

# Risk Matters



Dear Reader,

The UK Conservative and Liberal Democrat coalition Government was elected in May 2010 with a flagship policy of “Big Society” that puts power and opportunity into people’s hands to solve the problems they face. This policy commitment extends to public spending and health reform. The latest policy document on mental health “No Health Without Mental Health” (NHWMH) presents itself dressed in a sombre purple cover as befits our straightened times. It supersedes “New Horizons: A shared vision for mental health” a classic “New Labour” publication adorned with a calm view across a bay set off by pebbles in perfect balance, one upon another.

These apparently cosmetic differences set the tone for these publications. Whilst both are aspirational, the NHWMH is more business-like than its predecessor. Both, however, stress a growing movement that concentrates less on the management of mental health problems per se than the well being of the population as a whole. The development of these strands of thought can be traced to publications as disparate as the Black report “Working for a healthier tomorrow” (2008), the Marmot Review, “Fair Society, Healthy Lives” (2009) and “Healthy Lives, Healthy People” (2010). Most recently, the topic was aired by Dame Carol Black in her speech at the June 2011 Protection Review dinner.

This paper looks in more detail at the proposals of the NHWMH and the impact that might be felt by insurers as its proposals are implemented.

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## No Health Without Mental Health

The central “Big Society” message in this context is that Government wants to help all citizens to improve mental health by ensuring mental health problems are not stigmatised but are viewed like any other health issue. By changing perceptions, the argument goes, society will more easily identify those at risk or with current problems, and the provision of improved, localised services will help them to feel better about their lives and to cope when things go wrong.

NHWMH sets out a framework to achieve six main objectives:

1. More people will enjoy good mental health.
2. More people with mental health problems will recover.
3. The physical health of those with mental health problems will improve.
4. Those with mental health problems will feel more positive about the support and care they receive.
5. There will be a decrease in avoidable harm (including suicide).
6. There will be a decrease in stigma and discrimination.

In tune with much coalition rhetoric, there are clear statements about the role of Government in helping to meet these goals directly (e.g., by investing GBP400 million pounds in the Improving Access to Psychological Therapies (IAPTS) programme) and also indirectly, arguing that the reforms of the health and social care system such as General Practitioner (GP) commissioning and “health and well-being boards” will advance this agenda. However, there is a very clear message that responsibility lies not only with central agencies but also with the individual to look after their own welfare. The message is that we can ensure that we look after our own mental health better and be involved at a local level to improve the overall well-being of the community.

The National Health Service Confederation response to this paper, “Public mental health and well-being – the local perspective (2011)”, asks the most pertinent question in this debate: What is positive mental health and well-being? Sadly, their answer is as pat as those in other papers, defining it as a “positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment”. The important message, however, is that people with mental health problems can still experience positive

well-being. The Confederation interviewed a wide range of care providers, and unsurprisingly the majority thought that promoting mental health should be a priority for their organisations but by no means did as many believe that this was happening in practice.

One of the principle concerns raised by the Confederation is the ability of the well-being agenda to survive the current economic recession. The impact of the recession on health is complex. Whilst it might be intuitive that health would decline during harsh economic times, this is not universally the case. During periods of food rationing, for example the number of deaths from cardiovascular disease appear, to decrease. As income is squeezed and consumer confidence falters, people drive less but walk more and have less money to spend on unhealthy foods and activities. However, mental health problems and suicide increase during recessions, and health inequalities appear to get wider as those in society least equipped to cushion the economic effects fare the worst.

The Confederation's report quotes a UK GP saying "When money is tight, people look to fund hospitals, not well-being". By contrast, many commissioners of services see spending cuts as an opportunity to make public well-being a priority. They argue that it makes economic sense and is an important contribution to the economy to support people in getting back to work and thereby lift the burden on publicly funded support services, but perhaps they neglect the rather obvious point that there are relatively fewer jobs for which to get people fit.

It is argued that there is a strong economic case for wellbeing initiatives with a number of low cost programmes contributing significant cost reductions in the more traditional areas of mental health treatment. For example, evolving from the "Big Society" philosophy peer support, community gardening and cultural activities are touted as significant developments. NHWMH claims that the spending of GBP250 million on face-to-face debt advice would lead to savings of GBP50 million in legal costs, GBP30 million to the NHS and a further GBP220 million in productivity gains. Even more traditional interventions, such as systematically training all GPs to recognise and manage suicide risk, could result in net savings of over GBP500 million after one year through reduced direct care costs and indirectly through productivity savings and reductions in benefits claims.

Most mental health problems cause excess mortality, and for the most severe conditions, schizophrenia and bipolar affective disorder, life is shortened by 16 - 25 years in comparison to the general population. Suicide contributes to this, as do a number of illnesses related to lifestyle, mostly of cardiovascular origin.

Importantly, adults with mental health problems (including drug and alcohol misuse) smoke 42% of all the tobacco used in England. Not only are those with mental health problems more likely to develop cardiovascular diseases, (depression doubles the risk), but the outcome for those with cardiovascular diseases who then develop mental health problems, is worse. There is some evidence that treating the mental health problem improves the outcome, but this is not yet robust. Actively promoting good physical health in those who are experiencing mental health problems is likely to have a significant effect upon their outcomes, however.

With the recession, comes an opportunity to radically redesign health and well-being services focusing away from acute care to prevention. Should this agenda blossom, a number of changes may arise, some of which may be positive and others less so.

If these well-being schemes are effective when rolled out to a larger population, there is a real possibility of there being fewer insurance claims for mental health problems. Improvements in mitigating mental health in the work place and managing the return to work should result in significantly fewer and shorter invalidity and income protection claims.

Increased recognition and interventions at an early stage may mean that more serious illness does not develop and that a larger number of mild cases are identified that would previously have gone unnoticed. Underwriters have to be alive to the changing population that now bears these labels and understands the natural history and risks of this group. Signs of positive effects of the 'Big Society' and of NHWMH working successfully may be evidence of improved diet and physical activity (e.g., healthy BMI), good general health, moderate alcohol, zero tobacco use and a good work attendance record. For those who have been diagnosed with mental health problems, we may see evidence of a good care plan and a positive attitude towards treatment and rehabilitation.

#### Further reading

*Department of health (2009) New Horizons: A shared vision for mental health.*

*Department of health (2010) No health without mental health: a cross-government mental health outcomes strategy for people of all ages.*

*Department of health (2010) Healthy Lives, Healthy People: Our strategy for public health in England*

*Department of work and pensions (2008) Working for a healthier tomorrow. Dame Carol Black's review of the health of Britain's working population.*

*The Marmot Review (2010) Fair Society, Healthy Lives. Strategic Review of Health Inequalities.*

*NHS Confederation (2011) Public mental health and well-being – the local perspective*



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