



MENTAL HEALTH, DISCRIMINATION & INSURANCE

A Survey of Consumer Experiences 2011



ACKNOWLEDGEMENTS

This report was prepared by the Mental Health Council of Australia (MHCA) in collaboration with *beyondblue: the national depression initiative (beyondblue)*.

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Finally, the MHCA also acknowledges the work undertaken to improve insurance outcomes

for Australians with experience of mental illness by Mental Health and Insurance 2010-11 MoU signatories:

- Australian General Practice Network (AGPN)
- Australian Medical Association (AMA)
- Australian Psychological Society (APS)
- *beyondblue*
- Financial Planning Association of Australia (FPA)
- Financial Services Council (FSC)
- Mental Health Council of Australia (MHCA)
- Royal Australian College of General Practitioners (RACGP)
- Royal Australian and New Zealand College of Psychiatrists (RANZCP)

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FOREWORD

beyondblue is committed to improving access to insurance for people with a history of mental illness. We are pleased to be working with the Mental Health Council of Australia in this important area.

Everyone is entitled to fair and equitable access to insurance. The findings of this report suggest that people with a history of mental illness are discriminated against in a way that people with physical illness are not. For example, large premium loadings or blanket exclusions may be applied, but may not reflect the individual circumstances of the person or the level of risk they present to insurance providers.

Important work has been undertaken to address these issues through a Memorandum of Understanding between the mental health,

insurance and financial planning sectors. A key achievement has been the development of a *Mental illness and life insurance guide*, which provides people with accurate information about life insurance and the effect mental illness may have on an insurance application. This goes some way towards helping people better understand their rights and responsibilities, and addressing misconceptions that exist within the general community.

The findings reinforce there is still more to do – across all insurance types, not simply life and income protection. *beyondblue* will continue to work in collaboration with key partners and stakeholders, including people with personal experience of mental illness, to address discriminatory practices across the industry so equitable access to insurance is available to all.



DAWN O'NEIL AM
BEYONDBLUE
CHIEF EXECUTIVE OFFICER

ACRONYMS AND ABBREVIATIONS

ADA	Americans with Disabilities Act
AGPN	Australia General Practice Network
AMA	Australian Medical Association
APS	Australian Psychological Association
DDA	Disability Discrimination Act 1992
FPA	Financial Planning Association
FSC	Financial Services Council
IFSA	Investment and Financial Services Association
HREOC	Human Rights and Equal Opportunity Commission (now the Australian Human Rights Commission)
MHCA	Mental Health Council of Australia
MoU	Memorandum of Understanding
PND	Post-natal depression
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists

EXPLANATORY TERMS

Carer	For the purposes of the survey, a carer was defined as someone whose life is affected by virtue of his or her close relationship with a consumer, or who has a chosen caring role with a consumer. A carer may also refer to the consumer's identified family, including children and parents, as well as other legal guardians and people significant to the consumer.
Comorbidity	A general medical term to describe diagnosis of more than one condition. It is commonly used alongside terms such as 'dual diagnosis' and 'co-occurring disorders' which describe the diagnosis of an individual with co-existing substance use disorders and mental illness.
Consumer	For the purposes of the survey, a consumer was defined as a person who is currently using, or has previously used a mental health service.
Discrimination	The Disability Discrimination Act 1992 defines discrimination against another whereby the discriminator treats, or proposes to treat, the aggrieved person less favourably than the discriminator would treat a person without the disability in circumstances that are not materially different.
Insurance policy	An agreement in which a customer pays a company money and the company pays for costs incurred in the event the customer experiences an accident, injury, theft etc.
Insurance product	A type of insurance policy, e.g. car insurance, life insurance, private health insurance, car insurance, home and contents insurance, superannuation and income protection insurance.
MoU	A document describing an agreement between two or more parties. It expresses an intention by all parties to work together on a common action or series of actions. It is not a legally enforceable agreement.
Stigma	There are a number of ways to define stigma, but for the purposes of this publication, the term stigma refers to negative, discriminatory or prejudicial views and behaviours directed towards people living with a mental illness, because of their experience with mental illness.
Superannuation	An agreement in which an employee has a percentage of their pay compulsorily deducted by their employer and paid to a company. This company is then required to pay out these funds to the employee when they meet the legal eligibility criteria (i.e. upon retirement or when experiencing financial hardship).
Underwriting	The process of insuring someone or something, which may include obtaining further information from the applicant, seeking independent medical advice, undertaking a risk assessment etc.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	02
BACKGROUND	04
LITERATURE REVIEW	05
The consumer experience	06
Underwriting and assessing risk	06
Mental illness and the insurance industry	09
Stigma	10
Complaints and appeals	11
SURVEY METHODOLOGY	12
SURVEY RESULTS	13
Demographics	13
Applying for insurance	16
Claiming on an insurance policy	33
Taking action against insurance companies	40
Applying with other insurers	41
Further comments	43
Mental illness and insurance are incompatible	45
I'm different	46
The nature of mental illness	47
The morality of insurance companies	47
Exclusion	47
CONCLUSION	56



CLOSED

PLEASE CALL AGAIN

EXECUTIVE SUMMARY

Mental Health, Discrimination and Insurance: A Survey of Consumer Experiences 2011 details the results of a survey which captures the experiences of Australians living with mental illness when accessing insurance products and making claims against their policies. This survey builds on the work of a Memorandum of Understanding (MoU) between the mental health, insurance and financial services sectors, which aims to improve life insurance and income protection outcomes for Australians experiencing mental illness.

This survey revealed the substantial difficulties Australians with experience of mental illness face when seeking insurance products that are otherwise readily available to people without a history of mental illness.

Survey respondents reported significant difficulty and discrimination when applying for insurance products, particularly life insurance and income protection products, and when making claims against their policies. Mental health consumers often face higher premiums and exclusions on their policies and in many cases are refused coverage outright. Moreover, survey respondents stressed that insurance companies did not take into consideration their personal circumstances and instead made broad assumptions about their ability to maintain employment and their general level of function, and this in turn had negative implications for their application or claim:

I am much fitter and healthier physically than the average person, yet they approve income protection insurance to clinically obese, sedentary, office workers who I treat regularly in my clinic for not looking after themselves properly.

Survey respondents revealed a lack of awareness of their rights and responsibilities in relation to insurance applications, including their duty of disclosure, or their right to appeal a decision. Moreover, the matter-of-fact nature of some sales, underwriting and/or call centre staff in obtaining information about suicide attempts and/or ideation, for instance, was viewed as humiliating, embarrassing or undignified.

Given that one in five Australians will be affected by mental illness in any twelve month period, and one in two will be affected across the span of a lifetime, it is of great concern that Australians living with mental illness are still not able to access or maintain insurance policies at the same rate as other Australians.

The results of this survey highlight the work that still needs to be done in educating not only the insurance and financial sector workforce, but all Australians about the real-world experiences of mental illness, to break down the stigma and stereotypes that are so frequently applied to mental health consumers, and to minimise the disadvantage they experience as a result of misinformation and misconception. Moreover, considerable work needs to be done to increase knowledge and awareness of the insurance and financial services industries, how they work, and what products are better suited to people with mental health conditions etc., amongst Australians living with mental illness. This publication recommends that the mental health and broad ranging insurance, financial and superannuation sectors continue to work towards better understanding and addressing these gaps.

I was very concerned about the way in which these [questions] were asked eg (verbatim) "Are you currently suicidal or do you have plans to commit suicide within the next twelve months? Have you had suicide attempts? We need to know all of this because it will impact on your policy and ability to make claims. I can add it as an inclusion that suicide may be a possibility, but you will likely have to pay more. Would you like me to include that suicide is a possibility?"



BACKGROUND

In contemporary Australian society, holding a suite of private insurance policies is the norm; compulsory third party insurance is incorporated into car registration fees, superannuation funds often come with accompanying life insurance schemes, private health cover is available for the individual, and for Australian's wanting additional security for their finances or possessions, a whole raft of policies are available. Advertising and marketing campaigns frequently tell us that all these insurance options are available at limited cost, with minimal effort or disclosure of personal details, and often without requiring a medical examination.

Unfortunately many Australians who have at some stage experienced a mental illness are not afforded the same access to insurance products as those who have not experienced mental illness. Australians with experience of mental illness often endure increased premiums, excessive restrictions on their policies and outright rejection of their applications and claims when a history of mental illness is disclosed.

To ensure fairness and equity for people experiencing mental illness seeking insurance products, the MHCA and *beyondblue* began working in collaboration with a number of insurance and mental health sector representatives nearly 10 years ago with the aim of improving insurance outcomes for Australians living with mental illness.

In March 2003, the first Memorandum of Understanding (MoU) between the Investment and Financial Services Association (IFSA) (now the Financial Services Council) and mental health sector stakeholders was established in recognition of the issues faced by Australians living with mental illness in obtaining life insurance products. In more recent times, MoU membership has been extended to include representatives from the underwriting and medical professions. This collaboration has served to improve communication cross-sectorally, and has led to a series of publications aimed at both improving underwriting practices and claims treatment in respect to mental illness, and educating the broader community about their rights and responsibilities when applying for insurance, or making claims against their policies.

Part of this process involved conducting a survey to better understand the extent and nature of problems faced by people with mental illness when applying for, and making claims against insurance products other than life insurance. The survey was developed and disseminated in 2010, with consumers and carers having the opportunity to report upon their experiences, the results of which form the basis of this publication. The survey findings are supported by a comprehensive review of relevant literature undertaken by the MHCA, which is also included in this publication. Together, this research brings to the fore the real-life challenges Australians with experience of mental illness face in accessing and claiming against insurance policies.

LITERATURE REVIEW

The first National Inquiry into the Human Rights of People living with Mental Illness ('The Burdekin Report') undertaken in the early 1990s revealed the systemic nature of discrimination experienced by people living with mental illness when applying for, or making claims against, insurance policies:

The Inquiry was told that insurance companies frequently impose loadings, or even exclusions, on people who have (or have had) a mental illness. Witnesses considered these loadings and associated conditions were out of keeping with the true risk which their state of health implied. In particular, they considered that insurers took insufficient or no account of the type of illness, its severity, its prognosis, or its consequences for longevity or for income-earning capacity...¹

Seventeen years later, a survey undertaken by the MHCA and *beyondblue* entitled *Consumer Experiences of Mental Health and Insurance* revealed much of the same. Survey respondents reported higher premiums, exclusions and outright refusal of coverage as a result of their experience of mental illness. They expressed concern that broad and often stigmatised assumptions about people with mental illness were being relied upon by insurance companies when assessing applications and claims, instead of their personal circumstances and situation. They reported a lack of knowledge of their rights and responsibilities in relation to insurance applications and claims, and were angered or embarrassed by their dealings with insurance company staff.



¹ HREOC (1993). *Report of the National Inquiry into the Human Rights of People with Mental Illness*. http://www.hreoc.gov.au/human_rights/mental_illness/national_inquiry.html

THE CONSUMER EXPERIENCE

The struggle to access and maintain insurance policies is not solely restricted to Australian's living with mental illness. A New Zealand survey of mental health consumers undertaken in 2006 found that financial institutions, including banks and insurance companies, had discriminated against 20 per cent of respondents. Being turned down for mortgages and insurance policies was common for those who took part in the survey, and for those respondents who did manage to obtain insurance, they were often charged extra premiums and had extra conditions imposed on their policies.² A British study in 1996 published similar results. Their survey found that 25 per cent of respondents had previously been refused insurance policies or loans by an insurance or finance company because of a psychiatric diagnosis.³ The British mental health charity, Mind, found that these experiences were due to unfair discrimination from insurance companies, citing cases where people had not been given insurance as a result of experiencing mental illness 20 years ago.⁴

Anecdotal evidence supports Mind's finding that there is widespread discrimination in the insurance industry worldwide. In an Australian case, an academic was denied income protection insurance based on a history of depression. This was despite the fact that she had rarely taken a day off work because of depression and had nearly four months of sick leave owing to her.⁵

In reality, many people living with mental illness are able to retain full employment and participate in society, while a smaller proportion of people with mental illness require higher levels of care and support. Due to the wide variation in care and treatment required, many argue that any risk assessment that insurance companies use must include analysis that goes beyond diagnosis.⁶ This means also taking into account the person's level of functioning when determining the outcome of any insurance policy application.

