Chapter 1

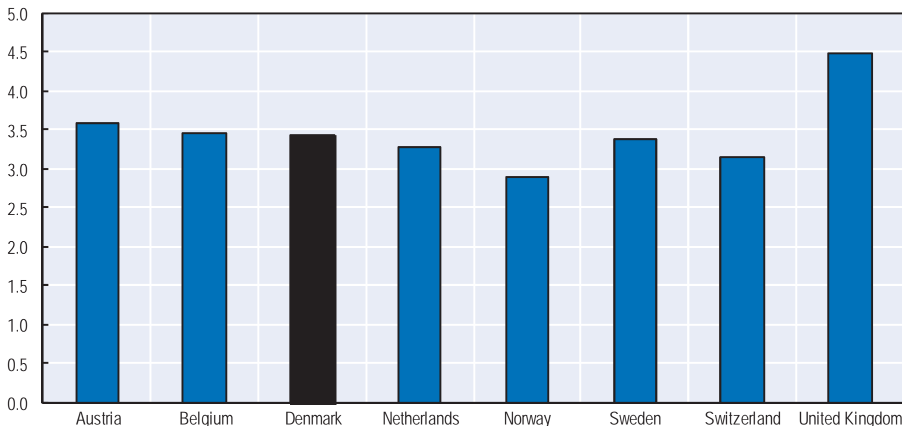
Mental health and work challenges in Denmark

This chapter discusses the current labour market performance of people with a mental disorder in Denmark compared to other countries in terms of their employment and unemployment situation, with a view on sickness absence and reduced productivity of those working. Building on the findings in the 2011 OECD report "Sick on the Job?" *it highlights the key challenges ahead, such as the high share of people on different social benefits who suffer from a mental health condition. The chapter also provides a description of the Danish benefit system and Danish employment policy and discusses the role of different levels of government.*

Mental ill-health poses enormous challenges for the well-functioning of labour market and social policies in Denmark as much as in other OECD countries. These challenges have not been addressed adequately so far, reflecting widespread stigma and taboos. The total estimated costs of mental ill-health for the Danish economy are large at 3.4% of GDP, which puts Denmark near the middle of the cost-range in the group of eight OECD countries shown in Figure 1.1.[1] Indirect costs in the form of lost employment and reduced performance and productivity are much higher than the direct healthcare costs: based on comprehensive cost estimates in Gustavsson *et al.* (2011), indirect costs, direct medical costs and direct non-medical costs amount to 53%, 36% and 11%, respectively, of the total costs of mental disorders for the economy.

Figure 1.1. **Mental disorders are very costly to society**

Costs of mental disorders as a percentage of the country's GDP, 2010



Note: Costs estimates in this study were prepared on a disease-by-disease basis, covering all major mental disorders as well as brain disorders. This chart includes mental disorders only.

Source: OECD compilation based on Gustavsson A. M. Svensson, F. Jacobi *et al*. (2011), "Cost of Disorders of the Brain in Europe 2010", *European Neuropsychopharmacology,* Vol. 21, pp. 718-779 for cost estimates and Eurostat for GDP.

Introduction: definitions and objectives

The OECD report *Sick on the Job? Myths and Realities about Mental and Work* concluded that a three-fold shift in policy is required to respond effectively to the challenges of ensuring greater labour market inclusion of people with mental illness (OECD, 2012a). More attention needs to be given to *i)* mild and moderate mental disorders as opposed to severe disorders;

ii) disorders concerning the employed and unemployed; and *iii)* preventing instead of reacting to problems arising from mental health issues.

Mental disorder in this report is defined as mental illness reaching the clinical threshold of a diagnosis according to psychiatric classification systems such as the International Classification of Disease (ICD-10) which is in use since the mid-1990s (ICD-11 is currently in preparation). Based on this definition, at any moment some 20% of the working-age population in the average OECD country is suffering from a mental disorder, with lifetime prevalence reaching 40-50% (Box 1.1).

Understanding the characteristics of mental ill-health is critical for devising the right policies. The key attributes of a mental disorder are: an early age at onset; its severity; its persistence and chronicity; a high rate of recurrence; and a frequent co-existence with physical or other mental illnesses. The more severe, persistent and co-morbid the illness, the greater is the degree of disability associated with the mental disorder and the potential impact on the person's work capacity.[2]

One important general challenge for policy makers is the very high rate of non-awareness, non-disclosure and non-identification of mental disorders – which is directly linked with the stigma attached to mental illness. It is also not clear that better and earlier identification would improve outcomes in all cases or might instead contribute to stereotyping and stigmatisation. This implies that reaching out to people with a mental disorder is more important than merely labelling them as suffering from a mental illness and policies that avoid labelling might sometimes work best.

The OECD report *Sick on the Job* identified two main directions for reform. First, more emphasis needs to be given to preventing problems; identifying needs; and intervening at key stages of the lifecycle, including during the transition from school to work, at the workplace, and when people are about to lose their job or to move into the benefit system. Secondly, a coherent approach across government services needs to be taken which integrates health, employment and, where necessary, other social services.

