



30 January 2020

Mental Health Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Lodged online: www.pc.gov.au/mental-health

Dear Commissioners

Mental Health Inquiry – Feedback on the Draft Report

The Actuaries Institute ("the Institute") welcomes the opportunity to comment on the draft report. We strongly endorse efforts to improve the system to prevent, treat and support recovery from mental ill-health and commend the breadth and ambition in the draft report.

Our submission relates only to those areas falling within the acknowledged expertise of the actuarial profession – essentially insurance, workers compensation, superannuation and related funding issues. We have not commented on issues relating to the National Disability Insurance Scheme.

Actuaries Institute Green Paper on Mental Health and Insurance

In October 2017 the Institute published a Green Paper 'Mental Health and Insurance'¹. The paper was very well received and dealt with how the various insurance schemes respond to and interact with people with a mental health condition.

The Green Paper identified eight 'root causes' of the systemic difficulties for the insurance sector in dealing with mental health coverage. It then identified nine areas where improvements can be achieved.

The Executive Summary in that Green Paper, listing the systemic difficulties and improvement opportunities, may provide a good framework to structure the Productivity Commission's examination of insurance-related issues. At the very least it is a way for the Commission to cross-reference that it has considered the most relevant issues.

Outline of this Submission

This submission from the Institute is structured as follows:

1. Mentally healthy workplaces and workers compensation
2. Private Health Insurance
3. Life insurance
4. Other comments and responses

¹ <https://actuaries.asn.au/Library/Opinion/2017/GPMENTALHEALTHWEBRCopy.pdf>

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We trust this input will assist you to finalise the Commission's report to government.

Please do not hesitate to contact me, or Elayne Grace, Chief Executive Officer of the Institute,
if we can be of further
assistance.

Yours sincerely

Hoa Bui
President



Mental Health – Productivity Commission Draft Report Submission from the Actuaries Institute

1. Mentally healthy workplaces and workers compensation

This section of the Actuaries Institute submission deals with the closely related issues of mentally healthy workplaces and workers compensation systems. It responds to the material in Chapter 19 of the draft report.

1.1. Mentally healthy workplaces – prevention

We support the significant focus in the report on prevention and reduction in mental health conditions through changes in the workplace.

1.1.1. What works best?

Our experience confirms the findings in the draft report that there are many new and existing 'interventions' but little good evidence of what works and in what situations.

The Institute generally supports the evaluation recommendations in Chapter 25 and suggests inclusion of evaluation of workplace and workers compensation initiatives in the program.

1.1.2. Possible omissions from the discussion

While we address specific recommendations made in the draft report, we note two initiatives that were not discussed in the draft report.

The first is the consensus statement on the Health Benefits of Good Work² from The Australasian Faculty of Occupational & Environmental Medicine and the Royal Australasian College of Physicians. The consensus statements have established good momentum in creating positive links between workplaces, clinicians and workers compensation. Unless the Productivity Commission has a good reason for omitting it (which would be helpful to know) we would like to think that it continues to have a helpful place at the centre of workplace developments.

The second omission is Mental Health First Aid. This idea gets a passing mention on page 742 but without any clear statement of support (or otherwise) from the Productivity Commission. This program has potential to be present in many if not most workplaces; just as first aid certificates are today. It creates the parallel with physical health and safety that is promoted in the early part of the draft report. We suggest that it could form a significant consideration in community-wide improvements, both inside and outside the workplace.

1.1.3. 'Stay at Work' is a powerful option

In recent years a new phrase has entered the workers compensation lexicon – that is to describe 'Stay at Work' before 'Return to Work'.

² <https://www.racp.edu.au/docs/default-source/advocacy-library/realising-the-health-benefits-of-work.pdf> and <https://www.racp.edu.au/docs/default-source/advocacy-library/afoem-realising-the-health-benefits-of-work-consensus-statement.pdf?sfvrsn=8>



The idea that treatment and recovery can occur while a person stays at work (perhaps on modified duties) can be a powerful one and should be part of the message from the Productivity Commission report. We recommend that the Productivity Commission explore identifying information and techniques that improve the chances of a 'Stay at Work' outcome.

1.1.4. Human resources and industrial relations issues

The draft report acknowledges that some work-related mental health issues are strongly related to interpersonal relationships and workplace conflict such as bullying (page 752). We encourage the Productivity Commission to take this observation further in proposing effective responses in the workplace context.

Anecdotally, many people follow a progression through:

- A human resources complaint or grievance
- An industrial relations dispute
- A workers compensation claim
- A total and permanent disability (TPD) or income protection claim through superannuation
- Social welfare including the Disability Pension.

None of these systems is easy to navigate on its own, let alone the combination. This is especially so for a person who is at a vulnerable stage of life due to a mental health condition.

We are not aware of any research directed at understanding how many people follow various parts of this progression or their experiences.

The experience of many actuaries working in the fields is that there could be major gains in outcomes possible if these pathways can be better understood and made coherent with each other. Relatively simple things like different medical examinations using different criteria make things more difficult for people with mental health conditions.

While there are clearly legal barriers (including privacy) to be overcome, the Institute suggests that the Productivity Commission is in a strong position to evaluate and recommend substantial reforms to deal with the issue of multiple dispute and insurance/compensation schemes.