UNDERWRITING AND ASSESSING RISK

Assessing the risks associated with any insurance or superannuation applicant is a core business feature of the voluntary private insurance market.⁷ These risk assessments, also referred to as underwriting, are key to ensuring the economic viability of the insurance industry. For example, if homeowners live in a suburb that experiences higher rates of burglary, insurance premiums are often higher. For people with pre-existing and deteriorating illnesses applying for health insurance, exclusions relating to these illnesses are contained within the insurance policy. Without this differentiation or legally defined discrimination between policyholders, the insurance industry could experience significant financial loss as a result of high costs or frequency in claims.

The insurance and superannuation industries ability to differentiate or legally discriminate between policyholders on the basis of mental illness is partially covered in the Australian Disability Discrimination Act 1992 (DDA). The DDA includes provision for discrimination based on disability for providers of insurance and superannuation when the discrimination is considered reasonable and based on actuarial or statistical data, or other relevant factors.⁸

In the United States, the Americans with Disabilities Act (ADA) does not appear to completely cover insurance either. Private health insurers, for example, can single out certain conditions for complete or near-total exclusion, as long as the exclusion applies to all members of the insurance plan. This situation has been known to happen even in situations where the insurer has no actuarial data to justify the discrimination based on diagnosis. This is despite the ADA requiring (as with the DDA) justification for any exclusion with actuarial data. In 2008, the United States Federal Government passed a mental health insurance parity Bill that bans insurance companies from setting lower limits on treatment for mental health problems than on treatment for physical problems. The Bill also disallowed higher co-payments. This Bill, however, does not get around the issue of insurance companies excluding coverage as long as it applies to all members of the plan.

While blanket exclusion of certain coverage for all policyholders is not allowed within the Australian insurance industry, there are still a number of problems associated with the DDA exemption for the insurance and superannuation industries. Whilst actuarial or statistical data does often paint an evidence-based picture of the risks associated with certain lifestyle choices, behaviours or experiences, there are too many opportunities for underwriters to inject their own views or bias into their work:



Underwriting is not solely driven by mathematics and science – underwriters frequently use intuition and experience in making their decisions, which is probably inevitable, although it is desirable that this should be backed by statistics wherever possible.⁹

² D. Peterson, L. Pere, N. Sheehan, G. Surgenor (2006). Experiences of mental health discrimination in New Zealand in Health and Social Care in the Community, 15(1). p8-25

³ J. Read and S. Baker (1996). Not Just Sticks & Stones: A survey of the Stigma, Taboos and Discrimination Experience by People with Mental Health Problems. <http://www.leeds.ac.uk/disability-studies/archiveuk/MIND/MIND.pdf>

⁴ BBC News (1999). Insurers "biased" against mentally ill. <http://news.bbc.co.uk/2/hi/health/358776.stm>

⁵ M. Johnstone (2001). Stigma, social justice and the rights of the mentally ill: Challenging the status quo in Australian and New Zealand Journal of Mental Health Nursing, 10. p204-205.

⁶ MHCA and *beyondblue* (2010). *Joint MHCA and beyondblue submission to Treasury consultation on unfair terms in insurance contracts*. http://www.mhca.org.au/documents/submissions/MHCA_bb%20INSURANCE%20DISCRIMINATION%20SUBMISSION.pdf

⁷ O'Neill Institute (2009), *Insurance Discrimination on the basis of health status: An Overview of Discrimination Practices, Federal Law and Federal Reform Options, Executive Summary in Legal Solutions in Health Reform*. p101

⁸ MHCA. *Legal Aspects of Insurance*. <http://www.mhca.org.au/legal-aspects#Discrimination>

⁹ T.A Moultrie and R.G. Thomas (1997). *The Right to Underwrite? An Actuarial Perspective with a Difference* in Journal of Actuarial Practice, 5(1). p8.



Moreover, underwriting often fails to fully consider individual circumstance, focusing on the 'illness' rather than fully considering how this fits into the bigger picture of how well a person is functioning in the various aspects of their life on a day-to-day basis. Underwriting needs to operate within a social context; where social attitudes change and medical evidence shifts, underwriters need to 'reflect [these] emerging statistics and changing social attitudes', as articulated by the Australian Institute of Actuaries of Australia.¹⁰

In the case of mental illness, there is increasing evidence highlighting the unique and diverse experience of mental illness, the ways in which symptoms manifest and the impact it has on the lives of individuals. Treatment options have increased and improved, and the underwriting profession needs to reflect these changes in its work. The Australian Human Rights and Equal Opportunity Commission (HREOC) Guidelines to the DDA for the insurance industry highlight the need for underwriters and assessors to consider relevant factors that increase or reduce the risks associated with mental illness, i.e. is the applicant receiving effective treatment for their illness so as to reduce risks associated with the condition. Moreover, an applicant's work attendance record and employment history would also be considered relevant when assessing the effect of an individual's mental illness in relation to income protection insurance.

MENTAL ILLNESS AND THE INSURANCE INDUSTRY

There is no doubt that mental illness presents significant challenges and controversy for the insurance and superannuation industries. In the case of life insurance, mental illness,

unlike many physical illnesses, is often hard to quantify. One study in the United States found that psychiatric language often varied from doctor to doctor, which caused confusion over the interpretation of a specific mental illness diagnosis. The term 'depression', for example, does not always distinguish between major or minor forms of the illness. The Australian HREOC's Guidelines for Providers of Insurance and Superannuation also highlighted this dilemma in its case studies: a discrimination complaint was brought against an insurance company by a woman who had an insurance application rejected as a result of her previous experience of post-natal depression (PND). This complaint led to the insurance company writing to a number of international underwriting companies to highlight the fact that PND is a specific and unique form of depression with different effects and duration when compared to other forms of depression.¹¹

Medical confidentiality is also often considered a barrier to the proper assessment of insurance applications, especially as psychiatrists and other mental health professionals tend to be cautious in their dealings with insurance companies. Further evidence of strained relations between the medical and insurance industries was discovered in a 1997 study of psychologists and health insurance agents, which found that 17% of insurance agents believed that individuals with insurance coverage used mental healthcare benefits unnecessarily, compared to eight per cent of psychologists. Moreover, a majority of health insurance agents (69%) believed that therapists used mental health benefits in a self-serving manner, compared to 15% of psychologists.¹² This mutual distrust between the two industries further complicates matters for consumers wishing to hold certain policies, and appropriately claim against them.

¹⁰ Institute of Actuaries Australia (1994). *An equitable risk classification system for all*. Cited in T.A Moultrie et al (1997) op cit.

¹¹ HREOC (2005). *Guidelines for Providers of Insurance and Superannuation*. http://www.hreoc.gov.au/disability_rights/standards/insurance/insurance_adv.html

¹² R.D. Hunter and C.S. Austad (1997). *Mental Health Care Benefits and Perceptions of Health Insurance Agents and Clinical Psychologists* in *Professional Psychology: Research and Practice*, 28(4). p366.

STIGMA

When considering the negative experiences reported by mental health consumers in applying for, and/or making claims against insurance products, it is necessary to consider the prevalence of stigma within our community towards people living with mental illness and how this might perpetuate inequities in insurance application and claim outcomes.

Stigma is often defined within an individual or psychological framework, where the focus is on "...examining the social-cognitive¹³ elements of the stigmatiser, who perceives a stigmatising mark, endorses the negative stereotypes about people with the perceived mark, and behaves toward the marked group in a discriminatory manner."¹⁴ This form of stigma most often manifests itself within interpersonal relationships, i.e. social exclusion of, or discrimination towards, individuals with mental illness. This form of interpersonal stigma permeates all levels of Australian society, and therefore is likely present within the insurance industry. If underwriting staff or insurance brokers, for instance, allow their own stigmatised views about mental illness to influence their work, this could have negative and unfair implications for people with mental illness who are applying for, or claiming against their, insurance policies.

These same stigmatising views are also often reinforced structurally within institutions. Policies and procedures employed by government or private institutions can often intentionally restrict opportunities or options for people with mental illness, or produce unintentional consequences that cause comparable negative outcomes.¹⁵ For example, structural manifestations of stigma relating to mental illness in the insurance and superannuation industries might include the use of underwriting policies which generalise the risks and consequences of mental illness and inhibit the consideration of unique and personal circumstances. This expression of structural stigma creates additional barriers to accessing insurance products for people with experience of mental illness, and could intentionally or unintentionally lead to inequity in private insurance coverage within Australia:

If I – an accomplished academic and professor with an impeccable work record – can't get insurance in this instance, what chance do others have who are less accomplished than I – who are on a lesser income, who are disabled, who suffer from more severe mental health problems than do I – what chance do they have to achieve equitable access to this kind of insurance provision?¹⁶



COMPLAINTS AND APPEALS

There are a number of avenues in which appeals relating to insurance company decisions regarding applications and claims can be made. The DDA, for example, allows people to lodge complaints where they believe that the insurance company in question has not properly substantiated their decision with actuarial or statistical data, or other reasonable grounds. In line with the DDA and other legislation relating to anti-discrimination, many of the complaints brought against insurance companies are resolved through conciliation processes. While conciliation processes are generally considered to be far more supportive of a complainant's needs, very few disputes resolved

through conciliation have resulted in admissions of liability or the setting of firm legal precedents when insurance companies do get things wrong.¹⁷ This can be problematic to people living with mental illness when considering the possibility of appealing a decision. Moreover, a complaint-driven process, as is articulated in the DDA, can also inadvertently disadvantage complainants as the process is often considered complicated and intimidating to individuals unfamiliar with complaint systems.¹⁸ An emphasis on preventative monitoring and evaluation of discrimination in the insurance and superannuation industries would offer a complementary mechanism for addressing possible discrimination against people with mental illness, without creating additional stress and worry for them.¹⁹

¹³ Social cognition refers to the thought processes used for understanding or dealing with people.

¹⁴ P. Corrigan, F. Markowitz and A. Watson (2004). *Structural Levels of Mental Illness Stigma and Discrimination* in Schizophrenia Bulletin. 30(3). p481.

¹⁵ Ibid.

¹⁶ Cited in M. Johnstone (2001), op cit. p205.

¹⁷ G. Innes (2000). *Disability Discrimination and insurance: Speech to Australian Life Underwriters Association and Claims Association conference*. http://www.humanrights.gov.au/disability_rights/speeches/2000/underwrite.htm.

¹⁸ WA Office of Mental Health (2003). *Submission to the Productivity Commission Review of the DDA 1992*. http://www.pc.gov.au/_data/assets/pdf_file/0005/41774/sub094.pdf.

¹⁹ Ibid.

SURVEY METHODOLOGY

AIM

The *Consumer Experiences of Mental Health and Insurance 2010* survey (the survey) aims to capture the views and experiences of mental health consumers and carers in applying for, or making claims against, insurance products. To date, there has been little systematic data collection undertaken in this area. The data presented in this publication will be used to inform future work undertaken by the MHCA, *beyondblue* and others to improve insurance outcomes for Australians with mental illness.

METHOD

The survey contained 28 questions, developed to capture broad information about mental health consumer experiences in applying for insurance products, and making claims against them. Eligibility to undertake the survey was restricted to individuals who self-identified as being a mental health consumer or carer. Quantitative and qualitative data analysis techniques were employed, including the use of thematic coding techniques and chi-square tests²⁰.