This report examines how policies and institutions in Denmark are addressing the challenge of ensuring that mental ill-health does not mean exclusion from employment and that work itself contributes to better mental health. A number of specific issues are addressed. How are the critical institutions and stakeholders – schools, employers, employment services, social services and psychiatric services – organised and resourced to identify people with a mental disorder? What is done and how quickly when a problem has been identified, and what is done more generally without stigmatising those in need? How are the different actors co-operating and how are different

services integrated to ensure people get the right services quickly to access the labour market, remain in their job or return to employment?

Box 1.1. **The measurement of mental disorders**

Administrative clinical data and data on disability benefit recipients generally include a classification code on the diagnosis of a patient or benefit recipient, based on ICD-10, and hence the existence of a mental disorder can be identified. This is also the case in Denmark. However, administrative data do not include detailed information on an individual's social and economic status and they cover only a fraction of all people with a mental disorder.

On the contrary, survey data can provide a rich source of information on socio-economic variables, but in most cases only include *subjective* information on the mental health status of the surveyed population. Nevertheless, the existence of a mental disorder can be measured in such surveys through a mental health instrument, which consists of a set of questions on aspects such as irritability, nervousness, sleeplessness, hopelessness, happiness, worthlessness, and the like, with higher values indicating poorer mental health. For the purposes of the OECD review on *Mental Health and Work*, drawing on consistent findings from epidemiological research across OECD countries, the 20% of the population with the highest values according to the instrument used in each country's survey is classified as having a mental disorder in a clinical sense, with those 5% with the highest value categorised as "severe" and the remaining 15% as "mild and moderate" or "common" mental disorder.

This methodology allows comparisons across different mental health instruments used in different surveys and countries. See *www.oecd.org/els/disability* and OECD (2012a) for a more detailed description and justification of this approach and its possible implications. Importantly the aim here is to measure and compare the social and labour market outcomes of people with a mental disorder, not the prevalence of mental disorders as such. For this report on Denmark, data from four different population surveys are used:

1. The *Danish National Health Interview Survey* (SUSY) for 1994, 2000 and 2005 (the 2010 round is not used because of several changes in definitions) where the mental disorder variable is based on the mental health and vitality items of the SF-12 scale, developed to measure quality of life and health.
2. The *Eurobarometer* for 2005 and 2010 where the mental disorder variable is based on a set of nine items: feeling full of life, feeling tense, feeling down, feeling calm and peaceful, having lots of energy, feeling downhearted and depressed, feeling worn out, feeling happy, feeling tired.
3. The *Survey of Health, Ageing and Retirement in Europe* (SHARE) for 2004 and 2006 where the mental disorder variable is based on the EURO-D depression scale, which is built on 12 items: depression, pessimism, suicidal feelings, guilt, sleep, interest, irritability, appetite, fatigue, concentration, enjoyment, and tearfulness.
4. The *European Working Conditions Survey* (EWCS) for 2010 where the mental disorder variable is based on a set of five items: feeling cheerful; feeling calm; feeling active; waking up fresh and rested; and life fulfilment.

The structure of the report is as follows. This first chapter sets the scene by looking at key labour market outcomes for people with a mental disorder, in Denmark compared with other countries, and describing the main systems catering for people with mental illness and the responsibility of different government levels. This is followed by chapters which look consecutively at the policy challenges Denmark is facing at a number of critical stages of a person's lifecycle, including: the period before a young person enters the job market; time spent at work and interventions happening under the responsibility of the employer; and when a person is at risk of leaving the labour market and entering the benefit system or is seeking to return to work. The last chapter examines the role and contribution of the health system in dealing with mental ill-health at each of these stages of the lifecycle. Each chapter concludes with specific policy recommendations.

The outcomes: where Denmark stands

Denmark was hit hard by the recent economic downturn. The country endured an unprecedented drop in production (output fell by 8% from peak to trough) and in 2011, GDP was still below its 2006 level (OECD, 2012b). Economic contraction translated into significant jobs losses. Unemployment rates have reached a 20-year peak, with a rate of 7.7% in 2011, and they more than doubled for young people. Long-term unemployment also increased to around one quarter. The situation has stabilised lately but it has not improved yet. The employment-population ratio also fell but remains high by international standards for all age groups (Table 1.1).