1.1.5. EAP as an obvious launching point

The draft report notes that Employee Assistance Programs (EAPs) are relatively common and generally (though not universally) well regarded by both employees and employers.

Adapting and building on this existing structure may be more efficient and effective than developing new employment-based structures. Commentary in the report suggests that standards of products and services can be improved, which is a tractable problem.

Social awareness of EAP services is still improving and concerns about anonymity are one of the driving factors preventing higher usage. However, we feel increased industry-wide awareness and ensuring consistent minimum access for employees will significantly improve EAP as a first-response structure.

If EAPs can be made reasonably effective, the pathway is clear to make adoption of an EAP compulsory for larger employers and possibly also for smaller employers via an industry-based service.



The Productivity Commission should consider this pathway as an alternative to extending workers compensation to no-fault treatment, discussed further below.

1.2. Workers Compensation issues

1.2.1. The workers compensation system is not a happy place to be

The Institute suggests that the Productivity Commission acknowledge up front that being reliant on the workers compensation system will limit the capacity to improve the individual experience. The combination of laws, processes and cultures makes it a difficult experience for most people making a claim, and this must be particularly so for those struggling with a mental health condition.

The relevance of accepting this fact is that successful reforms are likely to 'work around' the workers compensation system rather than relying on workers compensation to do more and to do it differently. There are too many barriers to change in workers compensation for this to be the pathway of choice for the goal of enhancing the individual care experience.

1.2.2. Causation is a conundrum

Access to workers compensation depends on being able to demonstrate work-related causation according to the legal standards relevant in the jurisdiction. The difficulty of determining causation with mental health conditions is evidenced by the various legal changes made to schemes over many years, including issues identified by the Productivity Commission:

- Defining contribution of work – 'significant, major, most significant ...'
- The carve-outs for reasonable management action.

The Institute suggests that causation will always be a conundrum with the workers compensation system that militates against greater reliance on workers compensation for treatment and recovery. Use of provisional liability has been an attempt to mitigate this difficulty, and we return to that topic below.

Complicating this issue is the possible access to coverage under life insurance offered by an employee's superannuation fund. Life insurance is covered in section 3 of this submission but inconsistent coverage for employees with different group policies has the potential to make causation more of a priority where mental health coverage in life insurance is significantly limited or excluded.

1.2.3. Same job and same employer is a problem

The conventional wisdom in workers compensation is that return to the same job at the same employer is the optimal outcome. A different job at the same employer is second best, and work at a different employer is a last resort for return to work. Legal obligations on employers, rehabilitation requirements and insurer practices all reinforce this standard approach.

The problem arises due to the very nature of many mental health conditions – to put it bluntly (and as the draft report states on page 752), the workplace is often a big part of the problem. Once a person has left work (in other words 'stay at work' has failed) sending them back to the same 'toxic workplace environment' is often doomed to failure and to make the condition worse.



Evidence of this problem can be seen in the research about the capabilities and approaches of some GPs in responding to work-related mental health conditions³. The research shows that some GPs are (for understandable reasons) reluctant to certify a patient as fit to return to work (whether or not on modified duties) due to lack of detailed understanding of the workplace and the risk of doing harm to their patient.

Our workers compensation systems have been unable to develop viable alternative approaches for mental health conditions and there is little chance that they will be able to do so. This is a further reason why reforms to workers compensation are unlikely to be the best pathway to improving outcomes and individual experience.

1.2.4. Return to work is more difficult in smaller businesses (draft finding 19.1)

The Institute strongly supports the first sentence of this finding: "Return to work for those with a psychological injury or mental illness is difficult if the injury or illness was related to personal conflict or wider cultural issues in that workplace that have not been addressed prior to return to work."

This is an important finding regardless of the size of the business, and useful proposals can derive from it.

However, where we differ is with the second part of the finding: that "these difficulties are more acute for smaller businesses ..."

The most important factor is the attitudes and culture in the workplace. There are good and bad in both small and large enterprises. The size of the business is not necessarily a relevant factor.

The argument about smaller businesses is often raised regarding physical injuries because of the difficulty of providing modified duties or a graduated return to work. For mental health conditions this argument will frequently be less relevant. The Institute suggests that at this stage of development drawing a distinction between large and small workplaces is not helpful and the focus be on attitude and culture to enhance individual experience rather than size of business.

1.2.5. The relevance of workers compensation insurance premiums

The discussion of incentives in workers compensation (between pages 752 and 761) appears internally inconsistent and not supporting the draft recommendation 19.3.

The discussion begins (page 752) by noting that previous claims experience impacts the price of insurance premiums and therefore creates incentives including:

- For the employer to avoid triggering a claim
- For the insurer to limit or delay compensation claims
- For governments to restrict overall eligibility and payments.

In this section it also notes that establishing the relevant connection to work can be difficult to prove in the case of mental illness and psychological injuries.

³ <https://www.ncbi.nlm.nih.gov/pubmed/26275607>; <https://www.ncbi.nlm.nih.gov/pubmed/28399837>;
<https://www.ncbi.nlm.nih.gov/pubmed/24647855>



The discussion of incentives, and potentially conflicting incentives, goes directly to the long-standing issue of the effectiveness of 'experience rating' in workers compensation. The topic continues to be widely discussed after more than 35 years, with proponents on both sides.

