Mental illness is a far bigger source of human misery than poverty or unemployment, according to research by **Sarah Flèche** and **Richard Layard**. They argue that we need to move beyond a purely materialistic conception of misery, and call for increased public spending on mental health.

Misery and mental health

Most analysis of human misery focuses on external factors – poverty, unemployment, physical illness or disability – and from this work spring the priorities of public policy-makers. But what about the 'inner' person: is mental illness a major source of misery; and could not policy do more about it?

The answer to both these questions is yes. To show the importance of mental illness, we use household surveys. They collect information on representative adults of all ages in Australia, Germany, the UK and the United States. These data show which people are most miserable – that is, the least satisfied with their lives – and which are not. And they tell us the characteristics of each group of people.

Figures 1 and 2 show the characteristics of those who are in misery in the United States and Australia. In the former, 27% of the most miserable people are poor, 13% are unemployed and 14% are physically ill. But 61% of the most miserable people have been diagnosed with depression or anxiety disorders. Many more of the least happy people suffer from mental illness than suffer from poverty or unemployment.

The position is similar in Australia. Even if poverty and unemployment are causing some people to be mentally ill as well, these findings show that a lot of people are suffering from mental illness unconnected with poverty or unemployment.

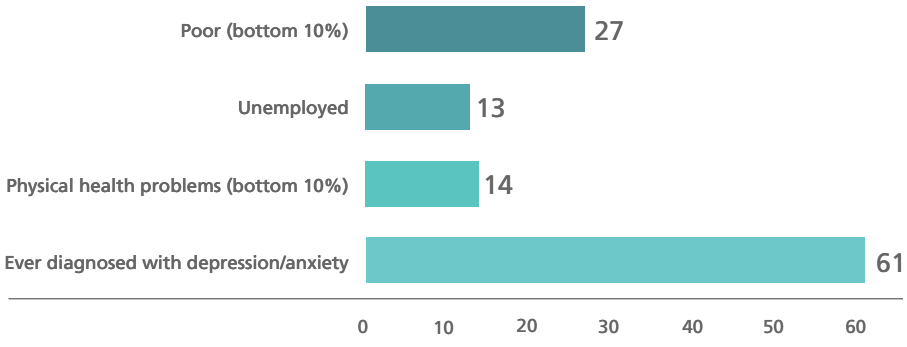
To come closer to causality, we have to use multivariate analysis. This confirms that more of the misery in each country is explained by mental illness than by low income or unemployment. Going further, if we look at changes over time in the life satisfaction of the same individual, more of the fluctuations in life satisfaction are due to fluctuations in depression or anxiety than to fluctuations in income or employment.

Why is such a striking feature of our society so little recognised? It is indeed surprising when at least a third of all families include someone with mental health problems that cause enormous distress (Layard and Clark, 2014).

One possible excuse is that until recently, surveys of mental health relied on people answering batteries of questions about their feelings rather than, as in Figures 1 and 2, about diagnosis by a third party. Without such external evaluation, the data could lead to a biased correlation between mental illness (as measured) and dissatisfaction with life.

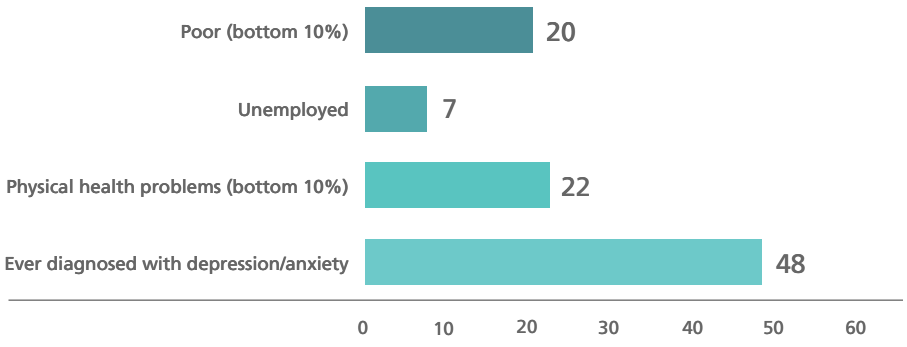
The only data we have for the UK and Germany are of that form. But as Figures 3 and 4 show, the findings are very similar to those for the United States and Australia, for which we have the more 'objective' measures of mental illness. And the multivariate analysis again shows that dissatisfaction with life can have many causes but mental illness is the most important. Indeed, it is at least as important as physical illness, which is not surprising when depression is, for example, 50% more disabling than the most common long-term physical conditions, such as angina, asthma, arthritis or diabetes (Moussavi et al, 2007).

Figure 1:
Percentage of those in misery having the characteristics shown (United States)



Note: Those in misery comprise the bottom 5.6% in terms of life satisfaction.
Source: Behavioral Risk Factor Surveillance System (BRFSS), with a sample size of over 200,000.

Figure 2:
Percentage of those in misery having the characteristics shown (Australia)



Note: Those in misery comprise the bottom 7.5% in terms of life satisfaction.
Source: Household, Income and Labour Dynamics in Australia (HILDA), with a sample size of 17,000.