Table 1.1. **Denmark's labour market was hit hard by the Great Recession**

Employment and unemployment indicators for selected OECD countries, 2000 and 2011

	Employment population ratio				Unemployment rate				Long term unemployment		Temporary work		Part-time work	
	15-64		15-24		15-64		15-24							
	2000	2011	2000	2011	2000	2011	2000	2011	2000	2011	2000	2011	2000	2011
Australia	69.3	72.7	62.1	60.7	6.4	5.2	12.1	11.3	28.3	18.9	4.8	5.2	23.7	24.7
Austria	68.3	72.1	52.8	54.9	3.5	4.2	5.1	8.3	25.8	25.9	7.9	9.6	12.2	18.9
Belgium	60.9	61.9	30.3	26.0	6.6	7.2	15.2	18.7	56.3	48.3	9.0	9.0	19.0	18.8
Denmark	**76.4**	**73.1**	**67.1**	**57.5**	**4.5**	**7.7**	**6.7**	**14.2**	**20.0**	**24.4**	**10.2**	**8.8**	**16.1**	**19.2**
Netherlands	72.1	74.9	66.5	63.6	3.1	4.4	6.1	7.7	43.5	33.6	14.0	18.4	32.1	37.2
Norway	77.9	75.3	58.1	51.4	3.5	3.3	10.2	8.6	5.3	11.6	9.3	7.9	20.2	20.0
Sweden	74.3	74.1	46.7	40.4	5.9	7.6	11.7	22.9	26.4	17.2	15.2	16.4	14.0	13.8
Switzerland	78.4	79.3	65.1	62.9	2.7	4.2	4.9	7.7	29.0	38.8	11.5	12.9	24.4	25.9
United Kingdom	72.2	70.4	61.5	50.1	5.5	8.0	11.7	20.0	28.0	33.4	6.8	6.2	23.0	24.6
United States	74.1	66.6	59.7	45.5	4.0	9.1	9.3	17.3	6.0	31.3	4.0	4.2	12.6	12.6
OECD	65.4	64.8	45.5	39.5	6.3	8.2	12.1	16.2	30.8	33.6	11.3	12.0	11.9	16.5

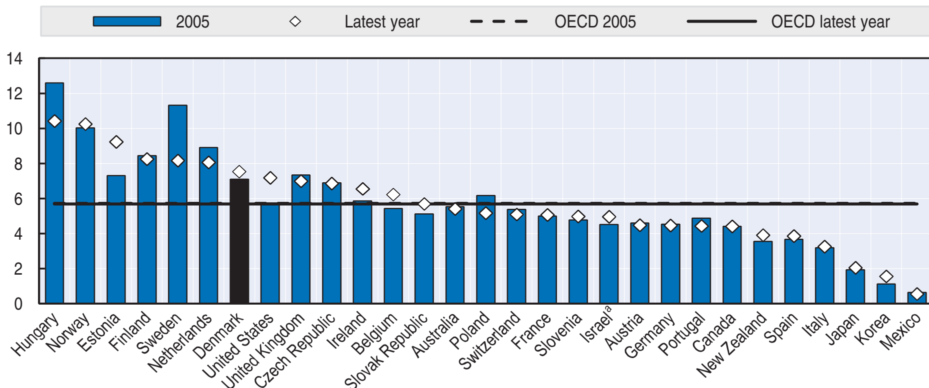
Note: Long-term unemployment data for the Netherlands refer to 1999 instead of 2000, part-time employment data for Australia to 2001 instead of 2000 and for temporary work, to 2001 and 2006 for Australia and to 2001 and 2005 for the United States.

Source: OECD Online Employment Database, www.oecd.org/employment/database.

At the same time, Denmark is among those OECD countries with a very high disability benefit caseload (Figure 1.2), and more generally with large numbers receiving health-related benefits of different kinds: high and stable numbers on disability benefit, high numbers on long-term sickness benefit, and increasing numbers on highly subsidised flexjobs and a special benefit (the so-called waiting allowance) for people waiting to be placed into such jobs (Figure 1.3). This implies that the situation today is one of high (largely cyclical) unemployment *and* high (structural) health-related inactivity. There is, however, a risk that the high rate of unemployment will push the disability benefit issue to the back of the reform agenda. Policy makers will have to resist this.

Figure 1.2. **The disability benefit caseload is comparatively high in Denmark**

Recipients of disability benefits as a proportion of the population aged 20-64, 2005 and 2010 (or latest year available)



Note: OECD is an unweighted average of the countries shown.

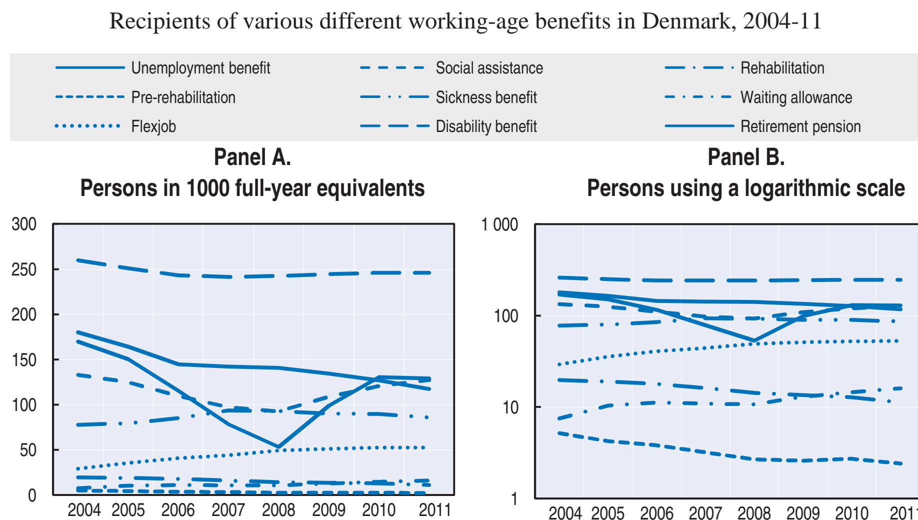
a. Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