The views of the actuaries with significant experience in the systems could be summarised as follows.

- (i) Experience rating makes sense – having a mechanism is better than not, at least for large employers.
- (ii) For smaller employers the incentives are not effective, because the likelihood of having a claim is very low and the impact on premium is small. A larger premium impact becomes punitive and unsustainable.
- (iii) Experience rating cannot be expected to change employer behaviour on its own – it must be only one part of a broader tool kit to influence workplaces.

The statement on page 756 about 'weakening the price signal' falsely assumes that an experience-rated price signal was effective in the first place and, at the same time, highlights perverse incentives to deny liability. The paragraph starting "The trade-off between ..." on page 759 reaches an unsupportable conclusion.

The Institute suggests that the Productivity Commission redrafts these pages to accurately reflect industry experiences.

1.2.6. Lower premiums and workplace initiatives (draft rec 19.3)

The experience of actuaries working in the field has been that offering reduced premiums for employers with interventions and programs (sometimes referred to as 'observed conditions') is extremely difficult and largely ineffective. There are numerous reasons for this outcome which are not cited here but can be expanded on if requested.

The Institute does not support draft recommendation 19.3.

1.2.7. The merits of provisional liability (draft rec 19.4)

Use of what is known as 'provisional liability' (payment of benefits prior to assessing the validity of a claim) is often suggested as a method for improving early access to treatment. The Productivity Commission promotes this measure in Chapter 19 (pages 761 to 767). We note that the Productivity Commission is suggesting payment of treatment costs, but not income replacement.

The experience of members of the Institute is that provisional liability should be approached with caution. It has been and is being tried in a number of jurisdictions, but we are unaware of any research or evaluation evidence of the outcomes. Anecdotally, the use of provisional liability has been a failure in some cases, failing to deliver the hoped-for benefits in worker outcomes and increasing scheme cost.

The Institute encourages the Productivity Commission to conduct a more critical examination of the experiences with provisional liability arrangements prior to finalisation of its report. The recommendations should include a continuing nationally-consistent program of evaluation and publication of findings.



1.2.8. Funding of treatment (info request 19.1)

The Institute is of the view that access to and availability of appropriate clinical services is a question to be resolved prior to asking how the treatment should be funded.

Our starting point is to suggest that the same health services available to all members of the community should be available to those in the workforce. If community-based services are developed as recommended by the Productivity Commission, precisely those services should be the first option for people with mental health conditions that might be related to work.

We also discussed in Section 1.1.5 above the merits of EAPs being an access point for mental health services that are timely, empathetic and relevant for the particular workplace.

If a successful workers compensation claim is made, then the workers compensation insurer should reimburse the relevant treatment costs. The Institute suggests that the critical point is to delink service access from making a workers compensation claim.

1.2.9. PTSD (single event) is much less problematic

Please note that these paragraphs do not relate to first responders. Those in first responder roles can be subject to numerous traumatic experiences and are vulnerable to serious PTSD.

The observation from the Institute is that PTSD arising from a single traumatic event has significantly higher rates of treatment success and much shorter average durations away from work. Our general understanding is that there are relatively effective treatments that are well understood by relevant clinicians.

It would be helpful for the Productivity Commission to note this observation, firstly because it helps people understand that not all mental conditions are similar in their impact and also because it helps draw attention to the existence of effective treatments.

1.2.10. Public sector and private sector experience

We encourage the Productivity Commission to observe and examine closely the difference in mental health related claims experience between public sector and private sector employment of a similar nature. There is compelling evidence that public sector employment produces higher rates of mental health related claims, and it is not obvious why this should be the case.

The Institute suggests that thorough and well-designed research into this experience could be very valuable. The community will certainly learn more about the factors involved and, most significantly, there might be valuable evidence about what does not work.

Issues such as this can be political and sensitive, and the Productivity Commission is a well-placed institution in the community to tackle it.

1.2.11. Constructive suggestions for workers compensation

The Institute does not share the views of the Productivity Commission about the merits of reform to workers compensation in providing more support for mental health conditions that may be work-related. There are, however, some constructive suggestions that we can offer:

- (i) Ensure early objective assessment, with the interests of the worker's recovery put first; this assessment would be better done as part of an expanded EAP rather than at the outset of a workers compensation claim



- (ii) Assess causation and workers compensation entitlement with full access and co-operation of the various relevant players – Human Resources, Industrial Relations, other insurances, treating clinicians
- (iii) Be more willing, at a relatively early stage, to acknowledge separation from previous employment and the benefits of seeking a new job, including by providing retraining and/or job search assistance.

1.2.12. Workers compensation data and interpretation (pages 747 to 751)

The draft report helpfully includes some high-level data on workers compensation claims relating to mental ill-health. The following notes provide additional clarification and observations.

