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10 Health and Healthcare

The vast majority of people in the world (92%) view mental health as being equally important to overall wellbeing as physical health is, if not more so.

Wellcome Global Monitor[1]

We all get sick at one time or another in our lives. All of us get physically sick, and at some point at least a third of us experience diagnosable mental illness.[2] Both types of illness cause us pain, disrupt our lives and can shorten them. As we mentioned in Chapter 5, both mental and physical pain are experienced in the same brain areas (the anterior cingulate cortex and the anterior insula). And mental illness can cause physical illness and vice versa.

Yet the healthcare system responds quite differently when our illness is mental rather than physical. If we are sick in body, we normally get treated. If we are sick in mind, we most commonly do not – even in the richest countries. This is a major cause of unnecessary suffering.

So in this chapter we shall begin with mental illness and consider:

- how prevalent it is,
- why we should take it more seriously and
- what cost-effective treatments exist and how they can be deployed.

Then, after looking at physical pain, we consider the length of life. The remarkable increase in this shows the power of medical science to improve the human lot.

How Much Mental Illness?

There is a difference between low wellbeing and diagnosed mental illness. Low wellbeing can be due either to current external circumstances (poverty, unemployment, recent bereavement and so on) or it can be due to something more internal, something that is partly or wholly psychological in origin.[3] Of course, nearly everyone

[1] The Role of Science in Mental Health

[2] For the United States, Kessler et al. (2005a) Table 2 estimate 46%.

[3] This could of course be due to **previous** experience. It could also be psycho-physical in origin.

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has some psychological hang-up or other. But to be defined as mental illness, the problem has to be severe enough to cause major distress and impaired ability to function.[4]

So to know the scale of the problem there has to be first a clear diagnostic definition and then a survey to see how many people it applies to. There are two main systems for diagnosing mental illness. One is the US Diagnostic and Statistical Manual **(DSM5)** and the other, broadly similar, is the WHO's International Classification of Disease **(ICD-11)**. Diagnosis is vital to ensure that people get the treatment that is most effective for their problem.

But to know the scale of the problem, we cannot rely on people coming for treatment. We have to have a household survey, ask people the diagnostic questions and then apply DSM or ICD to determine whether they count as mentally ill – in England, for example, there is a regular official survey of this kind.[5]

The most common mental disorders are either depression or they are anxiety disorders (like Post-Traumatic Stress Disorder (PTSD), Obsessive-Compulsive Disorder (OCD), panic attacks, phobias and generalised anxiety). In England, 17% of all adults are suffering from at least one of these so-called **common mental disorders** – with depression and anxiety disorders being equally common. In addition, 0.7% of people are suffering from the more serious 'psychotic' mental illnesses like schizophrenia. There are also other serious mental health problems like bipolar disorder, addiction and Attention Deficit Hyperactivity Disorder (ADHD), but these to a large extent overlap with the other disorders we have already described. Thus, in broad terms, some 20% of the adult British population suffer from diagnosable mental illness (excluding dementia). The same is true in the United States.[6] And in poorer countries, rates of mental illness are similar to those in richer ones.[7]

These are the numbers of people who are ill at a moment in time. But many more people experience mental illness at some point in their lives – at least a third of us do so. Much mental illness begins in childhood. At any one time at least 10% of children aged 5–16 have a diagnosable mental health problem – mainly anxiety disorders or conduct disorder (both of which can begin quite early in life).[8] Depression does not generally begin till the teens, and schizophrenia begins in the late teens or later. By the early 20s, rates of mental illness are higher than at any other age, and then they decline steadily as people age. The majority of people who experience mental health problems in childhood also experience them as adults, unless the problems are tackled early.[9]

[4] Similarly, for much physical illness, diagnosis requires cut-offs, e.g., 'high' blood pressure is defined as the level that causes an unacceptable risk of heart attack or stroke.

[5] For the latest survey of adults in England (in 2014), see McManus et al. (2016). For the United States, see 2019 National Survey of Drug Use and Health run by SAMSHA.

