental health policy in industrial enterprises (United Kingdom)
In the UK several large employers developed a 'Company Mental Health Policy', aiming to preserve the psychological well-being of employees. These programmes comprise a risk assessment approach (to promote realistic improvement in the design and management of work) and awareness raising initiatives (leaflets for management, one-day stress awareness workshops, etc.). This approach explicitly favours prevention-focussed interventions at the organizational level. These are considered to be more sustainable than rehabilitation or individual-level interventions.

Implementation of anti-bullying policy (Finland)
Bullying at work can result in severe stress, mental and physical health problems, posttraumatic stress disorders and increased sickness absence. Numerous (large) organizations in Finland devised and implemented policies and guidelines how to act in bullying situations. Supervisors and OSH personnel receive training and support how to deal with bullies and their victims, personally and within the organization.

Prevention of work-related violence in health care (The Netherlands)
A large majority of doctors and nurses in hospitals in the Netherlands have experienced psychological or physical violence and sexual harassment. The 'Safe Care Projects' in Dutch hospitals include a firm policy on aggression and violence. The policy comprises various elements: firstly, violent incidents are classified in three different types and dealt with accordingly ('yellow and red cards'). Other features are the improvement of safety aspects and training of staff in aggression control techniques.

Also other the international organizations (ILO, European Foundation) and sectorall organizations nowadays provide similar overviews of "best practices".

4.3.4 Prevention strategies for coping with anxiety, depression and stress related disorders (Europe)

July 2004 a report came out on programmes concerning mental health promotion and prevention strategies (including early detection and intervention of anxiety disorders, various forms of depression as well as stress related disorders). The study both covers a review of scientific literature and a status quo analysis on community, enterprise and institutional programmes in 15 European Member States[14].

The evaluation of programmes led to a selected list of "models of best practice", but many of them had not been evaluated yet in a more structured way. Notwithstanding, ten key recommendations for mental health promotion and mental ill health prevention could be formulated (Berkels et al., 2004).

The section on anxiety, depression and stress related disorders in 'Working Adults between 25 - 60 Years' recommends to integrate mental health promotion and prevention into occupational safety and health programmes. The 20 models of good practice selected focus mainly on enterprise level and show to vary as to level of intervention, e.g.:

- individual level (e.g. improve coping skills);
- social environment (e.g. policies to combat bullying);
- working conditions (e.g. reduction of risk factors or change of work organization).

Measures on company level should focus on anxiety and depression in employees by enhancing their internal locus of control and promote social inclusion. Instruments promoted are training and informing, strengthening skills and coping strategies, and the establishment of company policies on bullying, harassment and violence at work.

4.3.5 Occupational health and safety covenants (Netherlands)

Occupational Health and Safety Covenants are agreements between the government, employers' organisations and trade unions for a certain sector to reduce health risks, improve working conditions and reduce sickness absence and the number of persons claiming disability benefits.

The covenants, introduced in 1999, have a task setting nature with measurable targets, e.g. reduction of sickness absence rate by 20% within two years. Other issues covered may be: work pressure, physical pressure and RSI, interventions on aggression and violence, setting up a sickness absence management policy, promotion of early re-integration measures etc.

[14] The study covers three periods of life (children, adolescents and young people; working adults; older people) and different settings (e.g. educational settings, workplace, elderly care services).

At the end of 2003, about 51 safety and health covenants were operational, which apply to 3.3 million employees (46% of the Dutch working population). About 20% of the covenants regard measures to mental health related working conditions, like violence and harassment (e.g. police, health care) or work pressure and stress (e.g. banking sector, schools, municipalities, cleaning services).
Initial results of the safety and health covenants are positive. In the sectors for which a safety and health covenant has been implemented, sickness absence rates fell by 8.4% in 2002. In business sectors without a safety and health covenant, levels of sickness absenteeism have remained more or less the same (Arboconvenanten, 2004).