Source: OECD questionnaire on mental health.

How is the high rate of disability benefit receipt in Denmark linked to mental ill-health? First, across the OECD today a very large share of all new disability benefit claims is by people with a mental disorder; in Denmark, one of the "vanguard" countries in this regard, almost every second claim is now coming from this group (Figure 1.4). Importantly, those claimants tend to be further away from the labour market and more likely than others to access disability benefits after periods of long and repeated unemployment. OECD (2012a) concluded that this shift in the structure of new disability claims towards mental disorders is partly the consequence of a better awareness of such disorders, especially among people with a co-morbid somatic disorder, and the often false interpretation that such disorders would cause high and permanent work incapacity.

Figure 1.3. **The number of people receiving health-related benefits has changed very little in the past few years**

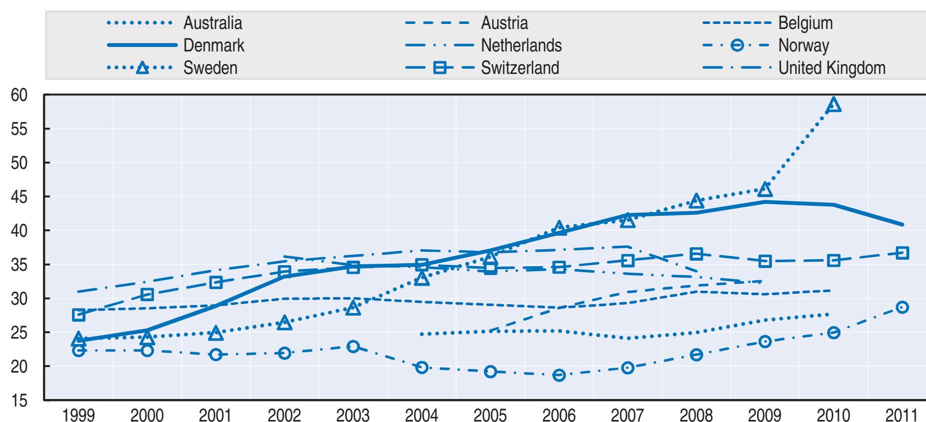
Recipients of various different working-age benefits in Denmark, 2004-11



Source: OECD calculations based on the Jobindsats Database.

Figure 1.4. **Disability benefit claims with a mental disorder are increasing**

New disability benefit claims with a mental disorder in % of all new claims, 1999-2011



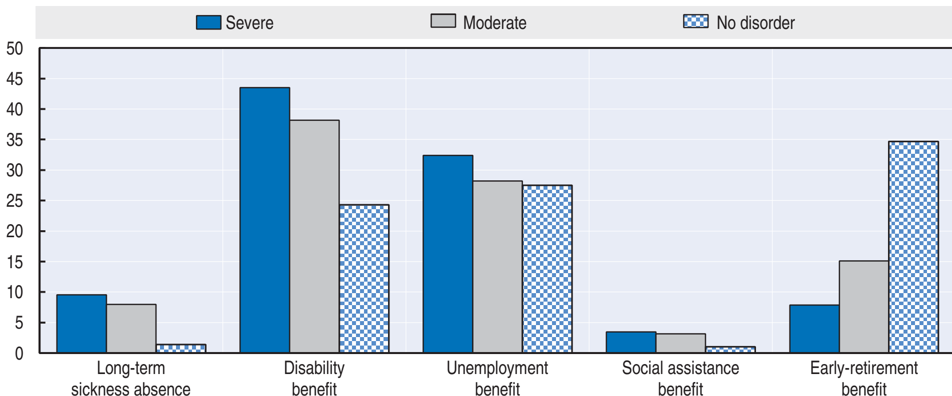
Note: Data for Norway do not include the temporary disability benefit. Belgium, the Netherlands and Sweden include mental retardation, organic and unspecified disorders which account for 13.4% of all mental-disorder inflows on average in countries where data allow identification of these subgroups.

Source: OECD questionnaire on mental health.