- Proportion of claims remaining stable (p. 748) – we are aware that since 2016-17 the proportion of claims relating to mental ill-health (note not "mental stress") has increased in many jurisdictions and the national figures will show an upswing.
- Figure 19.2 – The drops are likely to relate to various legislative reforms; in particular the drop from 2011 to 2014 is likely driven by major legislative reforms in NSW, but from 2017 the trend has reversed strongly. Since 2017 the numbers will have increased significantly – in some jurisdictions by as much as 50%.
- Figure 19.3 – the upward trend in time lost for mental ill-health claims has continued to increase since 2017 (the down-tick at the last point is not indicative of trend)
- Figure 19.4 – the coding of cause of claim is known to be unreliable and we caution against drawing any conclusions from the data on this graph.
- Occupation comments (p. 750) – the incidence rates need to be clarified, as per the next point; an alternative would be to compare the percentage of claims with the percentage of workforce; the high rates are generally all in public sector employment (see 1.2.10 above).
- Figure 19.5 – we note that the ANZSIC division (Public administration and safety – division O) includes all federal, state and local government white collar employees as well as those in the 'safety' occupations which are acknowledged to be higher risk. The description at footnote b is therefore misleading. A more meaningful picture of incidence would be provided if that ANZSIC group is split into at least into two segments – 'safety' occupations and the rest. We would anticipate the incidence rate for 'safety' to be much higher and for the rest likely to be below health and education but still above the others.

2. Private Health Insurance

This part of our submission responds to the findings regarding Private Health Insurance (PHI) and is structured around section 24.5 of the draft report (page 984). Our comments are based on applying the "Triple Aim" of healthcare: improving health outcomes, efficiency of cost and enhancing individual experience of care. We have applied this lens to PHI in the context of the system to prevent, treat and support recovery from mental health.

The section includes responses on:

- Private Health Insurance – Resident: Voluntary cover purchased by Australian citizens



- Overseas Student Health Cover: Mandatory cover purchased by those with a study visa

It is important that the Productivity Commission (and other policy makers) carefully distinguish between Health Insurance and Life Insurance. Health insurance (i.e. Medicare) is based on universal cover in the Australian Health system. PHI is an extension that, once purchased, has no underwriting or higher premiums or reduced cover based on current or past health conditions.

Life insurance does not have this system of 'community rating' and the product dynamics are very different.

2.1 PHI and funding of community-based healthcare (draft rec 24.5)

The Institute supports draft recommendation 24.5 in principle, namely:

"The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare with a view to increasing the scope for private health insurers to fund programs that would prevent avoidable mental health-related hospital admissions."

The following clarifications are suggested:

- We note that the "Improved Models of Care Working Group" stated that "existing regulations did not prevent alternative models of care from being adopted..." (page 988). We suggest the draft recommendation be reworded to include exploring opportunities for encouraging greater uptake of alternative models of care and to investigate how the definitions of admitted or non-admitted patient care within mental health potentially affect patient outcomes and impact their access to a continuum of care model.
- The recommendation is expanded to cover 'private health providers' and not just 'private health insurers'. In isolation reviewing insurance will not ensure provision of services. The intention here is to seek evidence-based service expansion of mental health services.

The suggestions are intended to align the recommended review of regulations with the triple aims of healthcare noted above.

2.2 Further comments on the PHI discussion (section 24.5, page 984)

On page 984 the report states, "In 2016-17, private health insurers paid approximately \$50 million in benefits for hospital-based mental health treatment ..." This figure looks too low. AIHW reporting on mental health expenditure indicates, "\$536 million was spent on specialised mental health services in private hospitals in 2016-17." We suggest the Productivity Commission remove the \$50 million quoted and confirm expenditure with AIHW. We think the accurate figure is in the order of \$500 million to \$600 million.

On page 985 the report states "Public and private hospital roles differ, with private hospitals generally servicing a population with less acute mental health conditions". The Institute notes that in addition to recommendations on funding, the capacity to deliver services may need to be investigated.



On page 986 the draft report states that the regulatory framework should "...permit (but not require) private health insurers to fund services outside of hospitals that could prevent their hospital cover holders from requiring hospitalisation". Under existing industry dynamics there is a complication that will need to be resolved if private health insurers are able to claim risk equalization (cost sharing) for such expenses. A PHI that elected not to fund such services would find themselves paying a share of costs for those that do provide such services if the cost of the services is included in the risk equalisation pool. A solution to this would be a standard benefits package on which claims experience is assessed for risk equalization purposes (as is the approach adopted in The Netherlands). With the recent standardisation of PHI product tiers (i.e. Gold, Silver, Bronze, Basic), the structure exists to incorporate such a standard benefits package at one of the tiers.

The Institute suggests that exploring such possibilities would be in scope of the review in draft recommendation 24.5.

There are a few other comments in the draft report that would benefit from clarification in respect of PHI:

- Under "stigma and discrimination in the insurance sector" (page 808) we note that in PHI there is no discrimination permitted based on age, current or previous claims or health status.
- On page 41 the draft report notes that access to insurance that covers mental ill-health has been raised as a concern during the inquiry. We note that for PHI there is no question of access – once a product has been chosen the cover and price is identical for all customers buying that product.
- On page 336 the draft report notes that "Carers have reported to us that they find the mental health service system complex to navigate and distressing when they are dealing with multiple professionals across the public and private health systems, private practitioners, and community based mental health service providers. (MHCA, sub. 489, p. 10)". This raises the question as to whether Private Health Insurers might be able to provide or fund navigation assistance.
- Information Request 3.2 — Out-Of-Pocket Costs for Mental Healthcare (page 177): The Institute agrees with this observation and notes that much improved information is needed on this part of the cost burden.