4.4 Social security related measures

A third category of measures can be found in the area of social insurance. Initiatives regard various issues: supervision of sick listed workers, disability assessment methodology and acknowledgement of mental health problems as caused by work ('occupational disease').

4.4.1 Specific criteria for evaluation of psychosomatic syndromes (Denmark)

Already in the 90s the Danish social security agency noted that the 275 local agencies showed large variations in the acceptation rate of claims for disability pension due to psychosomatic syndromes. Furthermore some politicians and patient organizations criticized the social security agencies for their reluctance to give disability pensions to claimants with syndromes like Fibromyalgia, Chronic Fatigue Syndrome and Chronic Strain Syndrome (CSS). Therefore, in December 1993 for these syndromes criteria for eligibility to disability pension were further elaborated (Birket-Smith, 2000[15]).

Recent Danish statistics show that claimants with Fibromyalgia, CSS and 'Whiplash associated disorders' more often receive disability pensions compared to the general acceptation rates (for all diagnoses). This phenomenon may be attributed to the growing pressure from patients organizations and the media. Moreover, Danish experts refer also to the lack of agreement in the medical profession on the nosological status and prognosis for these syndromes. However, presently revision of the guidelines for evaluating physicians is not considered as the annual number of new disability pensioners dropped drastically (from 30.000 to 15 800 in 2002).

4.4.2 Early assessment of persons with chronic fatigue syndrome (Belgium)

Belgian social insurance physicians not only evaluate short term work incapacity (sickness absence, up to one year), but subsequently assess eligibility to disability benefit payment. In 1999 the medical staff of the sick funds developed an assessment guideline for claimants with CFS. The initial action starts several weeks after the onset of sickness benefit payment. The guideline has a general character and includes both disability assessment tasks and ´counseling´ or advise to the patient on work resumption. The procedure comprises two steps (Vanden Wijngaert, 2001):

1. Data collection and relationship building

The initial step firstly aims to collect all relevant information (anamnesis, clinical examination, analysis of information from treating physicians), and – secondly – to create a basis for a trustful relationship of the evaluating physician with the patient.

[15] Literature and personal communication.

Subsequently, every 4 till 6 weeks the client has to consult the social insurance physician. After three of these consultations a decision is made: whether the insured will be evaluated as capable to work, or whether he/she further will be monitored and supported to return to work.
The method for identification of persons with CFS is not further specified or standardized. The evaluating physician firstly relies on information provided by the treating physician (diagnoses on sickness certificates, information additionally requested). Secondly, the information obtained in interviews with the patient is used to diagnose CFS. Both sources are reported to have equal relevancy.

2. Monitoring and support to work resumption
The second step taken by the social insurance physician comprises:
- further clinical investigations (e.g. neuropsychological test, spiro-ergometry);
- contact with the insured's family doctor and specialist (on therapy, work incapacity);
- contact with the patient's occupational physician (e.g. on opportunities and conditions for job retention).

In this stage the evaluating physician – together with the patient – makes a plan and time schedule for partial and full work resumption. In every contact with the patient this plan is checked and, when necessary, adapted.

Social security doctors reported that the experiences with the guidelines are positive: the number of conflicts has reduced, as have the discussions whether the diagnosis is 'real' or has ''any value''. No figures are available on the impact on work resumption or disability benefit take up. An other major value lies in a better documented file.

4.4.3 Evaluation of persons with mental disorders (Germany)

The German Pension Funds revised their guideline for disability evaluation of patients with mental disorders (VDR, 2001). The proportion of persons with mental disorders steadily rose and medical and vocational rehabilitation measures (paid by the pension fund) required a renewal of guidelines. The guideline has the status of 'Recommendation', namely for a sound socio-medical assessment of disability with respect to two aims: the need of rehabilitation measures and eligibility to disability pension. Consequently, it requires from the user of the guideline that he is familiar with recent developments in medical rehabilitation approaches for various categories of patients (e.g. psychosomatic disorders or alcohol/substances abuse).