The survey was hosted online utilising the commercial survey tool *Surveygizmo*. Information and links connecting to the survey were disseminated through MHCA online networks, MHCA member networks, and MoU signatory networks including *beyondblue*'s *blueVoices*. Hardcopy surveys were also available to participants, if requested. The analysis was conducted on surveys completed between 18 July and 23 September 2010.

This is the first MHCA-*beyondblue* published study on this topic and it will therefore form the benchmark upon which future surveys and consultations will be built upon and measured against. The ongoing measurement and reporting of consumer and carer experiences when seeking or claiming against insurance products will provide a way of assessing changes that occur over time.



²⁰ Relating to or denoting a statistical method assessing the goodness of fit between observed values and those expected theoretically

SURVEY RESULTS

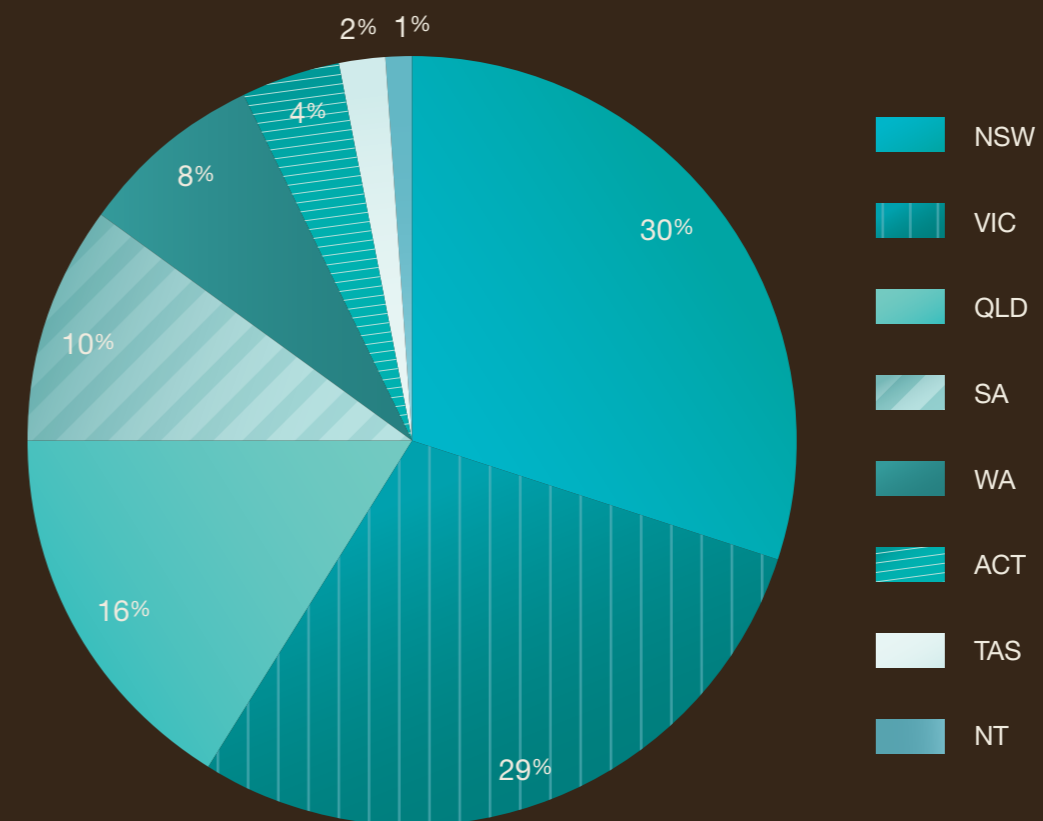
In total, 495 people responded to the survey. One respondent was excluded from analysis due to missing data, and a further 70 respondents did not fit the eligibility criteria. Of those, 424 respondents were eligible and included in the data set for analysis purposes. Some parts of the survey were irrelevant to some respondents and were therefore not answered by all respondents. For example, if someone had never made a claim they were not required to answer any further questions about the claims process.

DEMOGRAPHICS

STATE OF RESIDENCE

Respondents were asked in which state or territory they lived. More than half of the survey respondents were from either New South Wales (30%) or Victoria (29%). The Northern Territory (1%) and Tasmania (2%) had the least representation in this survey.

FIGURE 1: State of Residence (n=424)



EMPLOYMENT STATUS

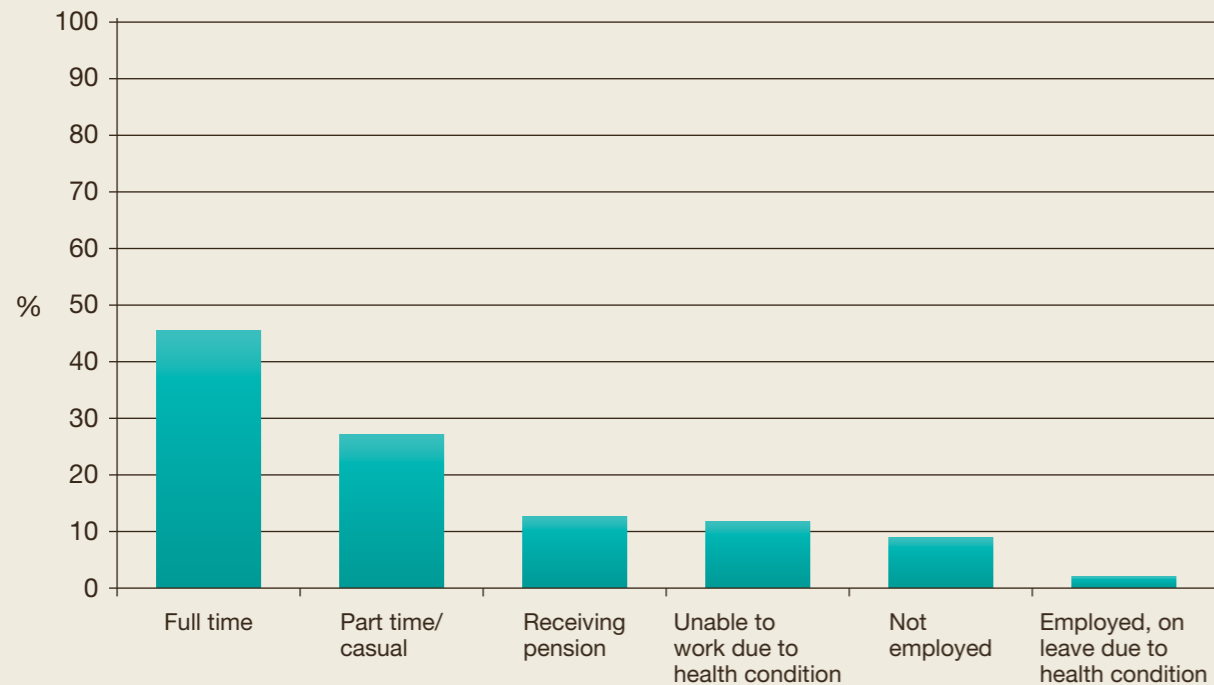
Survey respondents were asked about their current employment status. The proportion of respondents who were employed full time was 46%. Twelve per cent of the respondents were unable to work due to a health condition and 2% were employed but on leave due to a health condition. Some respondents indicated that they were employed part time or casual (27%) and were receiving a pension (13%) concurrently.

Respondents who were on leave from work due to a health condition were asked to provide details of the health condition. The health conditions most commonly cited were depression and/or anxiety.

For respondents who were unable to work due to a health condition, several conditions were cited. Many respondents listed more than one condition, with some respondents mentioning both mental and physical health conditions, for example one respondent answered 'cognitive dysfunction, bipolar type II, HIV, post-meningitis syndrome' and another answered 'back injury, mental breakdown and obstructive sleep apnoea'.

Many respondents also mentioned several co-occurring mental health conditions simultaneously, for example, one participant was unable to work due to 'unresponsive major depression and anxiety'. The most common comorbidities mentioned by participants were depression and anxiety. Other mental health conditions that were specified by respondents included: post traumatic stress disorder, schizophrenia, bipolar disorder and borderline personality disorder.

FIGURE 2: Employment status (n=424)



CONSUMER OR CARER STATUS

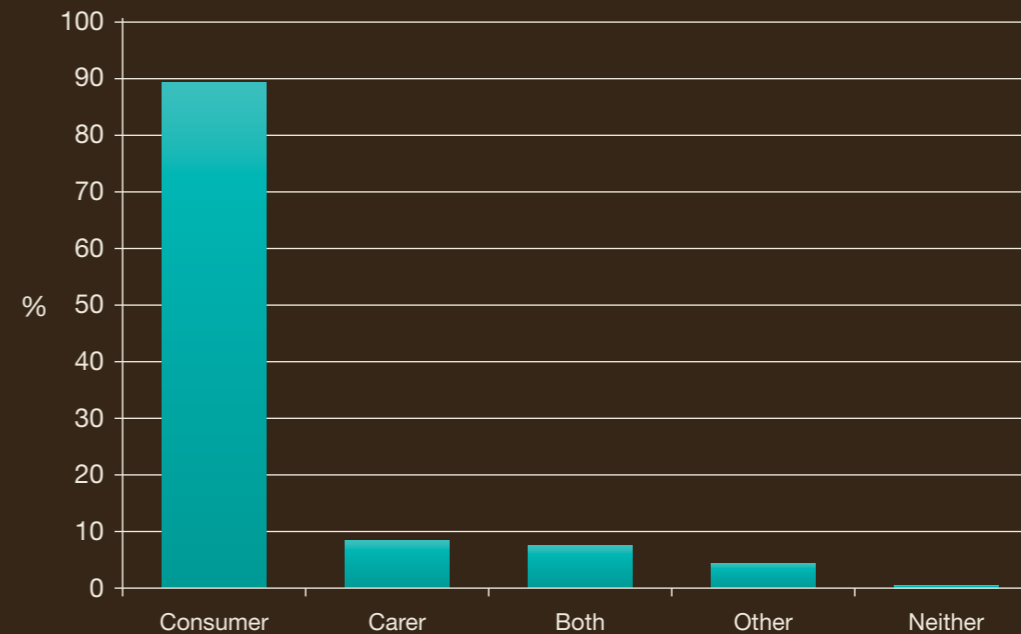
Respondents were asked whether they identified as a mental health consumer or carer. The majority of the survey respondents identified as being mental health consumer (89%) with a small proportion identifying as caring for someone with a mental illness (9%). A small proportion of respondents responded that they were both carers and consumers (8%).

When participants entered text in the 'other' box (n = 19), there were a variety of responses that indicated the need for participants to be able to put their situation into their own words. Some participants wanted to declare who it was they were caring for or who was caring for them as evidenced by this participant quote 'my wife has overseen my mental health situation for many years which is managed'. Leading on from this,

other comments also demonstrated the need for some participants to give insight into the treatment situation they were currently or previously in and demonstrate the lengths they had gone to in order to treat their mental health condition, for example, 'I have had minor depression for approx 2 years and still suffer from mild anxiety and panic attacks both of which are under control due to cognitive behaviour teachings'.

When respondents were asked whether or not they had ever been affected by mental illness, most indicated that they were currently affected by mental illness (66%) with a smaller number (42%) indicating that they had previously been affected by mental illness.