[6] The US figure is 20.6% – see 2019 National Survey of Drug Use and Health run by SAMSHA, Table 8.7B.

[7] Ayuso-Mateos (2010); and WHO (2017).

[8] On England, see Sadler et al. (2018).

[9] Kim-Cohen et al. (2003); and Kessler et al. (2005b).

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There is some evidence that mental health problems have become increasingly common, especially among young women (adolescents and young adults).[10] But mental illness has always been a serious issue.

There are at least four reasons why mental health should be taken more seriously than it often is:

- its impact on wellbeing
- its impact on physical health
- its impact on the economy
- the existence of cost-effective treatments.

The Effects of Mental Illness

On wellbeing and suicide

As we saw in Chapter 8, diagnosed depression or anxiety disorder is one of the biggest factors explaining the dispersion of happiness in advanced countries – and the biggest single cause of misery. Mental illness also has huge implications for other members of society, especially the person's family.[11]

It is a major factor in most **suicides**. Some 1.3% of all deaths in the world are from suicide[12] – and so are roughly 1% of deaths in the advanced world (see Figure 10.1). And about 90% of people who kill themselves are mentally ill when they do it.[13] Though a half of those who kill themselves are also physically ill, it is generally the mental pain that drives them to suicide: suicide is rare among physically ill people who are not also mentally ill.[14] Successful suicide is more common among men than women, but attempted suicide is the other way around. Almost every suicide is a tragedy – a life lost and a terrible blow to family and friends. And so are the other 'deaths from despair' that are now so common in the United States – the deaths from drug overdose or alcoholic liver disease.[15] There are many resources available to people in despair which they are encouraged to contact.

On physical illness

Mental stress and illness can also shorten life in other ways than suicide. Mental illness makes you more likely to contract all the main **physical diseases**.[16] And people

[10] For English data, see McManus et al. (2016); and Sadler et al. (2018).
[11] See A. E. Clark et al. (2018) Table 6.4.
[12] World Health Organization (2014). https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf.
[13] Barlow and Durand (2009) p. 251; Blumenthal (1988); Barraclough et al. (1974). Sixty per cent of them have depression.
[14] Williams (2001) p. 36. [15] Case and Deaton (2020).
[16] Patten et al. (2008) Table 1. Mentally ill people were also more likely to die. (But the authors warn against possible bias, since positive findings are more likely to get published.) On stroke, see also Pan et al. (2011) Figure 3. On cancer, see also Chida et al. (2008).

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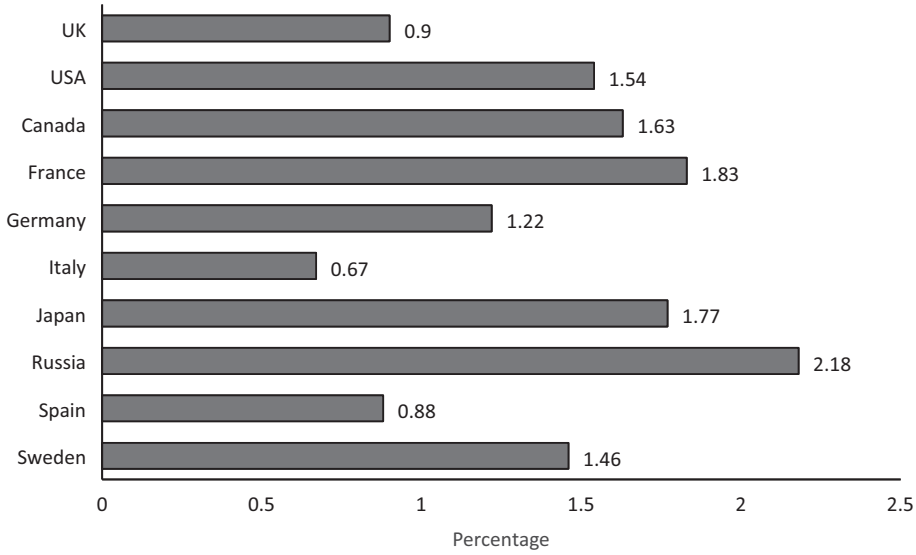