2.3 Overseas Student Health Cover (info request 18.3)

Overseas students are required as a condition of their visa to have health cover subject to a complying deed. With respect to the issues that the Productivity Commission seeks more information on we suggest:

- (i) "The merits of requiring tertiary institutions to take responsibility for ensuring international students have sufficient healthcare cover": In our view there is little merit in this suggestion. It is likely to result in a fragmented approach that is inequitable for students. An approach improving the individual experience of care regardless of education institution would be to change the deed to ensure providers signing up to the deed are providing adequate mental health cover. The suggested approach would be to discuss with the Department of Health how to amend the deed to ensure appropriate cover.



- (ii) Re “what reforms are required to improve the treatment of and support provided to international students?” (page 725): Data collection is currently fragmented for both insurers and providers. Our recommendation is that there should be a coordinated approach involving insurers, hospitals and tertiary institutions. The Department of Health can facilitate a means of collecting and publishing data. This will enable identification of trends in the needs of the student population regarding mental health across all providers, funders and education institutions.

3. Life Insurance

This part of our submission responds to the findings and recommendations regarding life insurance in Section 19 ('Providing additional insurance for high risk employees'), Section 20 ('Stigma and discrimination in the insurance sector') and Section 24 ('Life insurance – Funding arrangements').

Before turning to these specific questions, there is a point regarding life insurance that the Institute recommends the Productivity Commission consider. Most life insurance products (except for critical illness cover) provide cover for an outcome regardless of cause. Typically this outcome is being 'unable to work' either currently (for income protection) or permanently (for total and permanent disablement).

The draft report states that ASIC's evaluation of responses should consider whether the insurance industry has implemented standardised definitions of diagnosed mental illnesses that are used to assess risk. The Institute reminds the Productivity Commission that there are still serious legal impediments (in both insurance and competition laws) to this step that will likely require some legislative reform before effective action can be taken. Even after such reforms and amendments, use of standardised medical conditions for assessment of mental health conditions may not add much extra value because the definitions do not always provide an indication about the impact of the condition on the claimant's ability to work.

3.1 Providing additional insurance for high risk employees (Section 19)

On page 785, the draft report states 'that employees in certain occupations, such as emergency service workers and construction workers – where there was a higher risk of developing a work-related psychological injury or mental illness – should be able to access additional income protection insurance that covers psychological injury or mental illness, on a group basis through their employer'. Accordingly, the Productivity Commission is seeking further information (information request 19.3) on any barriers to employers purchasing income protection insurance for their employees on a group basis.

Most employees receive insurance cover via a superannuation fund that has been arranged on a group basis by their chosen fund's trustee. Cover provided can include income protection cover, although this is a voluntary benefit in many superannuation funds.

Employers could put in place arrangements to purchase income protection insurance through superannuation for their employees, although there are some significant barriers if this is to be done, exacerbated if this cover is specifically for mental health cover. These include choice of superannuation fund (an employer's employees will be in multiple superannuation arrangements, not just the employer's default(s)), broader salary continuance definitions typically used within superannuation, the need for the trustee not to inappropriately erode members' retirement incomes, offsets for workers' compensation cover, and complex opt-



in/opt-out rules that now apply following the recent Protecting Your Super and Putting Members' Interests First legislation.

Whilst an employer can, as an alternative to superannuation, provide insurance cover to its employees outside the superannuation environment, there is a danger that this will cause the insurance provided (whether inside or outside superannuation) to be 'junk' insurance as there can be double-up of cover with multiple 'competing' benefits available for those employees with employer cover and their own superannuation cover, exacerbated by offsets for workers' compensation cover provided.

While this response does not cover all of the details involved, on balance the Institute doubts that this represents a viable approach other than for limited groups in emergency services.

3.2 Stigma and discrimination in the insurance sector (section 20)

On page 808, the draft report notes that "discrimination – whether lawful or unlawful – is a relatively common experience among people with mental illness seeking insurance." However, on the same page, the draft report also acknowledges that "the life insurance industry paid over \$800 million to around 8500 people experiencing mental ill-health in the 12 months to June 2018" and "the life insurance sector is arguably the largest non-Government supporter of mental health sufferers in Australia."

The two contrasting statements above highlight the Actuaries Institute view that while life insurers may or not be discriminating against consumers with mental health conditions, there are systemic issues faced by the life insurance sector when trying to maintain affordable and sustainable products that appropriately respond to mental health conditions. Some of these issues, as detailed in the Green Paper, include (but are not limited to):

- **Diagnosis and subjectivity** – To our knowledge there is no widely accepted tool in the life insurance sector for assessing the severity of a mental health condition and/or the expected impact on a person's life.
- **Reliance on self-reporting** – The primary source of information about a mental health condition comes from individuals themselves. Insurance systems place a heavy reliance on medical experts to validate and assess the condition of a person making a claim. However, a medical expert in relation to mental health conditions has very little information with which to work other than what the person has told them. If ways can be found to get reasonably reliable validation of what a person says in self-reporting their mental health condition, many insurance issues may be resolved.
- **Severity and prospects of recovery** – Insurers providing TPD and income protection benefits are very reliant on the advice of the treating professionals, given their very limited opportunity to make early contact (as claims are typically notified well after the condition first manifests) and provide any support to facilitate return to work.
- **Secondary harm from claims process** – There is evidence to suggest that some people will develop or exacerbate mental health problems as a result of the stresses associated with the claim process. While many claims staff have received training to minimise discriminatory practices (as underpinned by the FSC Standard No. 21), the delays experienced before the outcome of a claim (including repeating their story numerous times) may exacerbate the claimants' conditions. However, we note the FSC Life Code includes provisions to minimise these secondary harms. This includes incorporating claim



assessment timeframes and ensuring a primary contact person for the duration the claim.