FIGURE 3: Consumer or carer status (n=424)



APPLYING FOR INSURANCE

INSURANCE PRODUCTS APPLIED FOR IN THE PAST

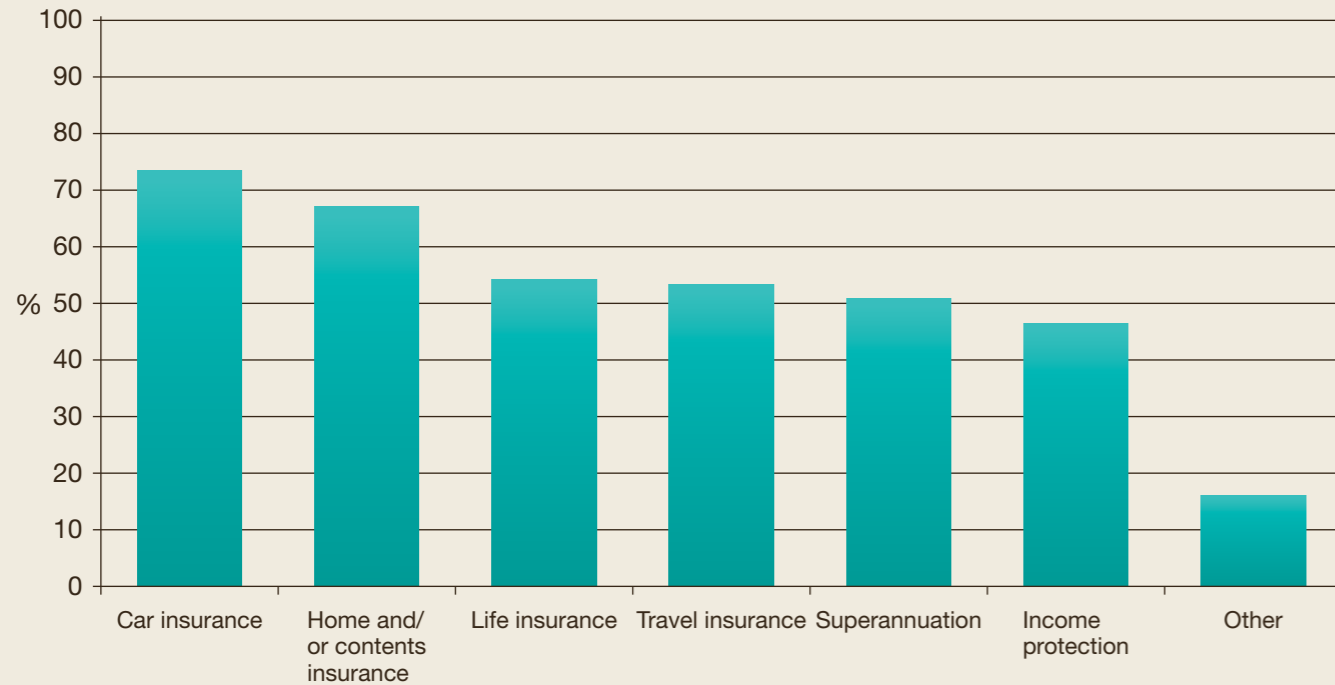
When survey respondents were asked about which insurance products they had applied for in the past, the majority had applied for car insurance (73%), and a similarly large proportion had applied for home and/or contents (67%). The insurance product that the least number of respondents had applied for in the past was income protection (46%).

Of the 68 participants who answered 'other' to this question, almost half (49%) of the participants mentioned health insurance. Other common responses were loan insurance, credit card insurance, trauma and total permanent disability.

DIFFICULTY IN OBTAINING INSURANCE

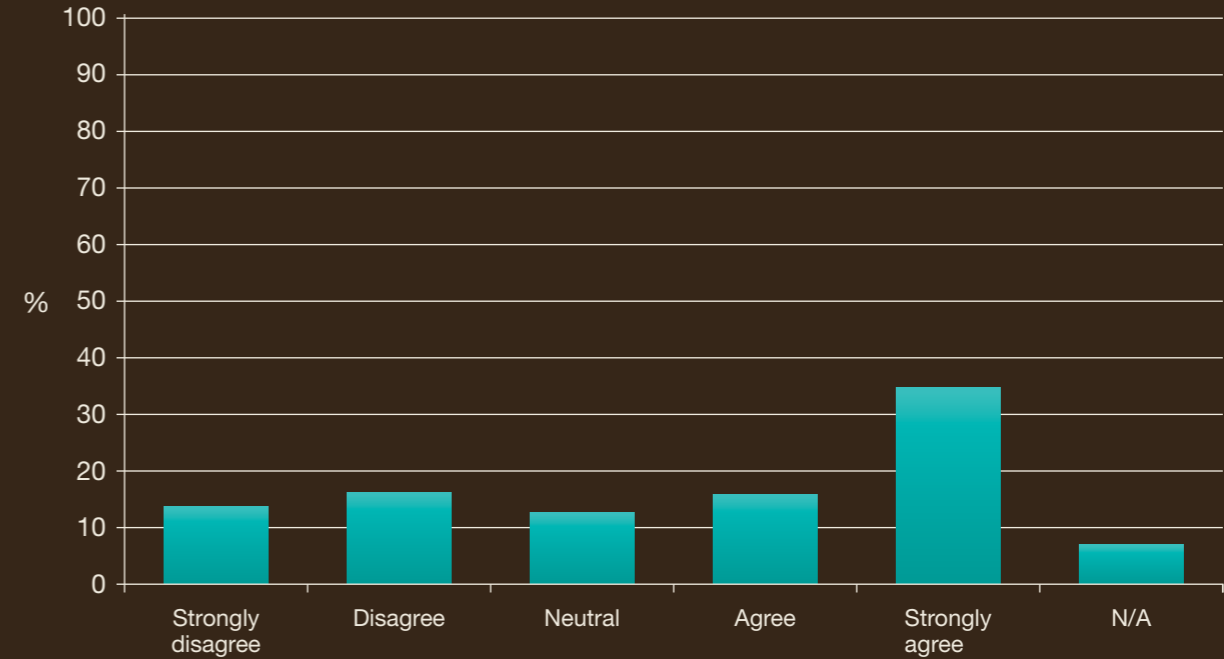
Participants were asked to indicate their level of agreement, on a five-point likert scale,²¹ with the statement, 'It was difficult for me to obtain insurance because I have/have had a mental illness'. The most common response was 'strongly agree' (35%).

FIGURE 4: Insurance products applied for in the past (n=424)



²¹ Strongly agree; agree; neutral; disagree; strongly disagree

FIGURE 5: 'It was difficult for me to obtain insurance due to mental illness' (n=424)

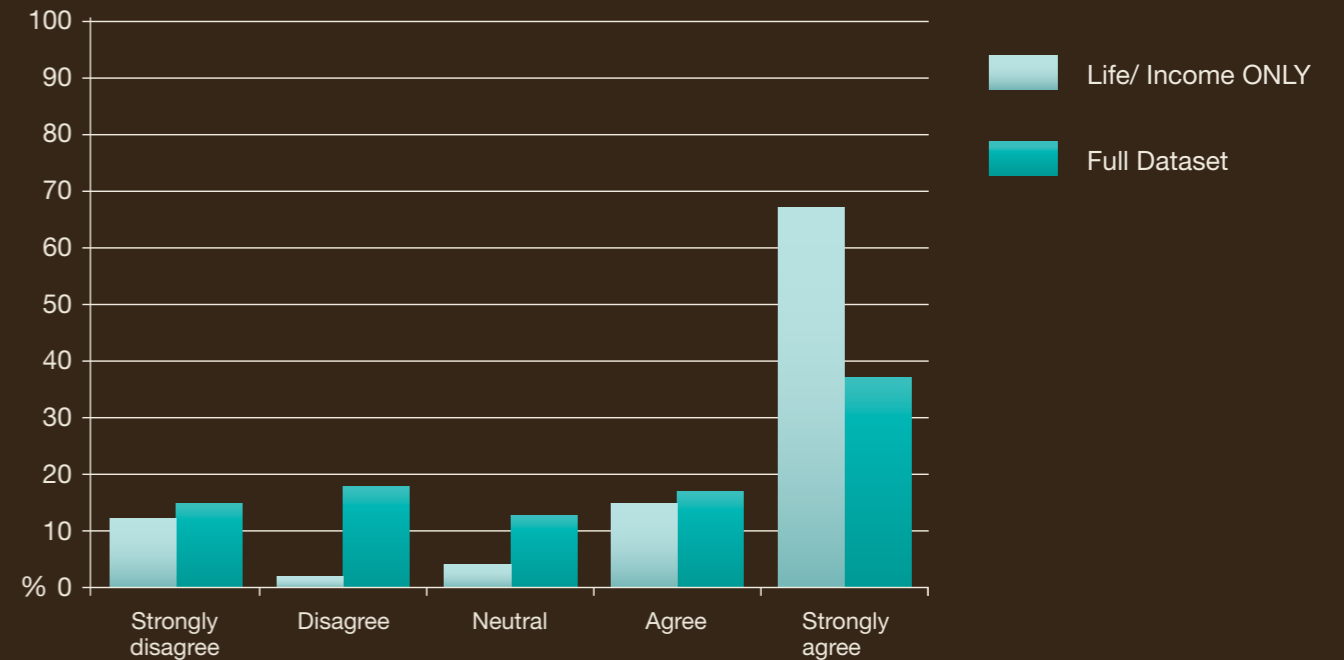


DIFFICULTY IN OBTAINING INSURANCE FOR APPLICANTS WHO HAD ONLY EVER APPLIED FOR LIFE INSURANCE OR INCOME PROTECTION

Survey participants who had only ever applied for either life insurance or income protection made up 12% of all responses (n=49), and these participants agreed more with the difficulty

statement compared to the overall sample ('strongly agree': 67%). The following graph presents the responses from life insurance/income protection applicants against the overall sample.

FIGURE 6: 'It was difficult for me to obtain insurance due to mental illness': Life insurance/income protection applicants (n = 49) compared to overall sample



INSURANCE PRODUCT MOST RECENTLY APPLIED FOR AND WHEN

Survey respondents were asked which type of insurance product they had most recently applied for. Despite the fact that a low proportion of the survey respondents had ever applied for income protection (46%; see Figure 4) compared to car insurance (73%; see Figure 4), this was the most common type of insurance that respondents had most recently applied for (34%). Life insurance was similar with only 54% of respondents having ever applied for this product (see Figure 4), and 29% of respondents having applied for it recently. While home, contents and car insurance had been applied for in the past by most survey respondents (see Figure 4), these were less likely to have been one of the most recent insurance applications of the survey respondents, along with superannuation (8%).

Respondents were asked how long ago had they applied for the insurance product. Most

of the survey respondents had applied for insurance recently, within the last year (40%), with only 12% of respondents having applied for insurance more than five years ago. Survey participants were also given an open question field so that they could name which company they had applied for insurance with. Of the 347 participants who responded, 33 had applied with more than one insurer and 22 could not remember who it was that they had applied through. Of the participants who listed one insurer, the most common was ING insurance (n=21). Fourteen participants had applied with AMP, 13 had applied with Comminsure and 13 with Allianz. Overall, there were many different insurance companies mentioned by participants. Caution should be taken when interpreting the frequency of insurance company complaints for a particular company given that these figures could be related to the size and number of insurance products offered by that company in the first place. It may not necessarily reflect good or poor performance by a particular insurance company.