Figure 10.1 Suicide as a percentage of all deaths
Source: Global Burden of Disease Collaborative Network; Global Burden of Disease Study Results (2019); Seattle, United States: Institute for Health Metrics and Evaluation (IHME), http://ghdx.healthdata.org/gbd-results-tool

who are already physically ill are more likely to get worse, if they are also mentally ill.[17] Why is this? There are some obvious channels. Mentally ill people are more likely to smoke and drink, take drugs, overeat and under-exercise. But a huge effect still remains on top of these factors. And the reason for this is that chronic stress changes the body in so many ways, as we saw in Chapter 5.

On the economy

Mental illness also imposes significant **economic costs**. This is because mental illness is mainly a disease of working age, while physical illness mainly occurs in old age. Figure 10.2 shows the percentage reduction in the average quality of life at each age due to mental and physical illness in advanced countries. As the figure shows, among people under 60, one half of all morbidity is due to mental illness.

These facts have huge economic implications.[18] First, disability. In OECD countries, nearly half of all the disabled people who are not working are suffering from mental rather than physical illness. Second, absenteeism. Among people who do have jobs, between a third and a half of all days off sick are due to mental illness. Third, 'presenteeism'. Even if they turn up at work, many mentally ill people are not fully

[17] Satin et al. (2009). See also meta-analyses by Nicholson et al. (2006) for depression and by Roest et al. (2010) for anxiety. For hospital consultations by patients with asthma, see Ahmedani et al. (2013).
[18] On what follows see Layard and Clark (2014) pp. 72, 73, and 86.

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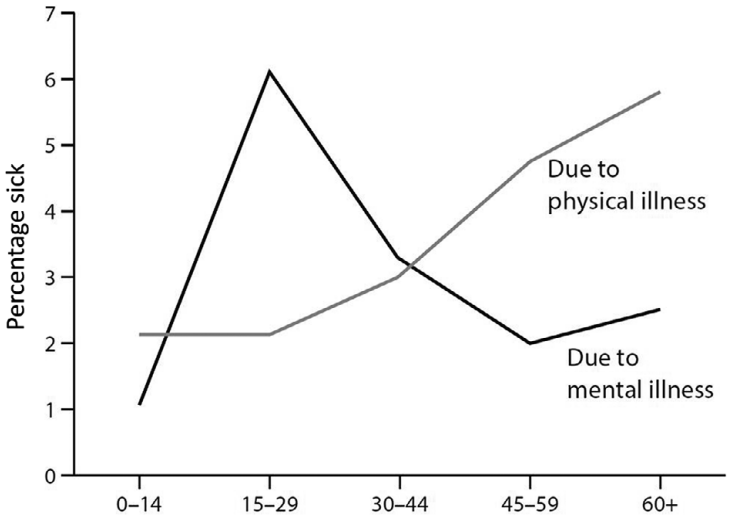

Figure 10.2 Rate of morbidity in different age groups
Source: A. E. Clark et al. (2018) Figure 6.2; based on WHO (2008); Analysis by Michael Parsonage

'there', and this is estimated to cost their employers at least as much as absenteeism. So the economic loss due to mental illness is, according to the OECD, at least 4% of GDP, of which one half is borne by the taxpayer. It follows that, if we treat more mental illness and more people return to work, we can save much money both for taxpayers, businesses and the workers themselves.

