

## **Achieving parity of esteem between mental and physical health**

### **Executive summary**

The recent English Mental Health Strategy *No Health without Mental Health* has made a commitment to 'parity of esteem between mental and physical health services', and has a clear objective to improve the physical health of those with a mental disorder. Such parity is long overdue and will both drive and underpin the other five objectives of the strategy and also contribute to the realisation of public health outcomes. It can be achieved in a number of ways, including changes in attitudes, knowledge, professional training, and practice. The rewards will be a healthier nation with improved wellbeing, and this is achievable through interventions that can save money in both the short and the longer term.

### **The problem**

Mental disorder is responsible for the largest proportion of the disease burden in the UK (22.8%), which is larger than cardiovascular disease (16.2%) or cancer (15.9%)<sup>1</sup>. This is due to mental disorder being relatively common, having a wider range of impacts and often continuing through the life course. Furthermore, it begins several decades before heart disease or cancer, with half of lifetime mental illness arising by the age of 14<sup>2</sup>. Overall, the economic cost of mental health problems to the English economy amounted to £105 billion in 2010<sup>3</sup>. However, only 10.8% of the NHS budget - £11.9 billion - was spent on NHS services to treat mental disorder during 2010/11<sup>4</sup>.

Despite such an impact, lack of parity is reflected by the most recent national psychiatric morbidity surveys finding that only a minority of those with mental disorder in England receive any intervention, which is in stark contrast to other disease areas such as cancer where almost all receive some intervention.

Those with mental disorder experience a range of increased health risk behaviour including poor diet, less exercise, more smoking and more drug and alcohol misuse. These give rise to reduced life expectancy and higher levels of physical illness several decades later. For instance, 42% of adult tobacco

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<sup>1</sup> WHO. Global burden of disease report; 2008.

[http://www.who.int/healthinfo/global\\_burden\\_disease/estimates\\_country/en/index.html](http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html).

<sup>2</sup> Kim-Cohen J, Caspi A, Moffitt TE, et al. Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort. *Arch Gen Psychiatry* 2003;60:709–17.

<sup>3</sup> Centre for Mental Health. The Economic and Social Costs of Mental Health Problems in 2009/10; 2010. [http://www.centreformentalhealth.org.uk/pdfs/Economic\\_and\\_social\\_costs\\_2010.pdf](http://www.centreformentalhealth.org.uk/pdfs/Economic_and_social_costs_2010.pdf).[

<sup>4</sup> Department of Health, (2011) National expenditure data 2003-04 to 2010-11 available at [http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH\\_075743#\\_3](http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743#_3)

consumption in England is by those with mental disorder<sup>5</sup>. However, those with mental disorder are less likely to receive interventions to address or prevent such health behaviour, despite clear evidence of the increased risk they experience and the availability of evidence-based interventions.

Research also consistently shows that people with mental disorder have higher rates of physical illness and die earlier than the general population, largely from treatable conditions associated with modifiable risk factors such as smoking, obesity, substance abuse, and inadequate medical care<sup>6</sup>. This not only results in increased long-term treatment costs, but societal costs in terms of productivity loss, making people with mental illness more vulnerable to social exclusion, poverty, unemployment and multiple social and family difficulties<sup>7</sup> thereby exacerbating the inequalities they already experience.

### **The solution**

Understanding the relationship between physical and mental health is fundamental to achieving parity. Poor mental health is associated with a greater risk of physical health problems, and poor physical health is associated with a greater risk of mental health problems.<sup>8</sup> Significantly, the combined costs of having the individual conditions in isolation are less than the costs of having them co-morbidly – it is the interaction between the mental and physical health problems that drives the cost of treatment up.<sup>9</sup>

The Royal College of Psychiatrists and others support an amendment to the Health and Social Care Bill to give mental health parity with physical health and act as a key driver for achieving the necessary cultural and other changes required to address these stark inequalities.

The Joint Strategic Needs Assessment (JSNA) can also ensure adequate information to inform commissioning in relation to: the numbers affected by mental disorder, the proportion receiving treatment and the proportion with particular health risk behaviours, such as smoking, receiving appropriate intervention.

Legislation has been shown to be effective in ensuring parity. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) in the United States<sup>10</sup> has brought forward concrete evidence of benefits by legislating for parity of mental

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<sup>5</sup> McManus S, Meltzer H, Campion J. Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. London: National Centre for Social Research; 2010. <http://www.natcen.ac.uk/study/cigarettesmoking-mental-health>.

<sup>6</sup> Thornicroft G, Brohan E, Kassam A, Lewis-Holmes E: Reducing Stigma and Discrimination: candidate interventions. *International Journal of Mental Health Systems* 2008, 2(1):3.

<sup>7</sup> Knapp, Martin and McDaid, David and Parsonage, Michael (2011) *Mental health promotion and mental illness prevention: the economic case*. Department of Health, London, UK.

<sup>8</sup> NICE Depression in Adults with a Chronic Physical Health Problem: Treatment and Management available at <http://www.nice.org.uk/nicemedia/live/12327/45913/45913.pdf> p23 accessed 14.02.12

<sup>9</sup> Unützer J, Schoenbaum M, Katon WJ, Fa MY, Pincus H, Hogan D, Taylor J (2009). 'Healthcare costs associated with depression in medically ill fee-for-service medicare participants'. *Journal of the American Geriatric Society*, vol 57, no 3, pp 506–10.

<sup>10</sup> The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), U.S. Department of Labor Employee Benefits Security Administration.

health<sup>11</sup>. The core principle is that *behavioural health* should be treated equally with physical illnesses. The law in the US was constructed to address the concerns about health care for large numbers of people with long-term conditions which could be improved by better integrating mental health support with primary care and chronic disease management programmes. Furthermore, similar legislation in Oregon resulted in no significant increase in cost<sup>12</sup>. An economic evaluation has also shown a fall in suicide rates (by 5%) in the early 1990s and 2000s in states introducing parity laws<sup>13</sup>.

Parity of esteem is a key element of the mental health strategy and should be core to the Health and Social Care Bill, to enable a range of NHS and public health outcomes to be achieved. The process of achieving parity is urgent and clear and should build on the knowledge, research and good practice which already exists in this area. The JSNA must provide transparency regarding progress. Enhanced health and wellbeing will result from the appropriate commissioning of health and public health services to enable progress to parity.

It is vital that parity should be driven and underpinned by appropriate amendment of the Health and Social Care Bill.

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<sup>11</sup> Barry, C., Huskamp, H., and Goldman, H., 2010, A Political History of Federal Mental Health and Addiction Insurance Parity. *The Milbank Quarterly*, Vol. 88, No. 3, pp. 404-433.

<sup>12</sup> McConnell KJ, Gast SHN, Ridgely MS, Wallace N, Jacuzzi N, Rieckmann T, McFarland BH, McCarty D: Behavioral health insurance parity: does Oregon's experience presage the national experience with the Mental Health Parity and Addiction Equity Act? *Am J Psychiatry* 2012; 169:31-38.

<sup>13</sup> <sup>13</sup> Lang, M. (2011) The impact of mental health insurance laws on state suicide rates. *Health Economics* DOI: 10.1002/hec