The evaluation guideline specifies the dimensions of the assessment and elements of the examinations. It further indicates which neuropsychological examinations can be done supplementary, when needed (e.g. EEG, EMG, CCT). Moreover, for several

mental disorders some additional points of attention have been listed, which should be covered in the assessment of functional capacities.

The guideline does not inform or give instructions for the timing of assessment or for early identification of patients. The moment of evaluation is fully depending on the patient, who sends in a request for rehabilitation or disability pension. This may be on his own initiative or on the initiative of the sick funds, which may stimulate the patient to apply for a rehabilitation plan or a disability pension.

4.4.4 Acknowledgement as an occupational disease? (International)

Recently a European working group studied the question of the recognition of illnesses of psychosocial origin as occupational diseases (Eurogip, 2004). The thirteen countries covered in the survey showed to recognize the mental or psychological sequels of an accidental event such as a hold-up, namely as an “occupational injury”. But other mental disorders or illnesses (depressions, neuroses, obsessive-compulsive disorders, etc.) related to psychosocial risks are rarely recognized (and hence compensated) as occupational diseases.

At present, such recognition as occupational disease is only possible in six countries (Belgium, Denmark, France, Italy, Portugal and Sweden). Illnesses of psychosocial origin do not appear on the lists of occupational diseases, but the victim has to provide proof that his (her) illness is work-related. And it shows to be complicated to prove that a difficult working environment is the “decisive” or “essential” cause of a depression, for example. As there are no clearly established definitions of work-related mental illnesses, each country sets its own criteria: e.g. “exceptional severity” and “permanent sequels” in Denmark; or: exclusion of illnesses related to interpersonal relations in Italy and Sweden. The acceptation rate of such claims, however, shows to be (very) low (Bakkum & Prins, 2004).

The other countries studied (Germany, Austria, Finland, Luxembourg, Switzerland, Spain and Ireland) for the time being offer no possibility of recognition of mental illnesses as occupational diseases. In the latter two countries only those illnesses registered on the list of occupational diseases are recognized as such. In Germany, based on the research carried out until now, “psychosocial” diseases do not comply with the definition of an occupational disease (which requires that some groups of people are, due to their professional activity, more exposed than others to specific risks). In Finland, a working group involving social partners, doctors, scientists, etc., unanimously considered that mental disorders should not appear on the list of occupational diseases, unless the existence of a causal link between a mental risk at work and a mental disorder could be demonstrated with certainty.

Further, the European Commission too, at the end of 2003, did not consider it advisable to include in the European list of occupational diseases the mental health complaints caused by psychosocial factors.

Finally, this does not mean that there are no claims for recognition of “psychosocial” diseases. In those countries in which recognition is currently impossible, research tends to confirm this position. In the other countries, the research is designed to better define the framework for recognition of and compensation for psychosocial diseases. In Italy, for example, instructions are to be circulated to the central and regional insurance offices regarding how to assess the risks involved and the worker's prior psychological condition, the diagnostic tests, and visits for forensic diagnostic.

But the developments as reported in the Eurogip study do not stop. June 2004 in Sweden a project has started under the auspices of the Medical Advisory Council (Swedish Labour Market Insurance Company, AFA) to find out when mental health disorders are attributable to work. The study will examine the evidence basis for assessments of associations implying causal relationships between mental health disorder and mental strain at work. In addition the team of experts will look at the evidence basis for assessment of somatic health disorder and mental work strain (focussing on pain syndromes of the neck and shoulder region). Subsequently, a few cases which have been processed by the judiciary, will be examined as to the assessments made and the reasons given for the decisions taken in court[16].

[16] Personal communication by P. Westerholm.

5 OVERVIEW AND DISCUSSION

This chapter gives an overview of the major findings of this exploration. We firstly will present in a comparative way the outcomes of the quantitative analyses. They allow to asses the relative position (benchmark) of each country compared to the country with the lowest rates. The second part is devoted to the wide range of measures that has been found across Europe. These measures or policies, however, cannot be related to specific countries, as in most countries the interest in disability due to mental health problems is quite new, and still is far remote from ´evidence based´ practices.