FIGURE 7: Insurance product most recently applied for (n = 424)

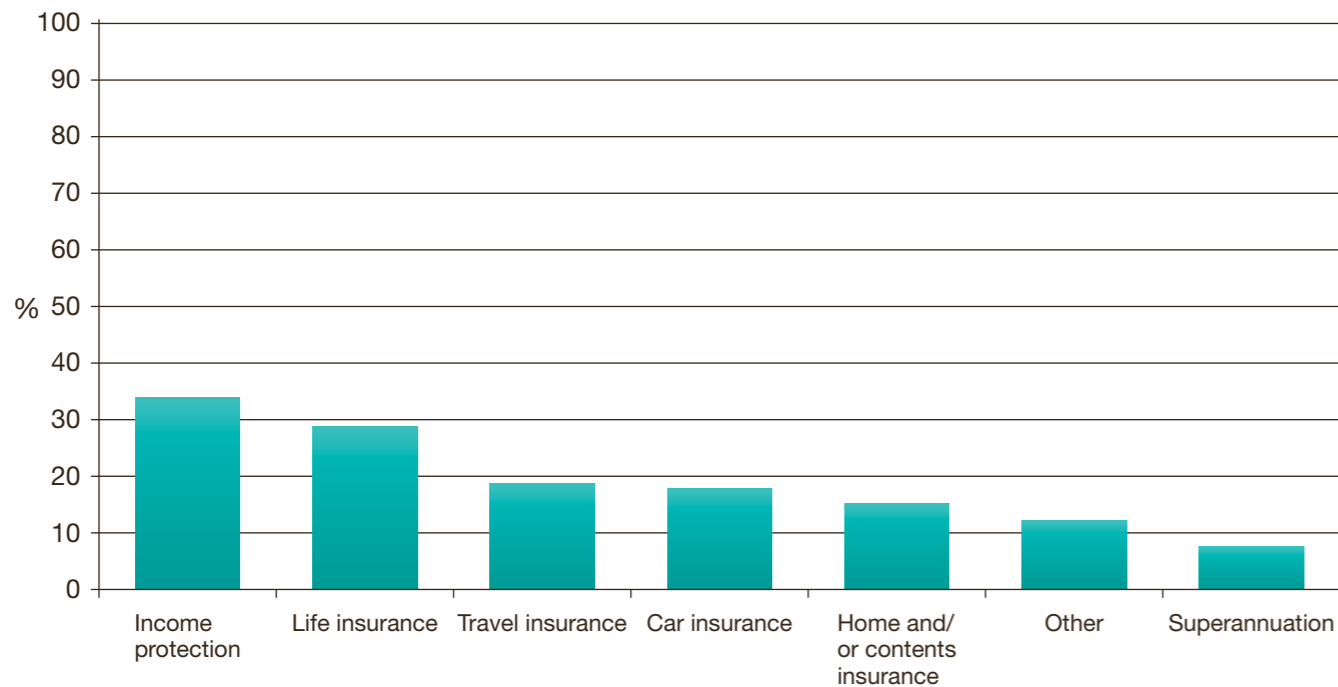
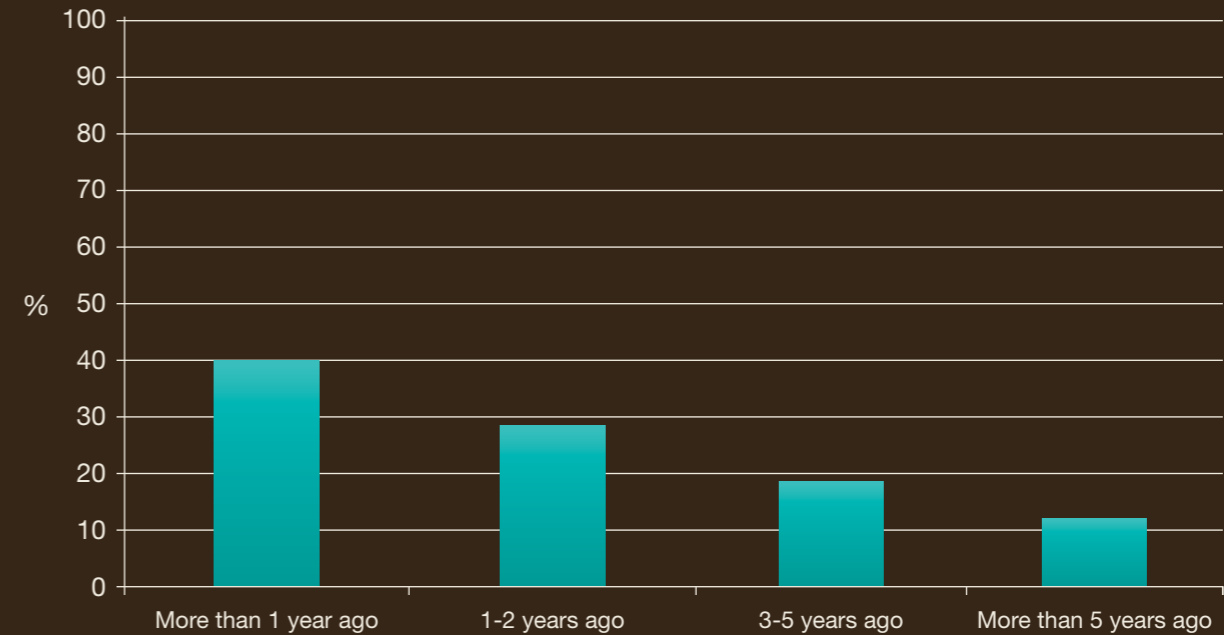


FIGURE 8: When did you apply for the insurance product (n = 424)?



METHOD OF APPLYING IN MOST RECENT APPLICATION

Survey respondents were asked about their most recent insurance application and the methods they used. The most common way that survey respondents had applied for insurance was through a third party (38%), for example a broker or bank. The next most common method of insurance application was over the phone (28%) or online (19%). Only 14% of survey respondents had applied for insurance in person. The small proportion of respondents who applied for insurance in person may reflect the change in service delivery in the insurance industry, with a move to online and phone based interactions.

This shift may have resulted in additional stress and difficulty for people applying for insurance as several respondents mentioned the embarrassment, humiliation and insensitivity surrounding phone interactions when asked for further comments at the end of the survey.

Participants who had applied for insurance via a third party were asked to provide details pertaining to the third party. Of the 159 participants who applied through a third party, 41 had applied through a financial planner, 38 had applied through a broker and 23 had applied through a bank. Other participants applied through travel agents, their superannuation, their employer, and various other parties.

As if life isn't hard enough without being treated like a freak by a complete stranger on the telephone.

All very undignified and humiliating, giving complex medical history to stranger over phone.

MENTAL ILLNESS RELEVANT TO MOST RECENT INSURANCE APPLICATION

When survey respondents were asked which mental illness related to their most recent insurance application, 71% of the respondents mentioned depression. Anxiety was the second most common response with 30% of respondents indicating that this was relevant to their insurance application. Schizophrenia was mentioned by the least amount of people with 3% of respondents indicating this was relevant. A substantial proportion (45%) of the participants selected more than one mental illness; this includes participants who chose both a predetermined response as well as 'other'. Fourteen respondents did not select any of the predetermined responses, choosing instead to identify as 'other' and provide a written response to the question.

Overall, 47 participants chose to include extra information in the text response box regardless of whether they identified with any of the predetermined responses or not. Most of the text responses given included specific details of the participant's diagnosis. Diagnoses that were mentioned which did not clearly fit into one of the predetermined responses included: post traumatic stress disorder, dissociative identity disorder, schizoaffective disorder and eating disorders. Other respondents mentioned conditions, which are sometimes included under the general term of anxiety, for example: obsessive compulsive

disorder and generalised anxiety disorder. One participant specified post-natal depression, while another specified major depression. This could suggest that individuals do not identify with broad labels such as 'depression' and feel the need to explain their individual circumstance.

In total, there were 38 respondents who did not select any of the answers, including 'other'.

OUTCOME OF MOST RECENT INSURANCE APPLICATION

Survey participants were asked about the outcome of their most recent insurance application. Over 37% of survey respondents received the insurance product they most recently applied for without any exclusions or increased premiums. Almost one-quarter (24%) of survey respondents received the insurance product with exclusions relating specifically to mental illness, and 22% who indicated that their insurance application was declined due to mental illness. The proportion of respondents who received their insurance products with increased premiums due to mental illness was 14%.

There were 77 participants whose insurance application was declined due to 'other reasons'. Several themes emerged from the written responses, including: the tactics and strategies adopted when applying for insurance, suspicion of insurers and the importance of the type of insurance applied for.

FIGURE 9: Method used to apply for insurance (n = 424)

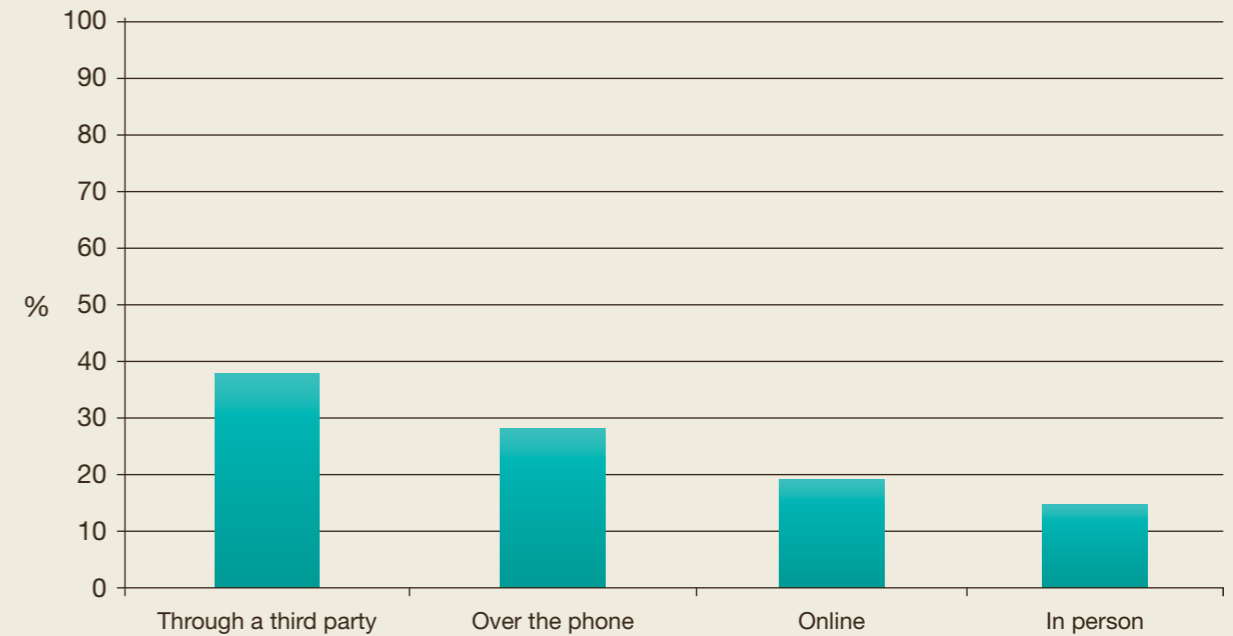


FIGURE 10: Mental illness relevant to most recent insurance application (n = 424)