Secondly, there is a strong link between mental ill-health and the benefit system in so far as people with a mental disorder receive a range of different working-age benefits. Figure 1.5, based on Danish Health Interview Survey data for 2005,[3] suggests of all those with a severe mental disorder who receive a benefit, some 43% receive a disability benefit and some 33% an unemployment benefit (the corresponding figures are 5 percentage points lower for those with a common mental disorder). People with no mental disorder receive early retirement benefits much more often. The 2005 data also imply that, taken as a whole, people with a mental disorder (either severe or common) are almost twice as likely to receive some working-age benefit compared with people with no mental disorder.

Figure 1.5. **People with a mental disorder receive various working-age benefits**

Proportion of different working-age benefits for people who receive a benefit, by mental health status, 2005



Source: Danish Health Interview Survey (SUSY).

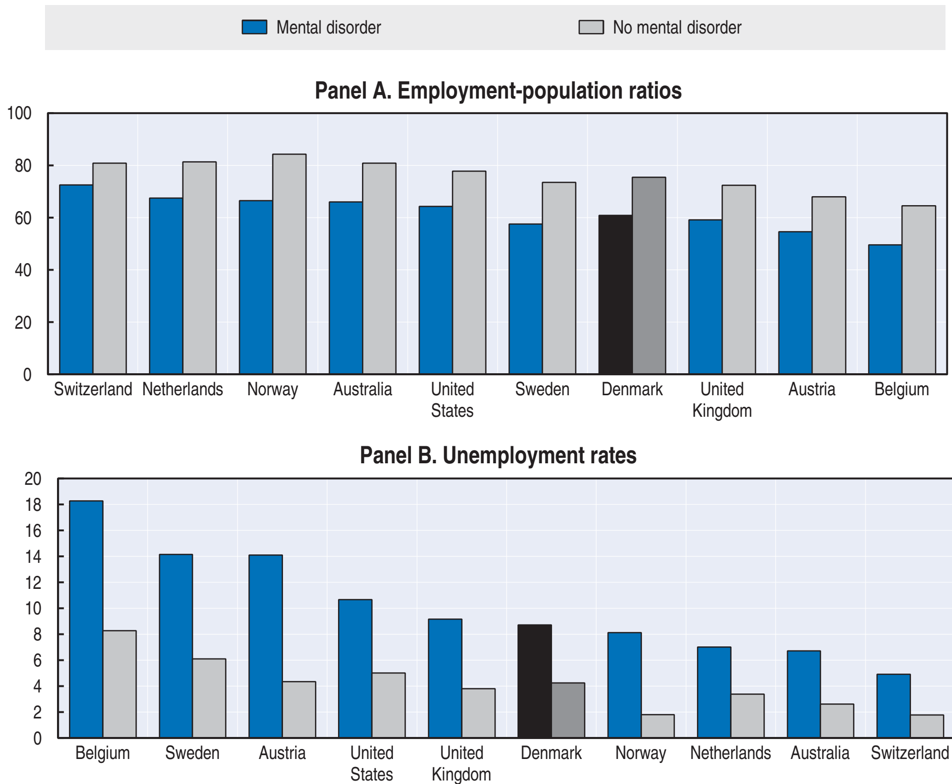
Consequently, many people with a mental disorder are unemployed. Across a range of OECD countries including Denmark, the unemployment rate of people with a mental disorder is consistently two to three times higher than for those with no such disorder – suggesting that many more of them would like to work (Figure 1.6, Panel B). The unemployment gap is related to the fact that people with a mental disorder are more likely both to be dismissed involuntarily and to quit their job voluntarily (OECD, 2012a).

That said, the employment rate of people with a mental disorder (which is a large group of about one-fifth of the population) is relatively high: around 60% in Denmark and closer to 65-70% in some high-employment countries, implying an employment gap with regard to people without a mental disorder in the order of 15 percentage points (Figure 1.6, Panel A).

Added to this, in Denmark but also in most other countries employment rates have increased less in the "past" ten years (1994-2005; *i.e.* before the jobs crisis) for people with a mental disorder than for those without and, similarly, unemployment rates have fallen less (OECD, 2012a; no data available as yet for years after the recent economic downturn).

Figure 1.6. **People with a mental disorder face considerable labour market disadvantage**

Employment and unemployment rates for people with and without a mental disorder, late 2000s