5.1 Benchmarks

Relatively low rates in Canada and Switzerland

The comparative analysis presented in chapter 2 and 3 showed that there are considerable differences between our countries regarding the number of persons on disability benefit. The Netherlands and Sweden 'almost traditionally' show the highest prevalence rates for disability benefit recipients, whereas Canada and Switzerland show the lowest numbers.

Disability recipients (stock)	
High	The Netherlands
Medium	Belgium, Germany, Sweden
Low	Canada, Switzerland

Growth in disability benefit recipients in 10 years	
High	Switzerland
Medium	Belgium and Sweden
Low	Canada, Germany, the Netherlands

Growth rates, however, demonstrated a slightly different pattern: here Switzerland, Sweden and Belgium are the countries with the steepest increase in benefit dependency. For most recent years Canada and Germany even show stable or decreasing numbers of recipients.

In the light of comparability of systems the German rates evoke questions as to the background of this phenomenon, as the economic and working conditions are similar to those in the other EU countries. The question can be stated whether the impact of the new disability pension scheme and criteria governing the influx in the scheme? However, also the level of sickness absence in Germany is the lowest since over 10 years.

Entering and leaving the benefit rolls

Also when we compare the annual number of new recipients (per 1000 insured) the same countries show the lowest levels: Canada's incidence rates are very low, whereas Switzerland and Germany also show moderate levels.

New disability recipients (influx)	
High	The Netherlands and Sweden
Medium	Belgium, Germany and Switzerland
Low	Canada

Completions (outflow)	
High	Belgium
Medium	Canada, the Netherlands and Switzerland
Low	Germany

As to the number of persons leaving the benefit rolls the picture is different, which is not surprising: when relatively many enter the scheme also relatively many may leave the programme. This phenomenon can be seen in the Netherlands, but also in the countries with low prevalence rates like Canada, Switzerland and Belgium.

It could be that these countries have elements in their criteria or administrative supervision elements (re examinations? return to work measures) which stimulate leaving the payment rolls. However our analysis of reasons for stopping benefit payment shows that reaching pension age is the main 'exit factor' for Germany, Canada and Switzerland. Considered from a health perspective it seems that disability benefit recipients in these three countries have a relatively high age and poor health condition (cf. high mortality rates in Canadian and German benefit recipients)[17].

[17] The data do not allow to explore which other morbidity aspects (e.g. the proportion of persons with congenital disabilities) affect these differences.

Both the lower weight of transfer to old age pension and low mortality rates (in particular in the Netherlands) suggest that recipients in Belgium and the Netherlands are younger, and – consequently – easier to (be forced to) re enter the labour market. For Belgium it should be added that the role of old age is disguised by the (strong) use of early retirement arrangements in this country (which allow leaving the work force when aged around 60 years).

Disability due to mental health problems

For the core issue of this paper, disability due to mental disorders, our comparisons show, that the pattern of differences is slightly different. Indeed for all diagnostic categories the Dutch rates are (considerably) higher, in particular when we consider the numbers of persons from young age groups who annually enter the benefit programme.

New recipients due to mental health problems	
High	Switzerland
Medium	Belgium, Germany, the Netherlands and Sweden
Low	Canada

Stock of recipients due to mental health problems	
High	The Netherlands, Sweden
Medium	Belgium, Switzerland
Low	Canada, Germany

However, mental disorders also are a growing concern in the Swiss social insurance: in the relatively moderate number of persons entering the benefit scheme, the highest proportion of persons with mental disorders is found (4 out of 10 new recipients).

Finally, for the countries with disability programmes which also compensate partial disability, it was shown that mental disorders are mainly ‘leading to’ full disability. The reasons for this phenomenon are not known. Not only the assessment methods or lack of evaluation guidelines may account for higher rates of full disability benefits. Also the attitude in insured and discretionary power of evaluating physicians may affect for this observation.