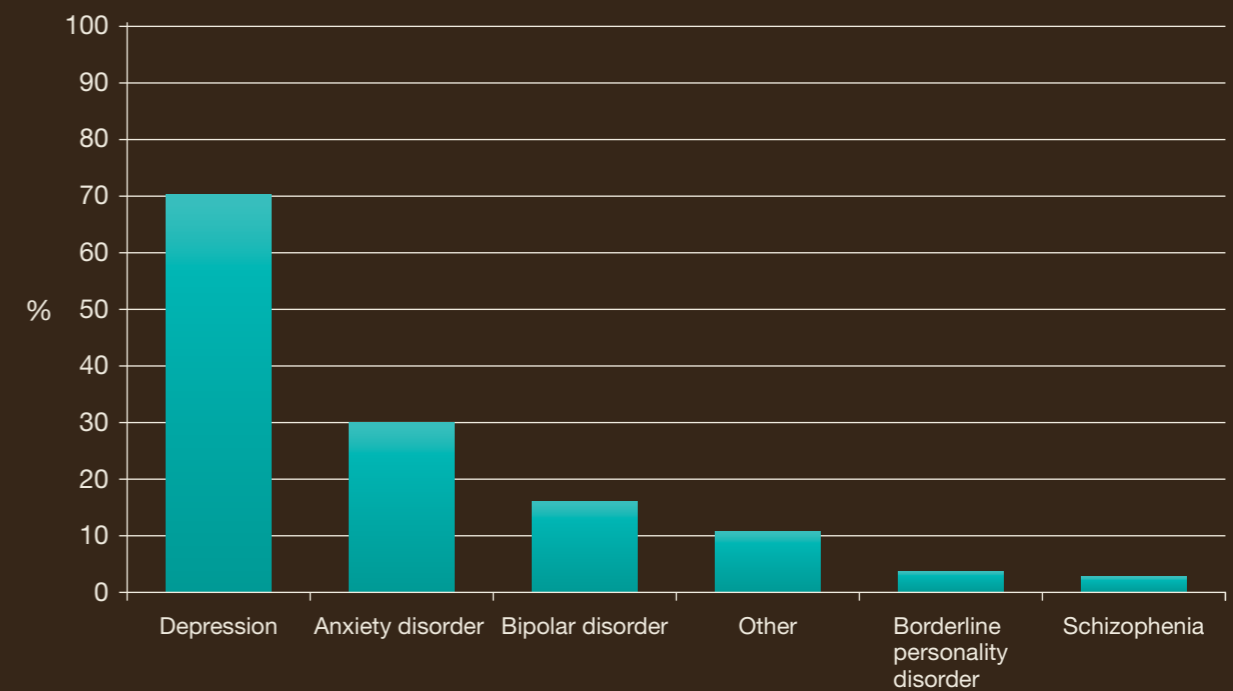
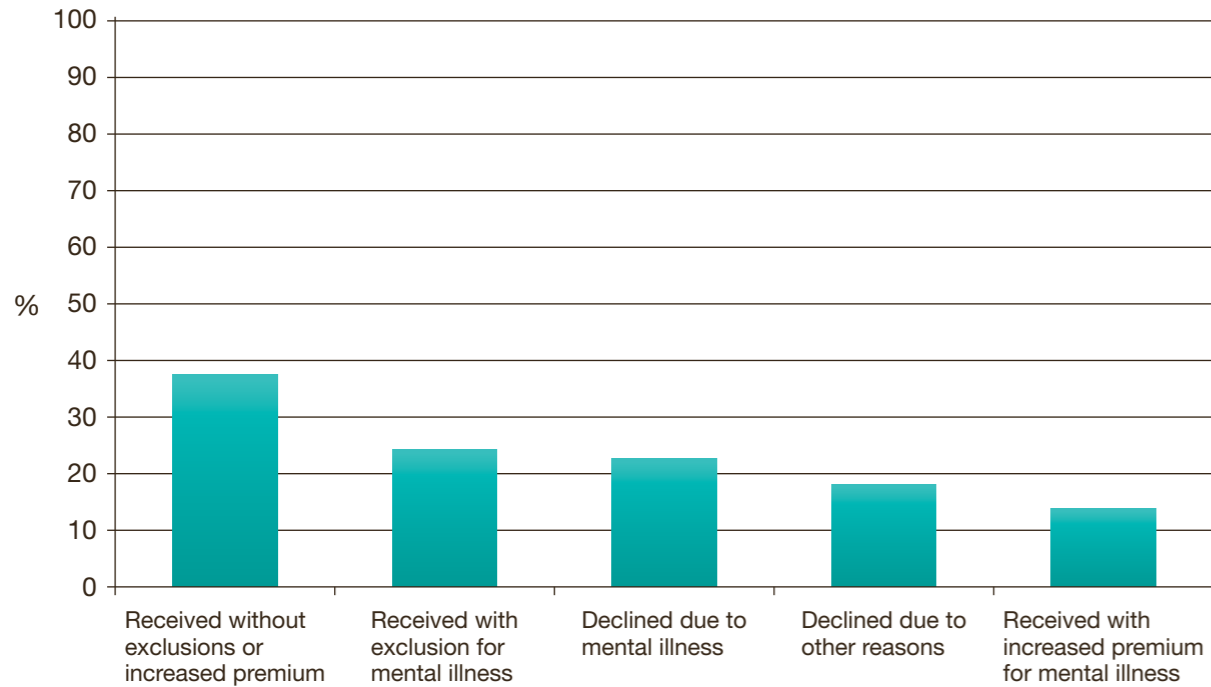


FIGURE 11: Outcome of most recent insurance application (n = 424)



The tactics and strategies adopted when applying for insurance included withholding information, not completing the application as it was stressful, and taking insurance out prior to diagnosis. Withholding information was a conscious tactic employed by participants in several cases as demonstrated by the participant quote:

I did not declare that I had depression/anxiety when applying for travel insurance and just hoped that my medication would keep me well while I was away.

Other participants protected their own personal information by having someone else apply for their insurance for them:

I get the insurances in my wife's name.

I have not applied since having mental illness 11 years ago. Husband does it.



Not completing the application was also a conscious tactic, although some participants expressed that there was external pressure to withdraw an application or not proceed with an application. This is illustrated in participant comments that point to another person advising against proceeding with the application:

My broker said that income protection insurance would be too hard to get because of my history so don't bother applying' and 'I was advised it would be declined and thus didn't take it further...

Another tactic mentioned by participants was applying for the insurance prior to diagnosis with a mental illness. Comments about the timing of the application and diagnosis of a mental illness might suggest that those who already had insurance in place perceived that their diagnosis might change the outcome of future applications.

Some participants mentioned the internal responses they experienced due to the insurance application procedure that resulted in them not proceeding with the application. This is illustrated by one participant who said:

...I decided not to take up the product for the time being b/c I felt discriminated against and deeply affected by the stigma and shame the whole process (answering the questions etc) made me feel.

Another participant confirmed the stress involved in applying for insurance when they stated:

...didn't end up submitting the application due to a previous experience and having the knowledge my agent gave me that I would need to undergo an assessment by a doctor I had never met (something that was just too traumatic to deal with at the time and probably would be if I decided to apply again).

The difficulty in providing details for past psychiatrists and filling out extra paperwork was also mentioned by other participants who did not proceed with the insurance application.

General suspicion of insurers was implied throughout many of the participant responses, however in some cases the suspicion was more explicit. For example one participant explained that the reason given for her application being denied was unrelated to her mental illness:

...but I was suspicious as a mental health nurse employed by the insurer had called and asked me extensive questions about my mental health history as part of the assessment of my application.

Another participant expressed suspicion regardless of whether the application was accepted:

...knowing how insurances companies argue re: associations I am sure they could manage to link many conditions and thus decrease payment.



Participants also spoke of how insurers either did not give reasons for declined applications or they gave very broad and generic reasons:

They wouldn't explain... it was just "based on medical evidence".

Was told I was a risk due to "health problems" did not elaborate on which ones.

Participants spoke of the importance of which type of insurance was being applied for when it came to the outcome. The most common types of insurance reported as being difficult to obtain were life insurance, income protection, travel insurance and health insurance. Car insurance was perceived as being easier to obtain successfully, although one participant expressed difficulty in claiming on a car insurance policy because they were taking antidepressant medication. Some participants stated that their history of mental illness was not specifically requested by the insurer which could be related to the type of insurance applied for.

Participants who had been refused insurance were asked if this decision had been explained to them adequately. Of those who thought the refusal had been explained adequately, it was common to mention that mental illness was considered to be too high a risk for insurers, this was explained by way of general trends of frequent and high insurance claims for people with mental illness. One participant did not entirely accept this response:

They said due to comorbidity experienced by people with schizophrenia that I was a higher risk. But this was not before they simply stated that because I had schizophrenia, this was the only reason for a refusal of cover.

Other participants expressed frustration at the treatment of all mental illness as high risk despite individual circumstances:

I don't qualify for the income protection insurance. Despite my letters explaining that my condition has never impaired my ability to work (I always worked FT) and despite a positive letter from my GP this was still refused.



This treatment of all mental illness as high risk was also revealed by participants when they spoke of 'automatic exclusion' and insurers telling them that they don't insure anyone with a mental illness. Further to this, some respondents spoke of a time when they had been declined insurance because of a mental illness that had occurred many years ago, and had been treated and/or resolved.

One participant was told that:

...too many people were claiming for depression and they were not prepared to insure people with depression. They stated that people were claiming like they used to with back problems, that too many people could feign depression and make claims.

This explanation of the exclusion of people with depression is quite harmful as it presents depression as an illness that can easily be feigned. These sentiments have the potential to perpetuate further stigmatisation of those with depression.

Interestingly, there were some similarities in the responses given by those participants who thought that their insurer had adequately explained their decision and those who thought there was no explanation of the decision. For example, many of the participants who thought the decision to decline insurance was not adequately explained said that they were told they were too high a risk for insurance. This suggests that the explanation by way of increased risk may be quite acceptable to some but unacceptable to others. One participant who found it unacceptable went to further lengths to get a more detailed and acceptable answer:

No their reasons were not adequately explained other than stating that due to my medical conditions I could not be insured. I was then made to request the insurer to send a report to my GP that went into some more detail such as insurance excluded due to bipolar and a lower life expectancy, but not any reasons why this was the case.

Another participant was told by an insurance broker that:

...people with mental illness are often nervous and this can be bad for their heart.

Many of the participants who felt that the reason for the insurance being declined was not adequately explained also mentioned the propensity for insurers to exclude all mental illness without considering the individual situation of the person.

OUTCOME OF MOST RECENT APPLICATION FOR INCOME PROTECTION OR LIFE INSURANCE PRODUCTS

Survey responses were analysed in order to identify if there were any differences in application outcomes for the two most common insurance products that were recently applied for, life insurance and income protection, in comparison

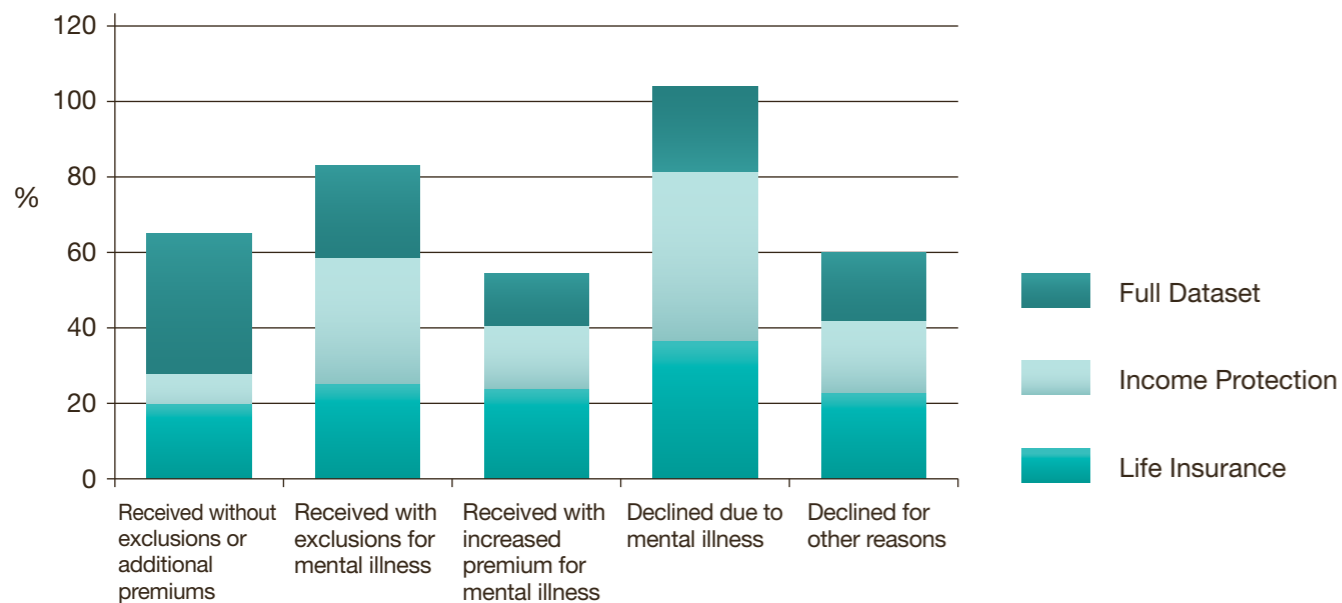
to the full dataset. The following percentages add up to over 100% as some respondents selected multiple answers.