3.3 Life insurers and funding of mental healthcare (Section 24)

The Actuaries Institute supports draft recommendation 24.6, in permitting life insurers to fund mental health treatments for their income protection insureds on a discretionary basis. The Actuaries Institute also acknowledges the concerns from advocacy groups (i.e. clinicians funded by life insurers may be pressured to inappropriately recommend that a patient return to work) and shares the Commission's views that appropriate regulations can mitigate these concerns.

However, while this recommendation is likely to aid in supporting claimants' return to work objectives, an inherent issue remains for life insurers that they do not know anything about the person making the claim or their condition until well after the condition has arisen and a claimant has left work. Evidence⁴ demonstrates that the longer a person is off work, the lower the chances of them returning to work.

As detailed in MetLife's submission (442), "there is currently no obligation for employers to report to superannuation trustees when a member is off work due to illness, nor is there an obligation for workers compensation providers to inform superannuation trustees when a worker is in receipt of benefits." Improved co-ordination between employers, workers compensation insurers, and life insurers, coupled with draft recommendation 24.6, may potentially increase the likelihood of claimants' objective to return to work.

Therefore, we recommend the Commission should also consider investigating the benefits and current barriers (including privacy) in improving the co-ordination between superannuation funds, workers compensation insurers, and employers.

3.3.1 Life insurers funding treatment for TPD products

The Actuaries Institute also suggests that draft recommendation 24.6 for insurer funding of mental health treatment be extended to total and permanent disability products (TPD) under certain circumstances.

Many insurers in the life insurance industry have recognised that providing a lump sum TPD payment may not be the best outcome for all claimants with mental health conditions. The lump sum relies on a person establishing that they are permanently unable to work, whereas income streams can assume that an eventual return to work may be achievable. Insurers are therefore adopting different strategies to help claimants with a mental health condition to return to work and are providing disability payments in instalments rather than a lump sum. In these circumstances, the same arguments as for income protection are relevant to allow insurers to fund treatment for their TPD insureds on a discretionary basis.

3.4 Further comments on life insurance discussion: access to clinical records

The draft report suggests that it may be advantageous to limit access by insurers to clinical records. In general, the Actuaries Institute is of the view that insurers need to have access to clinical records, including those for mental health conditions, for the following reasons:

⁴ Johnson D & Fry T 2002, *Factors Affecting Return to Work after Injury: A study for the Victorian WorkCover Authority*, Melbourne: Melbourne Institute of Applied Economic and Social Research



- **Comorbidity:** Comorbidities are associated with higher rates of disability (and longer recovery), health costs and poorer quality of life. As a result of this, a person with a mental health condition and other physical and/or mental health problems, poses a higher risk for a life insurer and more information may be required to accurately assess the risk. Comorbidities with mental health conditions occur quite frequently and having more information can better assist in understanding the complexity of claim/risk and can provide a more complete picture of the person being assessed. This can enable a more appropriate claims management response.
- **Poorer recovery when mental health conditions are involved:** Evidence shows that (on average) people with a mental health condition are slower to recover and return to work (if relevant). With income protection and TPD claims, psychological and cognitive barriers have been identified as the main factors preventing return to work⁵.
- **The prevalence of comorbidities and substance abuse:** Information on history of any substance abuse is critical for insurers as chronic, recurrent depression is associated with anxiety and substance abuse, and with common chronic medical conditions such as diabetes, cardiovascular disease and obesity. Where such comorbidities exist the prospects of a full resolution of symptoms is lower, and the risk of further episodes is higher⁶. Access to clinical records in such cases will help insurers make more informed underwriting decisions and insurers can continue offering sustainable and affordable products by charging appropriate premiums applicable in such conditions.

Given the importance of clinical records to ensuring appropriate claims management practices, the Actuaries Institute is of the view that withholding relevant information from the insurer would ultimately be detrimental to the claimant. Rather the key issue with access to clinical records that should be addressed is the way in which medical information is used in making underwriting and claim decisions. That is, reporting of symptoms should not be confused with diagnosis of conditions. For example, it should be clear that reporting some mental distress to the GP, or seeking counselling support, does not provide proof of a mental health condition.

4. Other comments and responses

4.1 Awareness in the insurance sector (draft rec 20.2)

As noted by the Productivity Commission this is an area where action has begun and initiatives should now be consolidated and evaluated. It will still be necessary to tailor responses to the circumstances of each segment of the insurance sector.

Some observations from the Institute on points of detail are set out below.

- a) The Financial Services Council is probably not well placed to extend standards or initiatives to superannuation funds and financial advisory groups because those entities are typically not members of the FSC. The drive needs to come from other entities, but the Superfriend training regime is an ideal service provider that can operate across several sectors.