The Treatment of Mental Illness

But can we really treat these conditions and help people to recover? The answer is Yes. We now have appropriate treatments for every type of mental health condition, based on the evidence of thousands of randomised controlled trials. The recommended treatments can be found in the **Cochrane Reviews** or in the official guidance produced by England's National Institute for Health and Care Excellence, otherwise known as **NICE**.[19]

Recommended treatments include drugs (for some conditions) and psychological therapy (for all conditions). **Drugs** are recommended for

- schizophrenia (e.g., chlorpromazine)
- bipolar disorder (e.g., lithium)
- severe depression (e.g., Prozac)
- some anxiety disorders (e.g., a benzodiazepine)
- alcoholism (a benzodiazepine to facilitate withdrawal, and naltrexone to reduce craving)

[19] See Layard and Clark (2014), chapters 10 and 13.

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Table 10.1 English government's recommendations for the psychological treatment of depression, anxiety and eating disorders

Condition	Treatment
Depression: moderate to severe	CBT or Interpersonal psychotherapy, each with antidepressants
Depression: mild to moderate	CBT (individual or group)
	Interpersonal psychotherapy
	Behavioural activation
	Behavioural couples therapy
	Counselling for depression
	Short-term psychodynamic therapy
Panic disorder	CBT
Social anxiety disorder	CBT or Short-term psychodynamic therapy
Generalised anxiety disorder	CBT
Obsessive-compulsive disorder	CBT
Post-traumatic stress disorder	CBT, EMDR*
Bulimia	CBT
	Interpersonal psychotherapy
Anorexia	In-patient weight-gain programme
	CBT
	Interpersonal psychotherapy
	Cognitive analytic therapy

*EMDR= eye movement desensitisation reprocessing therapy (considered by many to be a form of CBT).
Source: NICE recommendations

- heroin addiction (e.g., methadone replacement therapy and naltrexone)
- ADHD (Ritalin).

But **psychological therapy** is also recommended to be offered for every condition, Table 10.1 shows the most effective treatments for anxiety disorders and depression. Mental health problems are at the root of many other problems in society – for example, family conflict is often a mental health problem and effective psychological treatments exist, such as Cognitive Behavioural Couple Therapy (CBCT).

Some people argue that it does not matter much which form of therapy is provided – what matters is the skill and character of the **therapist**. But the evidence given in support of this view is not based on randomised trials – it is based on cases selected by therapists.[20] By contrast, when a given therapy is given by a range of different therapists with different characters but all using the same methods and trained to a high standard, the success rates of different therapists are remarkably similar.[21] What makes a large difference is how well the therapists are trained and whether they use the right therapy for each condition.[22] If this is done, at least 50% of patients will recover from most anxiety disorders or depression, after an average of some 10 sessions. For depression, this is the same recovery rate as with drugs, but the relapse rate after psychological therapy is one half that after drugs, unless the drugs continue to be taken.

[20] See Layard and Clark (2014) pp. 125–126. [21] D. M. Clark et al. (2006). [22] D. M. Clark (2018).

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Economic benefits of treatment

So what are the economic costs and benefits of making psychological therapy more widely available? The average cost of therapy per patient is around a half of the average monthly wage in a country. To set against this, the benefits come from two sources. The first is the effect of the therapy on peoples' **ability to work**. The evidence suggests that in a typical group of patients there are at least 4% who would not otherwise have worked but who will now work for at least an extra 25 months.[23] Thus, for the average patient who is treated, the result will be an extra month of work (4% times 25 months). Even if the patient earns only half the average national wage, this is enough to repay the initial cost of the treatment – since, as we have seen, that was also half the average monthly wage. So the overall economic balance is impressive (but the balance for different groups in society, like taxpayers, will be different – depending on how healthcare is financed).

There is also a second major economic benefit – the savings on **physical healthcare**. As we have already seen, mental health affects physical health. And it also affects the amount of physical healthcare a person actually receives. On average, people with given physical symptoms get 50% more physical healthcare if they are also mentally ill.[24] This applies equally to people with breathing problems, heart problems and diabetes. So, if their mental health improves, there are huge savings on their physical healthcare. In all these cases, psychological interventions have been shown to pay for themselves, through the large savings in physical healthcare costs.[25]

The shortfall in mental healthcare

Since treatment produces such large economic savings, one might expect that most people with mental health problems would receive treatment. This is of course what happens when people are physically ill – most of them get treated, at least in rich countries (over 90% of people with diabetes are in treatment). But most people with mental illness are not treated. In England, only 40% of adults with clinical levels of depression or anxiety disorder are in treatment,[26] and in most advanced countries it is less than this.[27] In low- and middle-income countries the **treatment gap** is even worse, with under 10% in treatment. The situation is worse for children: in England only 30% of diagnosable children get specialist treatment,[28] and in poor countries hardly any do so.