For survey respondents who indicated that they most recently applied for life insurance, 36% reported that their application had been declined due to mental illness, 25% received the product with exclusions for mental illness, 24% received the product with an increased premium for mental illness, 23% were declined for 'other reasons' and 20% received the insurance product without any exclusions or increased premiums.

For survey respondents who indicated that they most recently applied for income protection, 45% reported that their application had been declined due to mental illness, 34% received the product with exclusions for mental illness, 19% had their application declined for 'other reasons', 16% received the product with increased premium for mental illness and 8% received the product without exclusions or additional premiums.

The following graph gives a visual representation of the differences in application outcomes for life insurance and income protection, in comparison to the full dataset.

FIGURE 12: Outcome of most recent insurance application: life insurance, income protection compared to full dataset

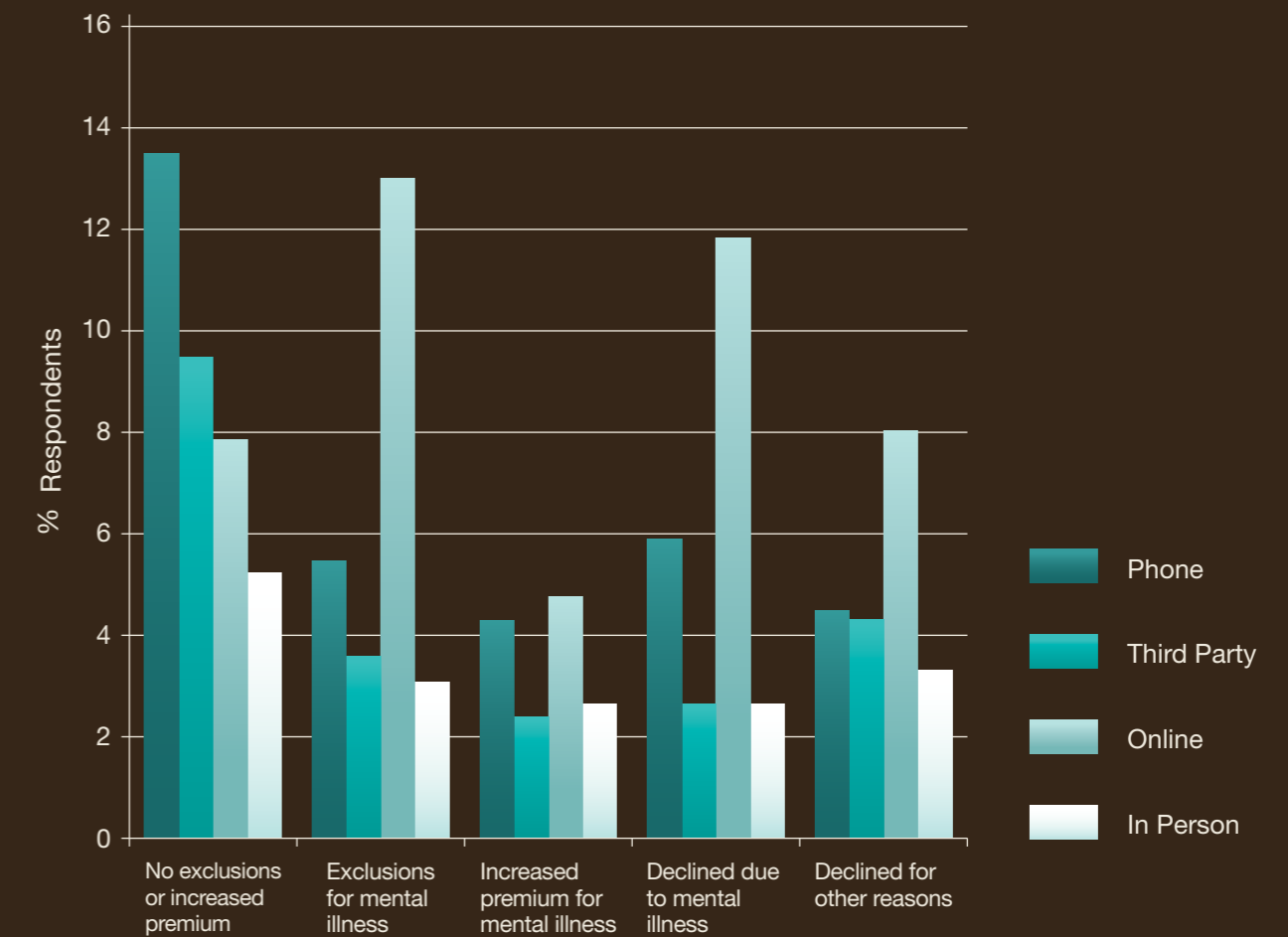


RELATIONSHIP BETWEEN METHOD OF APPLICATION AND OUTCOME OF APPLICATION

Respondents were asked how they had applied for their most recent insurance product and what the outcome of their last application was. Each of these questions allowed for multiple responses so respondents could choose more than one method of application and more than one outcome of application. In total, 9% of all respondents applied online and received the insurance without any exclusions or increased premium. Thirteen per cent of respondents applied over the phone and did not have any exclusions or increased premiums. Respondents who applied through a third party were likely to have their insurance declined due to mental illness (12%).

In order to allow for statistical testing of the relationship between the method of application and outcome of the application, responses to these questions needed to be recoded to remove overlap. The method of application was collapsed into two categories, 'online' and 'any other method'. If respondents indicated that they had applied online they were coded as 'online' regardless of whether they had entered multiple answers for this question. All other responses which did not select 'online' as the method of application were coded as 'any other method'. Responses that did not select any of the application methods were treated as missing data.

FIGURE 13: Method of application and outcome of application (n = 424).



A chi-square test was used to test for statistically significant differences in the outcome of the insurance application for those who applied online compared with those who applied using any other method. There was a statistically significant difference between the application outcomes of those respondents who applied online and those who applied using any other method ($p = 0.006$). The majority of respondents who had applied for their insurance online had received the insurance product with no exclusions or increased premiums (55%). People were more likely to have an insurance application declined due to mental illness if they did not apply online (23%). These results should be interpreted with caution as there are several other factors that may have impacted on the difference in outcome. For example, the type of insurance applied for and previous experience in applying for insurance.

Additionally, analysis is limited by the structure of the survey, which allowed for multiple responses to be given. As stated earlier, the survey responses with regard to the method of application had to be recoded resulting in a small compromise in terms of data integrity. While 19% of the respondents selected 'online' when asked for the method of application, 20% of respondents who applied online also selected other methods simultaneously and were included as having applied 'online'. There was no way of knowing which method of application led to the final outcome in terms of the insurance product. Therefore some of the respondents who chose multiple responses may have been categorised as having applied online when their ultimate method of successful application was over the phone, in person or through a third party.

FIGURE 14: Method of application and outcome of application following recoding (n = 330).

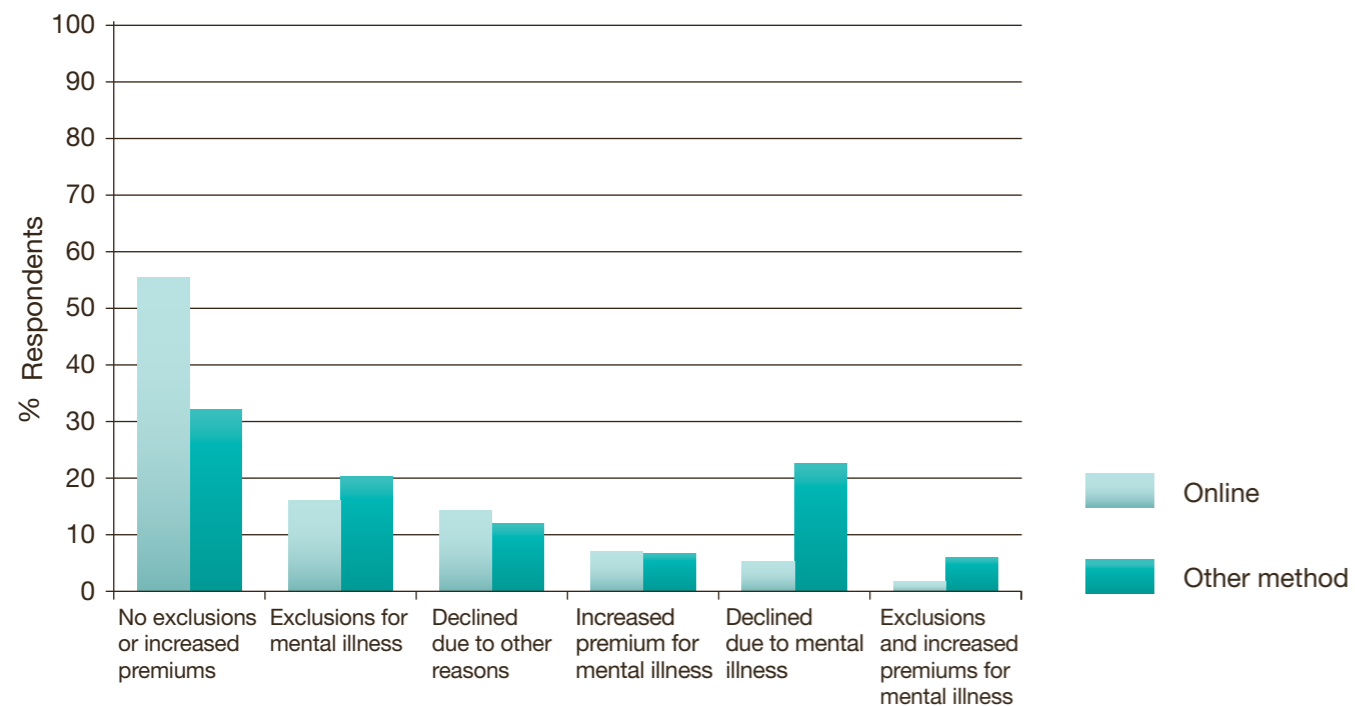


TABLE 1: Method of application by outcome of application

	% Online (n=56)	% Other method (n=274)	% Total (n=330)
No exclusions or increased premiums	55	32	36
Exclusions for mental illness	16	20	20
Declined due to other reasons	14	12	12
Increased premium for mental illness	7	7	7
Declined due to mental illness	5	23	20
Exclusions and increased premiums for mental illness	2	6	5
Total	100.0	100.0	100.0

$\chi^2 = 16.130, df = 5, p = 0.006$

THE RELATIONSHIP BETWEEN TYPE OF ILLNESS AND INSURANCE APPLICATION OUTCOME

Respondents were asked the outcome of their last insurance application and which mental illness was relevant to their last application. Each of these questions allowed for multiple responses so respondents could choose more than one outcome of application and more than one mental illness. In total, 23% of all respondents had depression and were granted insurance. Twenty per cent of respondents had depression and were granted insurance with exclusions and 17% had depression and were declined insurance due to a mental illness. While each of the application outcomes featured a high percentage of people with depression, this is more a reflection of how common depression was among the survey respondents when compared to other mental illnesses. As mentioned earlier in the report, 71% of all respondents indicated that they had depression.

Overall, 5% of all respondents had bipolar disorder and were granted insurance without exclusions or increased premiums. The same proportion of respondents had bipolar disorder, and had their insurance application declined due to mental illness (5%). Lower proportions of survey respondents had bipolar disorder and were granted insurance with exclusions (3%) or increased premiums (3%). For people who responded 'other' the most likely outcomes were either being declined for 'other' reasons (5%) or being granted insurance without any exclusions or increased premium (4%). Respondents who identified as having borderline personality disorder were most likely to either receive the insurance with no exclusions or increased premium (2%) or have the insurance declined due to mental illness (2%).