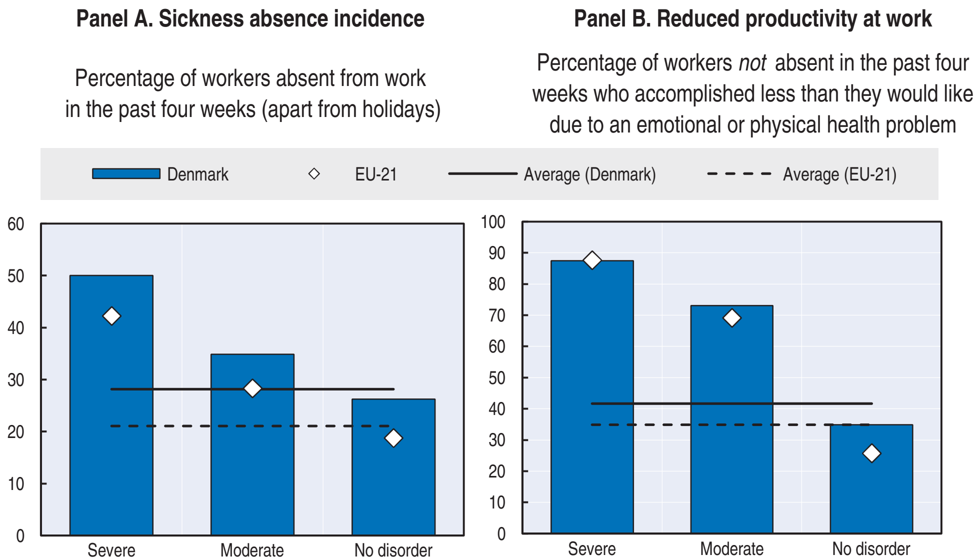


Source: OECD calculations based on national health surveys. Australia: National Health Survey 2007/08; Austria: Health Interview Survey 2006/07; Belgium: Health Interview Survey 2008; Denmark: National Health Interview Survey 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Survey on Living Conditions 2009/10; Switzerland: Health Survey 2007; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

With so many people with a mental disorder in work, a main question is how they are doing at work. As Figure 1.7 shows, this group is facing major problems on their job. People with a mental disorder take more sick leaves

and, more critically, report performance problems while at work far more frequently. Denmark is no different in this regard from other OECD countries, with around 90% and 70% of those with a severe and moderate mental disorder, respectively, reporting performance problems, compared with 30% of their peers without a mental disorder (Panel B). On the contrary, it appears that sickness absence is systematically higher in Denmark than in the EU average across all three groups (Panel A).

Figure 1.7. **Workers with a mental disorder report major problems on their job**



Source: OECD calculations based on Eurobarometer 2010.

The employment disadvantage also translates into a quite considerable income disadvantage. The poverty risk for people with a mental disorder reaches 20-30% in many OECD countries including Denmark. The low-income gap is larger in Denmark than in many other OECD countries, with the poverty risk being almost twice as high as for people without a mental disorder (Figure 1.8).

In conclusion, the biggest and in many ways intertwined labour market challenges for Denmark include:

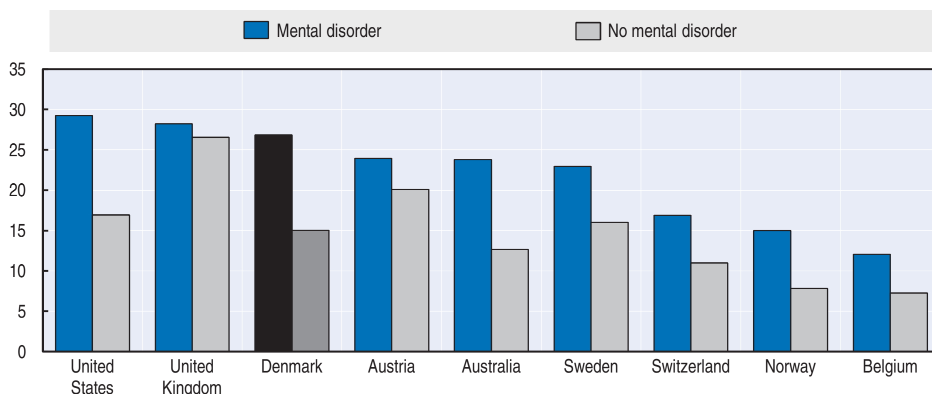
- The concurrence of high unemployment and high disability benefit receipt.
- The high frequency of mental disorders among those on these benefits.

- The employment disadvantage of those with a mental disorder.
- The on-the-job performance problems of people with a mental disorder who are employed.

How these challenges are being addressed by Danish policies and institutions is the focus of this report, following some basic description of relevant systems and institutions in the next section of this chapter. It should be noted that no hard facts are available yet on the impact of the recent economic downturn and the resulting jobs crisis on, first, the mental health status of the working and unemployed population and, secondly, the labour market chances of those with a mental disorder.

Figure 1.8. **Having a mental disorder is a major risk factor for low income**

Percentage of people with household-equivalised income below 60% of median income of the working-age population, latest available year



Source: OECD calculations based on national health surveys (NHS) or interview (HIS) surveys. Australia: NHS 2007/08; Austria: HIS 2006/07; Belgium: HIS 2008; Denmark: NHIS 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Living Conditions Survey 2009/10; Switzerland: Health Survey 2007; United Kingdom: Health Survey for England, 2006; United States: NHIS 2008.

