Executive summary

Background

In 1999 the government made mental health one of its three clinical priorities, alongside cancer and heart disease. It created a National Service Framework for Mental Health and appointed a National Director for Mental Health to oversee its implementation. Since then, backed by an increase in investment of more than £1.5 billion (around a 50 per cent increase), which has helped to fund growth in all the main mental health staff groups, mental health services in England have seen considerable change, in particular in the development of specialist secondary care services for people living in the community.

Recognising the significance of mental health in terms of both the health of the population and the cost to the government and taxpayer, in 2006 the King's Fund commissioned a review to estimate mental health expenditure in England for the next 20 years, to 2026. The review had the following broad aims. To:

- assess the current need for mental health services and the costs of services provided
- project needs and costs to the year 2026
- assess the impact that specific interventions may have on these costs.

Methods

Mental health need was assessed by obtaining prevalence data on specific conditions covering major mental health problems and combining these prevalence rates with population projections for England. The conditions included are those targeted by mainstream services and for which there is a reasonable evidence base as to the effectiveness of interventions. However, substance misuse was excluded. We included all age groups in the study with the exception of those aged below 5.

Typical service packages were defined from survey data and individual studies and costs were calculated. These were then combined with the numbers of people in each disorder group to measure the overall costs of services.

'Service costs' and 'total costs' were estimated. The former included direct health and social care costs, and, where possible, informal care and criminal justice services; the latter is service costs plus the costs of lost employment (considered relevant where a significant proportion of those experiencing the mental disorder were of working age).

It has been assumed that health and social care costs increase at an annual rate of 2 per cent above general inflation (the GDP deflator) – which is in line with similar reports. To estimate the cost of lost employment we also assumed that earnings in the population as a whole increase by 2 per cent a year over and above the GDP deflator.

TABLE 1: NUMBER OF PEOPLE WITH SPECIFIC DISORDERS AND CURRENT AND PROJECTED COSTS

Disorder	Number of people (million)		Service costs (£ billion)			Lost earnings (£ billion)			Total costs (£ billion)		
	2007	2026	2007	2026 (2007 prices)	2026 including real pay and price effect[c]	2007	2026 (2007 prices)	2026 including real pay and price effect[c]	2007	2026 (2007 prices)	2026 including real pay and price effect[c]
Depression	1.24	1.45	1.68	2.03	2.96	5.82	6.31	9.19	7.50	8.34	12.15
Anxiety disorders	2.28	2.56	1.24	1.40	2.04	7.7	8.34	12.15	8.94	9.74	14.19
Schizophrenic disorders	0.21	0.244	2.23	2.52	3.67	1.78	1.94	2.83	4.01	4.46	6.5
Bipolar disorder/ related conditions	1.14	1.23	1.64	1.8	2.63	3.57	3.83	5.58	5.21	5.63	8.21
Eating disorders	0.117	0.122	0.016	0.016	0.024	0.035	0.036	0.052	0.051	0.052	0.076
Personality disorder[a]	2.47	2.64	0.7	0.78	1.13	7.2	7.65	11.16	7.9	8.43	12.29
Child/adolescent disorders[b]	0.61	0.69	0.14	0.16	0.24	0	0	0	0.14	0.16	0.24
Dementia[b]	0.58	0.94	14.85	23.88	34.79	0	0	0	14.85	23.88	34.79
Total	8.65	9.88	22.5	32.59	47.48	26.1	28.1	40.97	48.6	60.69	88.45

Notes: [a] The costs for personality disorders related to 64.6 per cent of people with the condition (*see* Chapter 9). [b] The total costs are the same as the service costs as we have assumed that there is no lost employment for people with these conditions. [c] It has been assumed that real pay and prices increase by two percentage points above the GDP deflator.

Specific interventions for which there was an evidence base – such as the use of psychological therapies and home treatment teams – and for which data were available were then modelled to assess their impact on costs.

There are some limitations to the review and thus this report. These include:

- costs were estimated on the basis of primary diagnoses only
- children aged 0–4 were omitted
- less common diagnoses for which data were unlikely to be available were excluded (although the number of people with these other conditions is unclear, the Hospital Episode Statistics for 2004/5 show that they accounted for 2.2 million bed days out of a total of 8.7 million)
- learning disability was not included
- data on some services (including informal care and the criminal justice system) were not available for all conditions. However, we consider that non-health service costs will be incurred to some extent for all conditions.

These limitations mean the estimates of current and projected service costs made in this report are likely to be slight underestimates of the true figures.

Findings

Key findings from the review are shown in Table 1 above.

Summary of key findings

- The number of people in England who experience a mental health problem within the diagnostic groups studied is projected to increase by 14.2 per cent from 8.65 million in 2007 to 9.88 million in 2026 – a rise of more than 1.2 million people. On the whole, this increase in numbers simply reflects the expected increase in population by 15.1 per cent from 50.98 million currently to 58.68 million people in 2026.

