

3. HEALTH STATUS

Mental health

Good mental health is vital for people to be able to lead healthy, productive lives, but an estimated one in two people experience a mental health problem in their lifetime (OECD, 2015[1]). When people are living with a mental health problem it can have a significant impact on their daily life, contributing to worse educational outcomes, higher rates of unemployment, and poorer physical health. Figure 3.22 shows the impact of peoples' health on their daily activities and ability to work; people who reported a mental health problem were significantly more likely to say that their health had a negative impact on their daily life. In Norway and France, more than 50% of respondents who had been told by a doctor that they had a mental health problem felt that their ability to work or daily activities were limited. More can be done to help people participate in activities that matter to them, even if they have a mental health problem, including promoting timely access to treatment and integrating mental health and employment services.

Without effective treatment or support, mental health problems can have a devastating effect on people's lives, and can even lead to death by suicide. While there are complex social and cultural reasons affecting suicidal behaviours, suffering from a mental health problem also increases the risk of dying from suicide (OECD/EU, 2018[2]). A higher suicide rate also contributes to a significantly higher rate of overall mortality for people with serious mental disorders, as discussed in Chapter 6. In 2017, there were 11.2 deaths by suicide per 100 000 population in OECD countries. Figure 3.20 shows that suicide rates were lowest in Turkey and Greece, where there were fewer than five deaths by suicide per 100 000 population in 2017. Korea and Lithuania had the highest suicide rate, with 24.6 and 24.4 deaths per 100 000 population, respectively. The rate of suicide was higher among men than women in all countries; in Lithuania, the suicide rate among men was more than five times higher than that for women.

Suicide rates have decreased in almost all OECD countries, falling by more than 30% between 1990 and 2017. In some countries, the declines have been significant, including in Finland, Switzerland and Slovenia, where suicide rates have fallen by more than 40%. Other countries such as Chile and Korea saw suicide peaks in the past decade followed by a decline in more recent years (Figure 3.21). In Switzerland, suicide has fallen by 48% since 1990; rates of 'assisted suicide' are rising, mainly in older people, but since 2009 assisted suicides have been excluded from overall suicide data, explaining the sharp decline the year the reporting changed. Switzerland has taken steps to reduce deaths by suicide, such as introducing a suicide prevention action plan in 2016 that included providing fast access to mental health support, seeking to reduce stigma around suicide, and

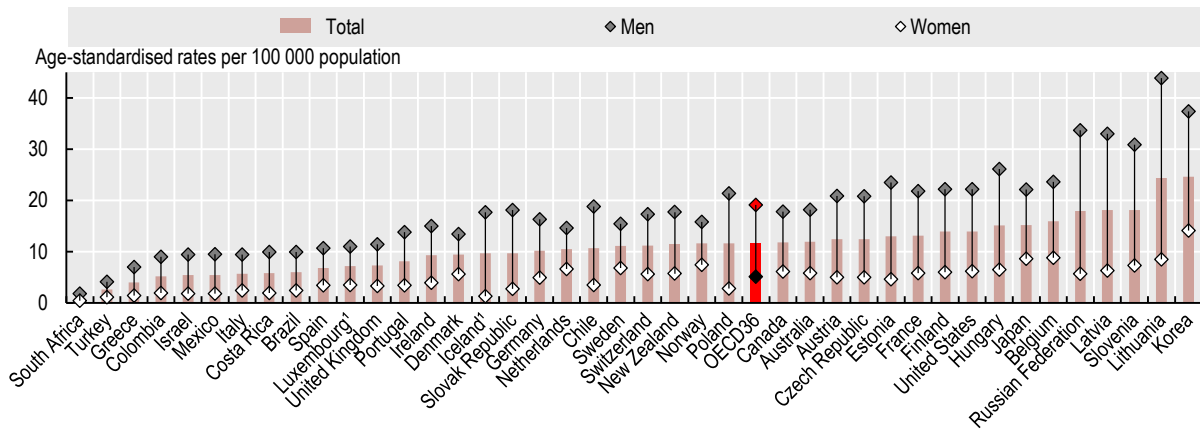
raising awareness of suicide risks. Finland, where a particularly significant decline in suicide was seen in the early 1990s, has recently moved away from stand-alone suicide prevention plans and includes suicide reduction in broader mental health strategies, focusing on improving treatment for mental illness, and implementing a network for coordinating suicide prevention (OECD/EU, 2018[2]).