Moreover, for adults, the main form of treatment is medication – drugs of one sort or another. Few get evidence-based psychological therapy. For example, in England in

[23] Proudfoot et al. (1997); Wells et al. (2000); Rollman et al. (2005); D. M. Clark et al. (2009); Fournier et al. (2014); Toffolutti et al. (2019).
[24] Katon (2003); Hutter et al. (2010); Naylor et al. (2012) p. 11.
[25] Chiles et al. (1999); Chisholm et al. (2016); D. M. Clark (2018); Gruber et al. (2019).
[26] McManus et al. (2016). [27] Chisholm et al. (2016).
[28] Sadler et al. (2018) give a figure of 25% for 2016 but more up-to-date information suggests 30%. For the United States, the Center for Disease Control report a figure of 20%.

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2014 only 12% of adults with depression or anxiety were receiving any. Yet psychological therapy is what the majority of them would prefer.[29]

Many celebrities, including sports stars and the British royal family have drawn attention to the low rate of treatment for mental illness. So what accounts for it? There are three main reasons. The first is **stigma** and the nature of the illness itself. People are often ashamed of having mental health problems, and so are their family. They frequently feel is it their fault. By contrast, most people feel that physical illness is something that just happens to you. So, there is much more public pressure for better cancer care than for better mental health care.

Second, most people do not realise what effective treatments we now have for most mental health problems. This is a case of **technological lag**. This lag is also one reason for the stigma – if you cannot be cured, many people will avoid you. But as people come to realise that effective treatments exist, the stigma will be reduced.

And there is a third reason for under-treatment – the slothful response of healthcare providers and insurers. Insurance companies often offer to pay for only 6 sessions of treatment – like paying for half a surgical operation. There is a simple principle that should apply to both mental and physical illness, which is '**parity of esteem**'. This means that a person who is mentally ill should be as likely to receive state-of-the-art treatment as someone who is physically ill.

Effective mental health services

How to achieve this ambition will depend on each country's system of providing healthcare. But in any system, there are four essential ingredients:

(1) clear decisions about which treatments are to be offered for which conditions,
(2) a system of training therapists to deliver these treatments,
(3) a network of services where the treatments are provided and
(4) monitoring of each patient's progress in order to guide treatment and to know what the service is achieving.

Good examples of such systems exist around the world. For example, in England, the **Improving Access to Psychological Therapies (IAPT)** programme began in 2008.[30] By 2021, it employed some 9,000 psychological therapists, mostly trained within the system, and it treated over 640,000 people a year for depression or anxiety disorders.[31] Over half of them recovered after an average of 7–8 sessions of treatment. Its system is now being copied in at least six other countries.

Another model bases most of the treatment in primary care – closer to the family doctor. A good example of this is Chile's **National Depression Detection and**

[29] See, for example, Chilvers et al. (2001); van Schaik et al. (2004); Deacon and Abramowitz (2005); McHugh et al. (2013). In England, NICE guidelines say that psychological therapy should be offered for all types of mental illness.
[30] D. M. Clark (2018).
[31] NHS Digital (2021). https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2020-21.