Dissatisfaction with life can have many causes – but mental illness is the most important

Implications for healthcare

What does this imply for the allocation of resources in healthcare? Governments in both the UK and the United States are committed by law to parity of esteem for mental health and physical health. So what does this suggest should be the share of total health expenditure going on mental health?

First, we have to realise that physical healthcare is concerned with more than enhancing the quality of life: it is also concerned with preventing premature death. Thus, World Health Organisation (WHO, 2008) analysis estimates that 38% of health-related reductions in the quality of life are due to mental illness; but if we allow for premature death, mental health accounts for 23% of the total burden of disease. By contrast, we spend only 13% of our total health budget on mental health.

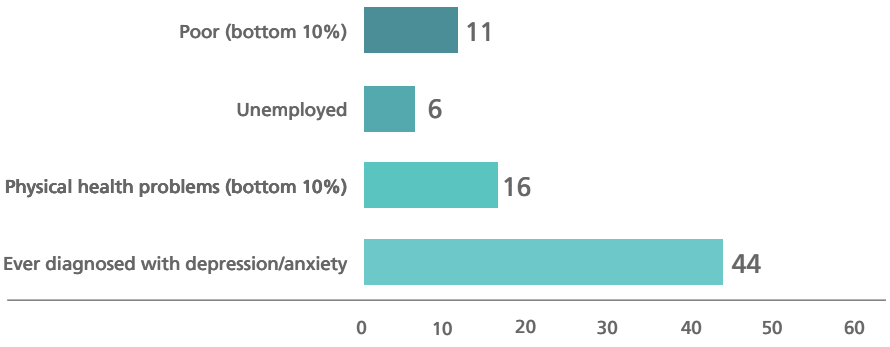
This could only be justified if we lacked cost-effective treatments for mental illness, and especially the most common problems of depression and anxiety disorders. So how cost-effective are the main available treatments?

Let us consider cognitive behavioural therapy (CBT) – the only treatment that the National Institute for Health and Care Excellence (NICE) recommends for all forms of depression and anxiety. With the information from our analysis, we can provide a simple evidence-based evaluation of its benefits and costs measured in terms of life satisfaction.

It turns out that when someone is treated for depression or anxiety and recovers, the increase in life satisfaction outweighs the cost of treatment by at least ten times. And this ignores altogether the cost savings that result from increased employment and reduced physical healthcare (Layard and Clark, 2014).

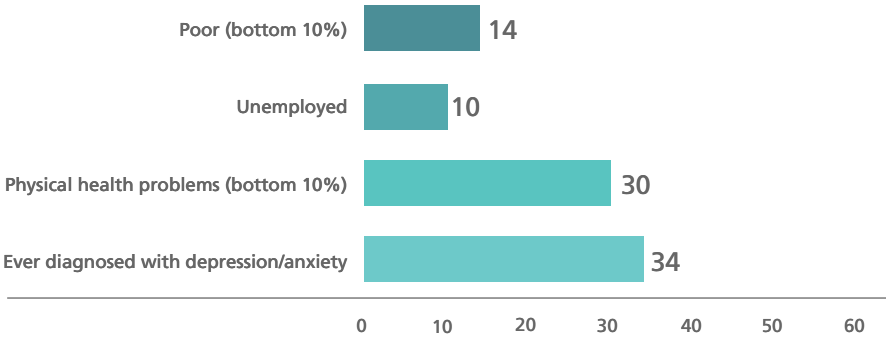
However one looks at it, mental health is a shockingly neglected issue. One reason is technological lag: many people do not realise that cost-effective treatments exist. But another reason is our materialistic conception of misery: when people picture those who are deprived in our society, they typically focus on external factors. But if people cannot enjoy life, they are just as deprived whether the cause is outside themselves or within. In this light, a new concept of deprivation is essential.

Figure 3:
Percentage of those in misery having the characteristics shown (UK)



Note: Those in misery comprise the bottom 9.9% in terms of life satisfaction.
Source: British Household Panel Survey (BHPS), with a sample size of 115,000.

Figure 4:
Percentage of those in misery having the characteristics shown (Germany)



Note: Those in misery comprise the bottom 8.7% in terms of life satisfaction.
Source: Germany Socio-Economic Panel (GSOEP), with a sample size of 53,000.

This article summarises 'Do More of Those in Misery Suffer from Poverty, Unemployment or Mental Illness?' by Sarah Flèche and Richard Layard, CEP Discussion Paper No.1356 (http://cep.lse.ac.uk/pubs/download/dp1356.pdf).

Sarah Flèche is a research officer in CEP's wellbeing programme. **Richard Layard** is the programme's director.

Further reading

Richard Layard and David M Clark (2014) *Thrive: The Power of Evidence-based Psychological Therapies*, Penguin.

Saba Moussavi, Somnath Chatterji, Emese Verdes, Ajay Tandon, Vikram Patel and Bedirhan Ustun (2007) 'Depression, Chronic Diseases, and Decrements in Health: Results from the World Health Surveys', *The Lancet* 370(9590): 851-58.

World Health Organisation (WHO) (2008) *The Global Burden of Disease*.