⁵ Lee, S, Kanhai, R & Poon, A 2015 *Super, Life and General Meet at the Crossroads* Presentation to Actuaries Institute Actuaries Summit, Melbourne, 17-19 May 2015

⁶ American Psychiatric Association 2013, *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, p.163-167



- b) We see no merit in expanding training requirements to include all employees of life insurers. Training needs to be fit for purpose and directed at the needs of specific roles. There is no benefit in training, for example, accounting or IT staff, unlike senior management or underwriting staff.
- c) The recommendation for ASIC to evaluate insurance industry initiatives does not play to ASIC's strengths. The only merit of ASIC as an evaluator is that it has the legislative authority. The Institute suggests that the National Mental Health Commission may be a more suitable body to conduct such an evaluation. This evaluation could readily include the issues of access to clinical records, currently proposed for the Office of the Australian Information Commissioner.

Consistent with some of our observations earlier in this submission, the Institute asks that the final report respond specifically to initiatives commenced and developed in recent years. Unless the Commission determines that an initiative is misguided and unlikely to be value for money, then supporting and guiding current initiatives is more productive than generalised observations and recommendations.

For example, in general insurance the new industry Code of Practice includes specific provisions about dealing with customers with a mental health condition, as well as vulnerable customers more broadly. While the Code is currently voluntary, this is expected to change in the near future as ASIC reviews and ultimately approves the Code.

There is also a specific monitoring and evaluation process, undertaken by the Code Governance Committee with the support of AFCA and oversight by ASIC. A two-year review of the effectiveness of the Code provisions is already agreed. The Institute suggests that recommendations for evaluation be made more specific by endorsing the provisions and reviews of the various Codes, rather than a broad 'evaluation by ASIC'.

An implication of this suggestion is that evaluations need to be specific to different products. The circumstances and issues are not the same for each product and an overall evaluation is unlikely to be fit for purpose.

While the Institute supports the general proposition that mental health conditions need to be treated equally as seriously as physical conditions, this does not mean that the same approaches can be applied across all circumstances.

4.2 Emerging evidence of risk

Actuaries working in the field have been observing that the statistical and scientific evidence shows that risk of recurrence is relatively high for most mental health conditions. This evidence has important consequences for product design, underwriting standards and the information needed from consumers. This in turn relates to the issue of 'stigma' and suggests that stigma issues with disclosure cannot be solved by simply not asking for the information.

The example in the table in Appendix A illustrates changes in wording of travel insurance products in the last two years, based on information published by the Public Interest Advocacy Centre⁷. While there is obvious and significant change to remove the exclusions, there is also a move to treating all past mental health conditions in the same way as other pre-existing conditions – by using terminology such as any treatment in the last 10 years or at any time.

⁷ <https://piac.asn.au/examples-of-insurance-policies-with-blanket-mental-health-exclusions/>



Looking at the disclosure requirements from nine travel insurance providers no policy will currently provide automatic coverage for any pre-existing mental health condition without disclosure and assessment, unlike some physical health conditions.

This approach requires a significant proportion of the population to disclose any previous mental health conditions to meet the disclosure requirements. This is an early indication that it may be unrealistic to expect a reduction in the 'stigma' of mental health conditions influencing the accessibility of insurance.

Finally, on this topic we note that the Institute is currently preparing educational material on anti-discrimination obligations which may ultimately result in professional guidance for actuaries in the field.

4.3 Training in other sectors

Draft recommendation 20.2 states that mental health training needs to be extended to all employees in the life insurance industry. There seems to be little or no value in providing such training for people for whom the issues have no relationship to their role, for example accounting or IT staff.

The Institute suggests that corresponding training be extended to relevant employees of the organisations where such claims typically arise. Suitable training and involvement in workplaces can clearly improve successful return to work and help GPs to be more confident about certifying a claimant fit to return to work.

4.4 Continuing evaluation (draft rec 22.5 and chapter 25)

Improving mental health and minimising the adverse outcomes for members of the community is a long-term initiative. It will require investments that will take some time to pay off and will involve competition for scarce funding (even with a large increase in government funding as identified by the Productivity Commission).

The Institute suggests that draft recommendation 22.5 be extended to recommend inclusion of the 'investment approach to welfare' in the remit of the National Mental Health Commission for planning and evaluation. This approach has been used increasingly in Australia since its introduction in 2015 and provides essential information to inform the priorities for investment in health and welfare.

Draft recommendation 25.4 covers the goal of targeting health outcomes but not the goal of avoiding inefficient funding or the goal of equity of access. The Institute suggests that NMHC reporting includes a section on efficiency of funding and a section on equity of access. Insurance related initiatives would need to be included.