- Prevalence rates for all mental disorders within all age groups are likely to remain broadly stable. The proportion of people with a mental disorder will fall very slightly from 17.0 per cent to 16.8 per cent of the total population.

- Although not the largest group of people with a mental disorder, those with dementia will see the largest increase in numbers, as a result of an increasingly ageing population, in particular people aged 75 and over. The service costs associated with dementia are far higher than all other conditions put together. They currently make up 66 per cent of all mental health service costs; by 2026 it is estimated that they will make up 73 per cent of all mental health service costs (at 2007 prices).

- Current service costs, estimated to be £22.50 billion, are projected to increase by 45 per cent to £32.6 billion in 2026 (at 2007 prices). This is primarily due to an estimated increase in service costs for people with dementia of £9.0 billion. Costs will increase by 111 per cent to £47.5 billion if the real pay and price effect (a 2 per cent annual increase in health prices over and above GDP deflator) is taken into account – again, primarily due to the impact of dementia.

- Many people with mental disorders are either not in contact with services or are in contact but are not receiving any treatment. It is estimated, for example, that 35 per cent of those with depression and 51 per cent of those with anxiety disorders are not in contact with services, and many conduct disorders and eating disorders among children and adolescents are undiagnosed and untreated. This means there is a significant potential to treat more people with these mental disorders if diagnostic services are accessible, treatment is available, and the individuals concerned are willing to accept it. Net savings are likely to occur if treatment is given to those currently not receiving treatment as reductions in lost employment costs should outweigh treatment costs. However, it is important to recognise that while the costs of care fall to primary care trusts (PCTs), the benefits largely accrue elsewhere, in terms of increased employment and tax revenue, and reduced benefits payments.

- The cost of lost employment, currently estimated to be £26.1 billion, is projected to increase by 7.7 per cent to £28.1 billion by 2026 (at 2007 prices). Although a relatively small increase (it is not affected by the rise in numbers of people with dementia, who may almost all be assumed to be beyond retirement age), this confirms the major adverse economic impact of poor mental health, which currently outstrips the direct NHS and social care service costs of supporting people with mental disorders.

- A number of service interventions might lead potentially to reductions in costs. For depression and anxiety disorders, increasing the number of people who are currently in treatment and who receive evidence-based interventions would increase service costs but could result in savings in total costs if treatment is effective and results in

TABLE 2: POTENTIAL ANNUAL SAVINGS FROM INTERVENTIONS TO TREAT DEPRESSION, ANXIETY DISORDERS, SCHIZOPHRENIA, BIPOLAR DISORDER AND DEMENTIA

Condition and interventions	2007	2026
Depression		
Medication for those currently untreated	£5–36 million	£8–61 million
Medication plus psychological therapy for those currently untreated	£1–9 million	£2–16 million
Anxiety disorders		
Medication for those currently untreated	£8–66 million	£13–102 million
Medication plus psychological therapy for those currently untreated	£1–7 million	£2–11 million
Schizophrenia		
Expansion of crisis intervention teams	£4–22 million	£7–37 million
Expansion of early intervention services	£0 million	£13–65 million
Introduction of early detection services	£0 million	Up to £19 million
Bipolar disorder		
Expansion of crisis intervention teams	£2–10 million	£3–16 million
Expansion of early intervention services	£0 million	£8–31 million
Introduction of early detection services	£0 million	Up to £4 million
Dementia		
Reduction in prevalence among those aged 65–74	£0.2–0.6 billion	£0.4–1.2 billion
Reduction in prevalence among those aged 65–84	£0.8–2.4 billion	£1.7–5.2 billion

The range of potential savings depends on how many more patients are treated and how quickly new services come online

increased employment. Increasing the number of people receiving medication provides a much greater economic gain than psychological therapies, which may produce similar benefits compared to medication but are far more expensive. Such savings are shown in Table 2 above.

- With regard to schizophrenia and bipolar disorder and related conditions, savings (mainly in reduced inpatient costs) could be realised by expanding the use of crisis intervention and early intervention services. Early detection and intervention services for psychosis can lead to a reduced need for services at a later stage and therefore cost savings.

- All the evidence-based interventions examined had the potential to reduce costs and should be pursued, so that scarce resources can be directed to best effect. However, in no cases would any savings from such interventions – which might be counted in millions of pounds – make a significant impact on the overall level of mental health costs, which can be counted in billions of pounds. The one exception would be reducing the prevalence of dementia in those aged under 85.

- Recommendations include:
  - a commitment from future governments to ensure that funding meets expected increased costs
  - a sustained effort to support people with mental health needs of working age who are not in employment to return to work
  - the expansion of evidence-based interventions in primary care settings for people with depression and anxiety disorders, crisis services in the community and early intervention services for psychosis
  - the establishment of better systems of early detection and treatment of dementia
  - more research into the cost-effectiveness of a range of interventions, including mental health promotion and prevention initiatives.