5.2 Backgrounds

Notwithstanding the restrictions of the data compared, some substantional differences could be noted. The scope of this study does allow a full overview of major background factors, but on the basis of recent cross-national studies some can be discussed.
A wide range of factors and conditions now could be mentioned that come into consideration as potential explanation of these differences.
Differences that refer to conceptual and statistical sources of variation in the data have been controlled for as much as possible.
The background of the differences observed should partly be sought into the features of the disability benefit programmes. In most of the countries where a disability *pension* is paid younger persons are relatively less entering the scheme compared to countries where not a pension formula dictates the benefit level. Another explanation in this area can be sought in non-medical eligibility criteria, e.g. minimum insurance periods (e.g. Germany: 5 years and Canada: 4 years). Finally, the definition of disability as well as the assessment and decision methodology may vary considerably across countries.
An other category of explanations might be found on company level: the personnel and social policy of the employer vis-à-vis his employees, his working conditions policy and way of sickness absence management. Earlier cross-national studies showed that during the sickness benefit payment period factors like job protection ('risk of dismissal') or early interventions (by occupational physician or social security agency) may operate as 'filters' for claiming disability benefits.

Finally the medio-cultural context also seems to play a role, e.g. standards and definitions of illness and patient behaviour, health beliefs, health care conditions (e.g. waiting periods, concepts of psychiatric diseases). These not only regard the patient/ insured but also the treating and occupational physician[18].

5.3 Intervention vis-à-vis disability due to mental health problems

Some of the issues that may explain the cross-national differences are now also being addressed in a preventive or reactive way. Our inventory of initiatives and measures to deal with disability due to mental health problems showed that efforts to prevent disability due to mental health problems are mainly to be sought in two areas: firstly the enterprise and secondly social security.

[18] For instance Verhaak et al. (2004) noted in Swiss family doctors a higher tendency to 'label' physical health complaints of patients as mental problems than their colleagues in some other countries.

Focus on work place and enterprise

The focus on the enterprise and working environment has many roots. Firstly work may be part of the causes of mental health problems: working conditions like negative management style or low social support may lead to mental health problems, depressive episodes etc. Further, these problems may cause high costs of sickness absence. On the other hand the enterprise also may create conditions for preventionaction: existing occupational health and safety structure in the work place facilitate the provision of (e.g.) mental health promotion activities.

So it is not surprising that the majority of strategies, policies, pilot projects and studies explore or promotes measures to be applied in the province of employment. In some countries (e.g. the Netherlands) such employment related measures also may be taken over in collective agreements, which explicitly regard prevention and intervention in sickness absence due to psychosocial problems.
Such company oriented measures are facilitated with supporting actions from international and national organizations, which may provide a wide range of tools for a variety of problems (e.g. work stress, depression, aggression, bullying).

It should be noted that most of the measures proposed have not been evaluated (yet), or evaluation only considered implementation aspects. On the other hand also opinions are heard that ‘models of best practices’ should be promoted which can not wait for scientific evaluation, as implementation will show ‘whether it works or not’.

Mental health problems and social insurance

The second province of measures can be located in the social insurance sector. In several countries similar instruments have been designed to deal with sickness absence and disability due to mental disorders. Here both the preventive approach is chosen (e.g. screening, before benefit claims are send in) and ‘secondary prevention’ measures, when the person already is on (short term) benefit receipt.
Further, the disability assessment process and quality is subject to revision in some countries. In this area there is a common problem in various the countries A conference on disability assessment in clients with psychosomatic complaints showed, that in all (13) participating countries sickness and disability benefit administrators 'struggle' with operating the scheme for this category of clients. Disability evaluation and assessment of the need of rehabilitation showed to be widespread problem in European countries (Prins et al, 2000).

'International market' of interventions

Notwithstanding the limitations of the sources examined it may be concluded that this inventory of instruments provides insight into a wide range of approaches. Especially information on disability management and other employment related approaches is becoming easily available. International working groups, exchange platforms as well as IT technology may further facilitate the work of actors who are to design policies to prevent and tackle mental health problems in the working age population.

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