Appendix A – Travel Insurance wording changes

Insurer	Wording of exclusion (pre 1 June 2017*)	Wording of exclusion (as of 1 Jan 2020)	Treatment of Pre-Existing Condition
Nomad	We won't pay for costs arising in any way from 15. Any mental illness as defined by Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), whether or not the condition arises independently or is secondary to other medical conditions, including but not limited to: dementia, depression, anxiety, stress, or other mental or nervous conditions (except claims following assault as outlined under Section 1.5 – Clinical psychology (Explorer Plan); behavioural diagnoses; a drug or alcohol addiction; eating disorders.'	Removed	No explicit reference to mental health, but references any medical condition, currently ongoing or experienced at any time in the past, involving your back, neck, brain, heart, circulatory system or respiratory system, or cancer 23 Conditions on the "Automatically covered pre-existing medical conditions" list with no mental health conditions
Allianz Australia	We will not pay under any circumstances if: cl B.8: Your claim arises from or is in any way related to mental illness including: dementia, depression, anxiety, stress or other mental or nervous condition; or conditions that have resulted in behavioural issues; or a therapeutic or illicit drug or alcohol addiction.	Removed	Categorises any mental health condition receiving treatment in the last 10 years as an existing, similar to heart, brain, circulatory system, blood vessels, the respiratory system, kidneys, liver or pancreas, or cancer 36 Conditions are considered "which we may cover with no additional premium payable" of which none are mental health-related



American Express AU	cl 11: We will not (under any Section) pay for claims arising directly or indirectly from: (18): Your nervous, anxiety or stress disorders resulting in a disinclination to travel or complete Your Journey.	Removed	Any mental health condition with advice or treatment is considered pre-existing. Have 52 conditions on the "Approved Medical Condition Table" of which none are mental health
CoverMore Travel Insurance	We will not pay for: 20. claims directly or indirectly arising from Your anxiety, depression or mental or nervous disorders. (pre 1 June 2017)	Changed to cover if diagnosed by a Registered Psychologist or Psychiatrist that prevent travel We will not pay for claims caused by: 4. anxiety, depression, mental illness or stress (or arising directly or indirectly from, or exacerbated by, these conditions) unless referred to and diagnosed by a Registered Psychologist or Psychiatrist as a new condition (i.e. not an Existing Medical Condition) and: a) You are certified as unfit to travel by the treating Registered Psychologist or Psychiatrist; or b) the treating Registered Psychologist or Psychiatrist certifies that it was medically necessary for You to amend or cancel Your Journey to assist a Relative or another person	Any mental health condition requiring current medication or hospitalisation in the last two years 35 conditions on the "Existing Medical Conditions We automatically include" list of which none are mental health
Citibank	cl 10: We will not pay (under any Section) for claims arising directly or indirectly from: (16): Your or a Travelling Companion's nervous, anxiety or stress disorders resulting in a disinclination to travel or complete Your Journey.	Removed	Any mental health condition receiving treatment before receiving cover is a pre-existing condition 14 conditions are "pre-existing conditions that are covered", with no mental health conditions on the list



<p>HSBC AU</p>	<p>p 36-40: To the extent permitted by law we will not pay if: Your claim arises from or is in any way related to: mental illness or: dementia, depression, anxiety, stress or other mental or nervous condition; or conditions that have resulted in behavioural issues; or a therapeutic or illicit drug or alcohol addiction.</p>	<p>Removed</p>	<p>Categorises any mental health conditions receiving treatment in the last 10 years as an existing, similar to heart, brain, circulatory system, blood vessels, the respiratory system, kidneys, liver or pancreas, or cancer 36 Conditions are considered "which we may cover with no additional premium payable" of which none are mental health-related</p>
<p>Real Travel Insurance</p>	<p>p 48: We will not pay for any claim or loss under any circumstances if Your claim Arises from: cl 28: or is in any way related to depression, anxiety, stress, mental or nervous conditions</p>	<p>Changed to only apply to cancellation claims to only cover new conditions that prevent travel 3.2 We will not pay any claim or loss: m. As a result of Mental Illness (including depression, anxiety, stress, mental or nervous conditions) suffered by You, a Relative or another person unless:</p> <ul style="list-style-type: none"> • a Mental Illness diagnosis has been made by a Registered Psychiatrist and • the treating Registered Psychiatrist certifies that the Mental Illness prevents You from starting or finishing Your Journey; and • the Mental Illness has first occurred or first manifested as a new condition during Your Period of Insurance. 	<p>Any condition in the last 5 years, suffered from or received any form of medical advice, treatment or medication for 43 Conditions on the "Automatically Covered Pre-Existing Medical Conditions" with no mental health conditions</p>



Travel Insurance Direct	We will not pay for any claim arising from or relating to the following: cl 27: Any mental illness defined by DSM IV including but not limited to dementia, depression, anxiety, stress, or other nervous condition, behavioural diagnoses such as autism, eating disorders, a drug or alcohol addiction.	Removed	Any condition with symptoms, diagnosis or medication ever 43 conditions on the automatically accepted conditions list with no mental health conditions
Virgin Money	We will not pay for: B.7 Your claim arises from or is in any way related to: mental illness; or dementia, depression, anxiety, stress or other mental or nervous condition; or conditions that have resulted in behavioural issues;	Removed	Categorises any mental health conditions receiving treatment in the last 10 years as an existing, similar to heart, brain, circulatory system, blood vessels, the respiratory system, kidneys, liver or pancreas, or cancer 36 Conditions are considered "which we may cover with no additional premium payable" of which none are mental health-related

* As provided by the Public Interest Advocacy Centre available at <https://piac.asn.au/examples-of-insurance-policies-with-blanket-mental-health-exclusions/> with the exception of CoverMore Travel Insurance which is based on policy wordings available online