Definition and comparability

The registration of suicide is a complex procedure, affected by factors such as how intent is ascertained, who is responsible for completing the death certificate, and cultural dimensions including stigma. Caution is therefore needed when comparing rates between countries. Age-standardised mortality rates are based on numbers of deaths divided by the size of the corresponding population. The source is the WHO Mortality Database; suicides are classified under ICD-10 codes X60-X84, Y870.

Figure 3.22 uses data from the Commonwealth Fund 2016 International Health Policy Survey of Adults. It is possible to identify adults who responded "yes" to "Have you ever been told by a doctor that you have depression, anxiety or other mental health problems" and track their responses to other survey questions. This figure shows the rate of responses to the question "Does your health keep you from working full-time or limit your ability to do housework or other daily activities?". Respondents who answered "yes" to this question are identified as "with a mental health problem" and those who responded "no" as "no mental health problem". Respondents identified as "no mental health problem" may have another health problem. The data have shortcomings, including some low response rates and a limited sample size (see also Box 2.4 in Chapter 2). Interpretation of questions may be different across countries; further, it is not known whether respondents were living with a mental health problem at the time of responding, and self-reported prevalence can be affected by stigma around mental health problems. The rate at which respondents reported having been told they had a mental health problem was fairly consistent with national prevalence estimates except for France, where respondents were significantly less likely to report a mental health problem than other national estimates suggest.

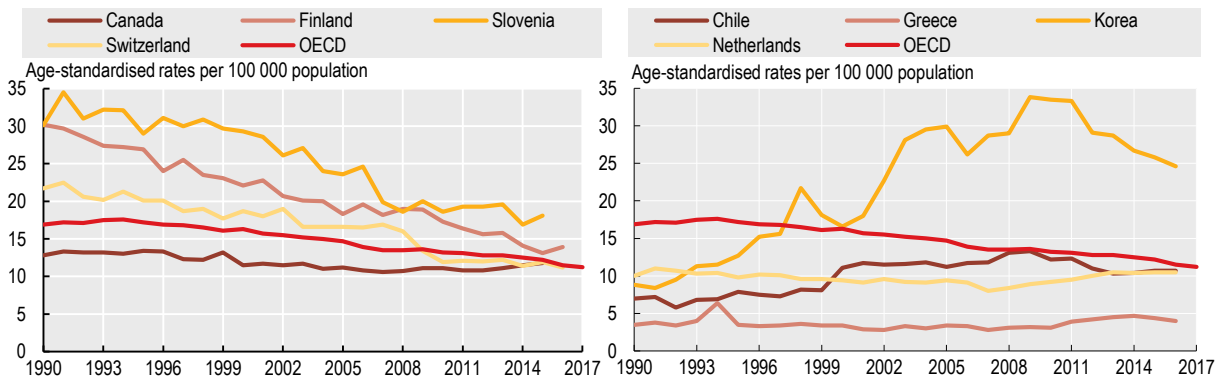
Figure 3.20. Suicide rates, 2017 (or nearest year)



1. Three-year average.
Source: OECD Health Statistics 2019.

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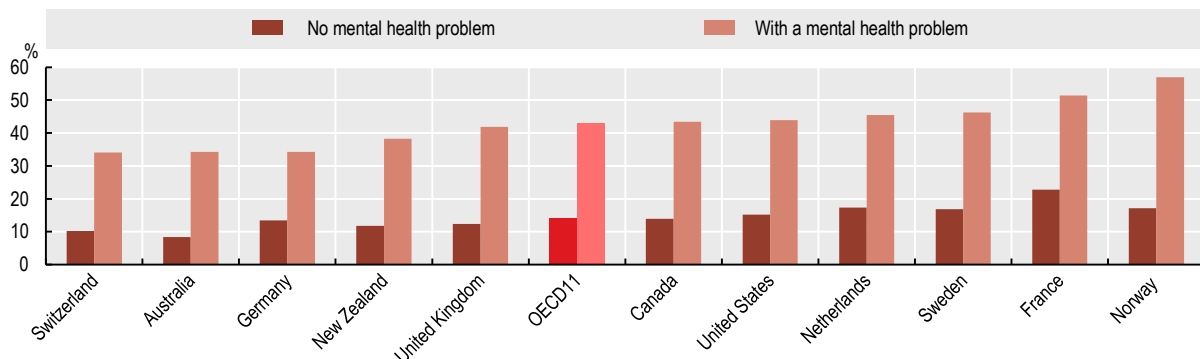
Figure 3.21. Trends in suicide, selected OECD countries, 1990-2017 (or nearest year)



Source: OECD Health Statistics 2019.

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Figure 3.22. People whose health kept them from working full-time or limited their daily activities, 2016



Source: Commonwealth Fund International Health Policy Survey 2016.

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