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Treatment Program. Here treatment is organised by the family doctor and includes medication as well as psychological therapy. In poorer countries, the most feasible approach is to train general healthcare staff in the rudiments of diagnosing and treating mental health problems.[32] Trials show that such an approach can deliver good results, and this is the approach pursued in six poorer countries belonging to the EMERALD consortium.[33]

Clearly similar principles should apply to the treatment of **children** as of adults. There are good evidence-based treatments for all the main conditions in childhood, and it makes no sense if people with mental health problems have to wait until adulthood to get their treatment. For example, social phobia generally starts in childhood. But in the United States, half the people with it never get treated, and those who do get treated have already lived with the problem for, on average, 25 years.[34]

Up to now, most psychological treatment has been delivered face to face. But this is changing rapidly, due to the **digital revolution** and the experience of COVID-19. One change is the use of online video platforms like Zoom to conduct one-on-one therapy. This is often more convenient[35] but it leaves the economics of the therapy unchanged. A more revolutionary innovation is computerised treatment – supported by brief telephone or Zoom contacts with a live therapist. For example, there is a face-to-face treatment for social phobia with an 80% recovery rate. But it has also now been put into an audio-visual form online (supported by much less time of telephone assistance from a live therapist). The recovery rate is not significantly lower.[36] As more and more therapies are put online, the prospects for mentally ill people worldwide will be transformed – especially if the programmes are free.

Physical Illness – Pain and Shortened Lives

Let us turn to **physical illness**. This reduces wellbeing by causing pain and restricting activity. And it shortens life.

A quarter of the world's population report (in the Gallup World Poll) that they experienced a lot of **physical pain** yesterday.[37] And the importance of pain is illustrated in a pioneering US time-use study.[38] A representative sample of American adults were asked to reconstruct the previous day into episodes, and then in each episode they were asked to say to what extent they experienced pain of any kind, on a scale of 0–6 (0 not at all, 6 very strong). This made it possible to compile for each person what percentage of time in the previous day they had spent in any sort of pain (and separately what percentage they had spent in serious pain at levels 4–6).

[32] Singla et al. (2017). [33] Semrau et al. (2015). [34] Wang et al. (2005) Figure 2.
[35] In IAPT, the total number of sessions given by the programme was undiminished during the COVID-19 lockdown, as was patients' recovery rate.
[36] See also Andersson (2016). [37] Macchia and Oswald (2021). [38] Krueger and Stone (2008).

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Table 10.2 The experience of pain: By people with different levels of life satisfaction (United States)

Satisfaction with life	Average % of time in any pain	Average % of time in extreme pain
Very satisfied	22	8
Satisfied	29	12
Not satisfied	41	24
Not at all satisfied	54	36
All	29	11
Under 20	21	7
Age 80–89	35	15

Source: Krueger and Stone (2008)
Note: Extreme pain is levels 4–6 (on a scale of 0–6).

As Table 10.2 shows, people with high life satisfaction spent less time in pain, and vice versa. There is probably causation in both directions. But the table is important in showing the strong connection between high life satisfaction and the absence of pain.[39]

Physical health also affects how long you live. One of the greatest inequalities is the inequality in the length of life. The standard deviation of the age of death in England is now 14 years. But this compares with 29 years a century earlier. So the coefficient of variation (SD/mean) of length of life is about 0.17, which compares with the coefficient of variation of life satisfaction which is about 0.27.

Health Policy-Making

Clearly, to judge a situation we need to take into account the length of people's lives as well as the quality of their life. And when we evaluate a policy (such as a healthcare plan) we need to take into account both the length and quality of life. How?

This dilemma faces policy-makers on a daily basis. Suppose, for example, that a healthcare provider has enough money to treat either

(A) 100 cancer patients with a drug that will extend their lives by 1 year at a wellbeing level of 6 or
(B) 100 depressed patients with a therapy that will raise their wellbeing for 20 years from an average of 6 to an average of 6.5.

Which should she do?

The wellbeing approach says that what matters is the total effect on wellbeing. As we put it in Chapter 2 (and ignoring discounting), social welfare looking forward is

$$S = \sum_i \sum_t W_{it} \tag{1}$$

[39] Men and women experience similar levels of pain.