The context: systems, institutions and governments

The Danish benefit system

Labour market policy making in Denmark needs to be seen against the backdrop of its well-known *flexicurity* approach, which is characterised by a combination of three pillars: moderate employment or job protection; high and accessible unemployment benefits; and a strong focus on active labour market programmes. The ease of hiring and firing in Denmark relative to many other OECD countries means that people with a mild or moderate mental disorder are likely to oscillate more frequently than less

disadvantaged workers between employment and unemployment. They may therefore have been particularly vulnerable to job loss following the 2008 global economic and financial crisis as unemployment rose more steeply in Denmark than in many other OECD countries.

Beginning with the previous government (acting until mid-2011) and as continued by the new government, a number of steps are being taken to reform Denmark's flexicurity system. In mid-2012 the duration of unemployment benefit payments was reduced from four years to two years, thereby reducing significantly the generosity of the unemployment benefit system. After two years, the unemployed will be moved onto means-tested social assistance payments. Moreover, further measures are being introduced to activate people on health-related benefits – by attempts to reform more comprehensively both the disability benefit system and the scheme of flexjobs (subsidised jobs for those with a reduced work capacity).

The Danish benefit system has four pillars (Box 1.2): two largely unemployment-related schemes, unemployment insurance benefit and social assistance; and two *main* health-related schemes, sickness benefit and disability benefit (the latter being the most "important" of all benefits when measured in full-year-equivalent recipients; Figure 1.3). In addition there are four *smaller* health-related schemes: rehabilitation benefit, aimed at re-establishing the person's work capacity; pre-rehabilitation benefit to prepare a person for rehabilitation; flexjob benefit, a wage subsidy for those with reduced work capacity; and waiting allowance, a special benefit for those waiting to be placed in a subsidised flexjob.

The other two flexicurity pillars are also well documented. First, the OECD index of employment protection legislation (EPL) suggests that Denmark is among those countries with the least strict EPL, with much lesser protection than its Nordic neighbours especially in relation to individual dismissal of permanent workers (Venn, 2009). Secondly, Denmark is among the countries with the highest income-replacement rates for those who are unemployed, for both the shorter-term and the longer-term unemployed (OECD Benefits and Wages Indicators). The recent cut in the unemployment benefit payment duration from four years to two years will have a significant impact in reducing generosity for singles but not for couples and not those with children more generally.

Box 1.2. **Characteristics of selected Danish benefit schemes**

Unemployment insurance is a voluntary system, requiring membership in an unemployment insurance fund and paying membership fees for at least 52 weeks in the past three years. Currently, only around three in four of the labour force (both employees and self-employed) are insured – this share being lowest and falling fastest recently among younger workers. To re-qualify for benefit, 26 weeks must be spent in paid employment within a three-year period. Eligibility requires to register as a jobseeker with the municipal job centre and to be available and actively looking for work. Activation requirements include weekly confirmation (to the fund) of still being unemployed and available for the labour market and regular interviews with the job centre. Unemployment benefit is paid for two within six years (previously four within six years), with a three-week waiting period in case of voluntary job quit. Payment amounts to 90% of previous earnings but within a narrow minimum and maximum; the latter is worth a bit over 50% of the average wage and the minimum is about 82% of the maximum benefit.

Social assistance ("cash benefit") is a tax-financed benefit of last resort for people who experience a "social risk event" such as unemployment. For people who are ready for the labour market, job search is a prerequisite for eligibility, while other groups have to satisfy other conditions such as treatment and/or activation. Payment rates which depend on age (those under 25 years receive less than those 25 years and older) correspond to roughly 60% and 80% respectively of the maximum unemployment insurance benefit for a single person with and without dependent children (payment rates are calculated for the individual, *i.e.* a married couple can get twice this amount).

Sickness benefit is tax-financed and covers the entire active population with only minor eligibility requirements, including people who receive unemployment benefit or hold a flexjob. Benefits are payable for up to one year in 18 months, with occasional extension by up to six months. Payments are earnings-related, with the maximum payment being equal to the maximum unemployment benefit. Via collective agreements, however, most employees receive a full-wage payment for a considerable period, typically several weeks for blue-collar workers and even up to one year for white-collar workers. Payment of a partial sickness benefit is possible and more frequent recently.

Disability benefit is tax-financed and residence-based. Benefits are permanent flat-rate payments corresponding to almost 70% of net earnings on average, with the full benefit rate for a single person with 40 years of residence being worth 90% of net earnings (with a pro-rata reduction with less than 40 years of residence). Benefit eligibility requires that the person is unable to work in a subsidised flexjob, as determined by a resource profile based on the person's health but also many other life domains. There is no partial disability benefit (the earlier existing graduation by degree of capacity was abolished in 2003) but payments can be accumulated with earnings in a rather generous way.

In conclusion, the net replacement rate on disability benefit is much more generous than on the other main benefits, providing a strong financial incentive (and no activation threat) to get on a disability benefit. Rehab and pre-rehab benefits and waiting allowance provide similarly high payment rates, and flexjob subsidies can be even higher than this.