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and the test of a policy is the size of its impact on social welfare, given by

$$\Delta S = \sum_i \sum_t \Delta W_{it}. \quad (2)$$

In our example, the impacts on social welfare from the two alternative policies are

A : $100 \times 1 \times 6 = 600$
B : $100 \times 20 \times 0.5 = 1000$.

The first policy produces 600 more Wellbeing-Years or WELLBYs. The second produces 1,000 more. It is therefore more desirable.

A similar approach to this has been used by health planners in many countries for many years. It is known as the 'QALY' approach. So the aim of the healthcare system is to produce the largest number of '**Quality-Adjusted Life-Years**' **(QALYs)**. This is very similar to the approach advocated in Chapter 2 where the aim of all public policy is to produce the largest number of Wellbeing-Years. But QALYs are generally limited to the so-called health-related quality of life.

The guidelines from England's NICE then recommend treatments for which the cost per QALY is less than about $40,000. In this analysis, the quality-of-life is measured on a scale of 0–1, with 1 corresponding to normal healthy life, whereas in our analysis, wellbeing is measured on a scale of 0–10, with 7.5 corresponding to a normal healthy life. But the basic approach is the same: once a person is dead, their score is 0. They contribute nothing to social welfare. The World Health Organisation has a similar approach. They talk in terms of '**Disability-Adjusted Life Years**' **(DALYs)**, but that means almost the same as Quality-Adjusted Life Years.

But how, you might ask, do NICE or the WHO actually measure the quality of life associated with each illness? WHO uses panels of doctors to determine the point between 0 and 1 corresponding to each illness. NICE asks members of the public the following 'time trade-off' question, 'Suppose you faced 10 years of life with this illness. How many years of healthy life would be of equal value to you as those 10 years of illness?' If the answer is 8 years, the QALY value for that condition (on the scale 0–1) is 0.8. Neither the WHO nor the NICE method is completely satisfying. Wellbeing science can provide a more direct approach by just asking people with each illness how satisfied they are with their lives.[40] This research has yet to be done but in this view health policy should ultimately be based on WELLBYs including impacts on the family.

Finally, let's return to the big picture of human progress. As we showed in Chapter 6, there has been little progress in average wellbeing worldwide since 2006/8. But there have been huge advances in life expectancy – from 68.7 back then to 72.4 in 2017/19. These gains in life expectancy have been particularly high in sub-Saharan Africa (7 years), the former Soviet Union (5 years) and Asia (3 years). Much of this is due to improved public health and physical healthcare.

[40] Dolan and Kahneman (2008).

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Conclusions

- Mental and physical illness are intimately related. Both cause pain in the same area of the brain and reduce our ability to function normally.
- Some 20% of the population would be diagnosed as having a mental illness. But in most advanced countries under a third of them are in treatment (mostly medication).
- Though severe conditions require medication, evidence-based psychological treatment is recommended for all conditions. With recovery rates of at least 50%, these treatments are highly cost-effective, because they enable many more people to work productively and they also reduce the demand for costly physical healthcare.
- Physical pain is an important determinant of life satisfaction. Physical health also prolongs life.
- To evaluate any healthcare-intervention, its benefits should be measured in WELLBYs. These need to be high enough relative to the cost.

Questions for discussion

(1) Does the concept of mental illness make sense? How does it differ from low mood due to objective external circumstances?
(2) How important is the correct diagnosis of mental illness?
(3) Are online treatments likely to be of much use for mental illness or is the quality of the therapist crucial?
(4) Why is so much mental illness untreated?
(5) In this chapter, is it claimed that in a group of depressed or anxious people treated with psychological therapy, there will be 4% who would not otherwise work who will now work for at least an extra 25 months – or equivalently there will be an average increase in work of 1 month per person treated. Does the evidence cited in note 23 convince you of that?
(6) Do you agree with the WELLBY measure of social welfare as a good basis for policy evaluation?
(7) How important is it to keep people alive at very high cost if this will only provide a very low quality of life? Should it be legal to assist a terminally ill person in pain to end their own life?

Further Reading

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