The responsibilities of different government levels

The key role of the Danish municipalities

Denmark has three rather independent government levels all involved in social, health and labour market policy making and policy implementation: the municipalities, the regions and the state – with the guiding principle in determining responsibility being to provide services at the lowest possible level. Each of the three government levels has different roles, with a range of regulations to control actions and provide incentives to implement policies as intended.

Social and labour market policy is predominantly in the hands of the 98 municipalities, the average size of which has changed recently as a consequence of local government reform (Box 1.3). Municipalities deliver policies through several service units: the job centre, which is responsible for all employment matters and services for all clients, and different benefit units. This setup opens a lot of possibilities for co-ordinated one-stop-shop actions even though benefit units can be quite isolated from the job centre and social and employment services are also split up. The full responsibility of the job centre for all clients irrespective of their benefit status and labour market distance implies that all jobseekers with a mental disorder have a chance to be treated equally. Moreover, the separation of benefit units from employment services is a simple way to avoid pressure on the caseworker while at the same time providing legal security to benefit claimants.

Box 1.3. **Local government reform in 2007**

With a big administrative reform in 2007, the map of Denmark was changed. The number of municipalities was reduced from 271 to 98 in order to create units big enough to manage the varied comprehensive service demands and policy challenges: a legal minimum population size of 20 000 per municipality was set (although in reality a few municipalities are smaller than this); with an average size of 55 000 the Danish municipalities are now much larger than those in other OECD countries. At the same time, the previously existing 15 counties were replaced by five regions, each with a population between 0.6 and 1.6 million, with health care as their main responsibility. Together with this organisational reform, responsibilities of the three levels were also changed in various ways. Overall, today about 48% of total public spending is in the hands of the municipalities, about 43% under the state and the remaining 9% under the new regions (Ministry of the Interior and Health, 2007).

The National Labour Market Authority has responsibility for national labour market policy, in the name of the Ministry of Employment which is setting annual goals.[4] It is also responsible for monitoring of the municipal job centres. This is done through benchmarking against a set of indicators;

the collection of better data; and increasing transparency *e.g.* by way of a regular newsletter which publishes information on the poorest performers. The national government tries to steer municipal responsibility through an elaborate financial reimbursement mechanism: different municipal actions are reimbursed by central government funds at different rates (see Chapter 4 for a more detailed discussion).

Municipalities are also responsible for compulsory education (both primary and lower-secondary schools) including special education for school-age children. Upper-secondary education, adult education and universities, on the contrary, are under state responsibility.

The role of the new Danish regions

The new regions established in 2007 have one main responsibility: health care. This includes hospitals, psychiatric services, and health insurance, *i.e.* general practitioners (GPs), specialists and the reimbursement for medication. However, municipalities also have health responsibilities (and more than prior to local government reform), comprising prevention, rehabilitation outside of hospitals, home care and treatment of substance abuse as well as school health services.

This structure creates new challenges for all aspects involving health and municipal affairs – or, for that matter, for co-ordinating mental health care and treatment (a regional responsibility) with rehabilitation, employment services and job placement (a municipal responsibility). In order to support the new structure, a new health management information system (HMIS) was developed centrally and made available to all municipalities and regions. The system disseminates detailed data on citizens' use of health services.

Regional funding is largely through block grants from the state (about 75% of total revenue of the regions for health care). However, there are two additional components aimed at steering regional and municipal actions: an activity-related subsidy by the state (about 5% of revenue) to encourage the regions to increase the activity level at the hospitals; and an activity-related contribution by the municipalities (about 20% of revenue) depending on their citizens' use of the regional health care system.

Notes

1. Mental disorders, as defined in this report, exclude intellectual disabilities which encompass various intellectual deficits, including mental retardation, various specific conditions such as specific learning disability, and problems acquired later in life through brain injuries or neurodegenerative diseases like dementia. Organic mental illnesses are also outside the scope of this report.

2. The diagnosis also matters, but mental illness of any type can be severe, persistent or co-morbid. The majority of mental disorders fall in the category mild or moderate, including most mood and anxiety disorders.

3. Data of this type are only available for the year 2005 (the 2010 round of the Danish Health Interview Survey has seen too many changes in definitions to be exploited for this report). Today, in the midst of a job crisis, more people would be found on unemployment and social assistance benefit; and with the reduction of the unemployment benefit payment period, another shift from unemployment to social assistance benefit is forthcoming.

4. The employment goals for 2010, by way of example, were as follows: *i)* to minimise the number of people unemployed continuously for more than three months; *ii)* to reduce the number of people on sickness benefit for more than 26 weeks compared with the previous year; and *iii)* to minimise the number of young unemployed under age 30 who receive social security benefits.

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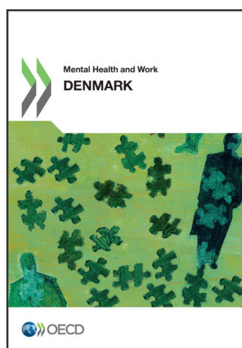

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