In order to allow for statistical testing of the relationship between mental illness and the outcome of insurance application, responses to these questions needed to be recoded to remove overlap. The outcome of application was collapsed into three categories, 'Accepted with no exclusions/increased premium', 'Accepted with exclusions and/or increased premiums' and 'Declined due to mental illness'. Respondents who indicated that their insurance was declined for other reasons were not included in this analysis. Respondents who gave conflicting or incompatible responses, for example 'accepted with no exclusions or increased premiums' and 'declined due to mental illness' were treated as missing data and excluded from the analysis.

Mental illness was recoded so that those respondents who selected more than one diagnosis were recoded as 'multiple diagnoses'. If respondents did not answer this question they were treated as missing data and excluded from analysis. Once the responses were recoded, the proportion of respondents within each category for mental illness changed. Depression was still the most common mental illness (42%) and multiple diagnoses was the next most common category for mental illness (39%).



The outcome of respondents most recent insurance outcome was compared with the mental illness that was relevant to their application and a chi-square test was used to test for any associations. Due to low cell counts, the chi-square test was corrected using Fisher's Exact²². Although the test for association did not reach statistical significance (p = 0.955), there were some slight differences in the proportion of people from each mental illness category who were able to gain insurance without any exclusions or increased premiums. The trend overall, across all mental illnesses, was for an adverse outcome to occur, including having insurance declined or having exclusions or increased premiums. While it would appear that people with schizophrenia are the most likely to access insurance without exclusion or additional premiums (67%), this needs to be interpreted with caution as there were only three people who indicated that they had schizophrenia. There was slight overrepresentation of people with bipolar disorder in terms of having insurance declined. There was also a slight overrepresentation of people with bipolar disorder and people with anxiety disorders in having an adverse outcome.

Within each of the mental illness categories there were very slight differences in the outcome of the insurance application. For example, 40% of the respondents with depression were able to obtain insurance with exclusions and increased premiums, slightly fewer (39%) obtained insurance without exclusions or increased premiums. For people who indicated multiple diagnoses, most (39%) were able to access insurance without exclusions or increased premiums, with 35% experiencing exclusions and increased premiums and a lower proportion having insurance declined (26%). People with bipolar disorder were most likely to have insurance granted with exclusions and increased premiums (36%), or have insurance granted with no exclusions or increased premium (33%), than to have insurance declined (30%).

FIGURE 15: Outcome of application and mental illness (n = 424)

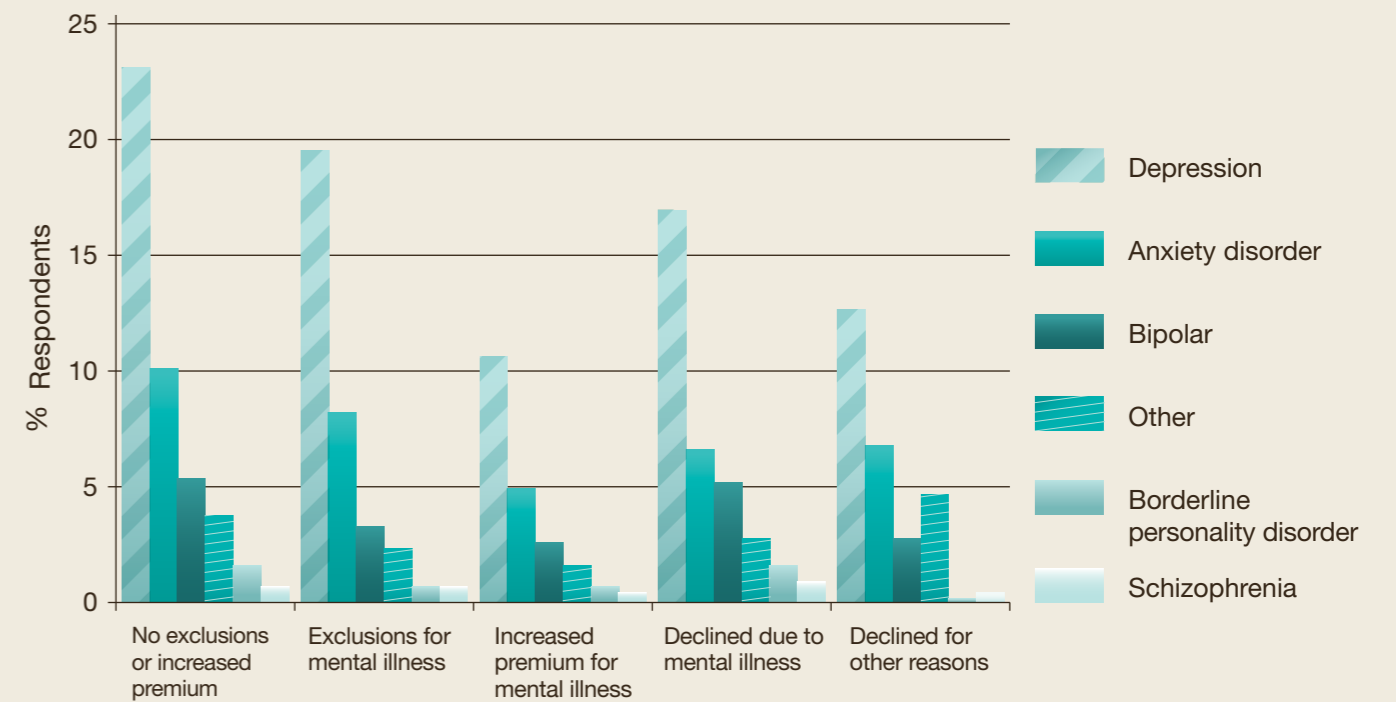
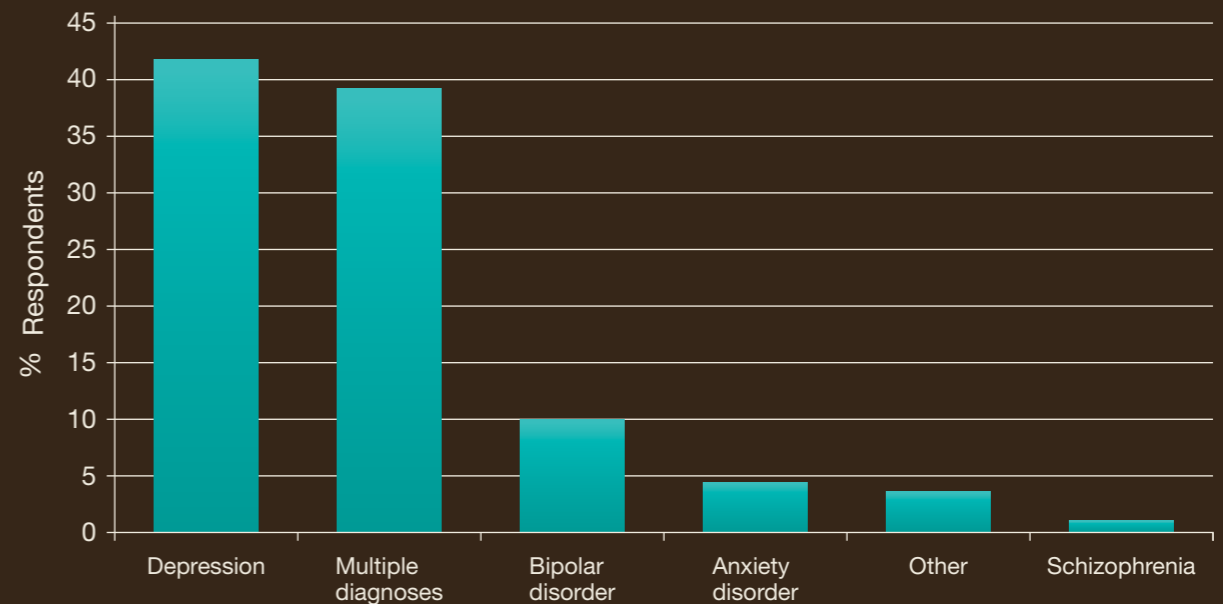


FIGURE 16: Mental illness relevant to insurance application following recoding (n = 386)



²² A statistical significance test used in the analysis of contingency tables where sample sizes are small

FIGURE 17: Outcome of insurance application and type of mental illness (n = 319)

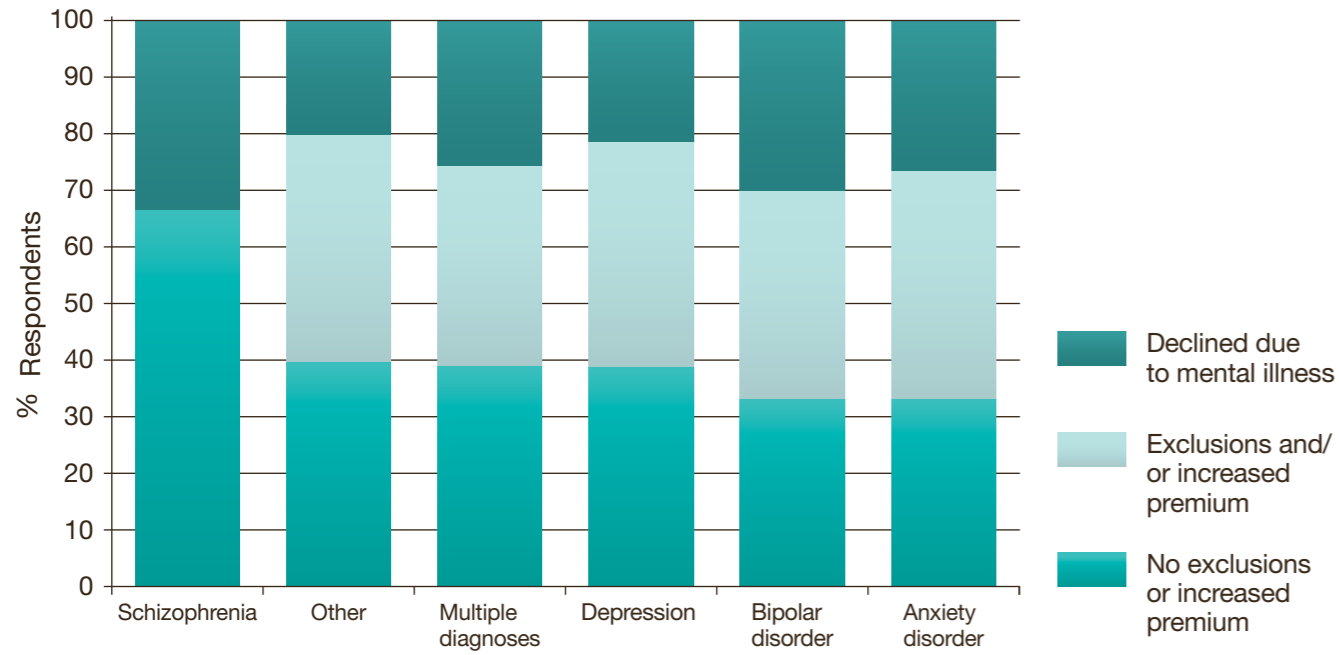


TABLE 2: Outcome of insurance application and mental illness (n = 319)

	No exclusions or increased premium %	Exclusions and/or increased premium %	Declined due to mental illness %	Total %
Schizophrenia (n = 3)	67	0	33	100
Other (n = 10)	40	40	20	100
Depression (n = 141)	39	40	21	100
Multiple diagnoses (n = 117)	39	35	26	100
Bipolar disorder (n = 33)	33	36	30	100
Anxiety disorder (n = 15)	33	40	27	100

$\chi^2 = 4.229, df = 10, p = 0.955$ (chi-square test has been corrected using Fisher's Exact)

CLAIMING ON AN INSURANCE POLICY

Survey respondents were asked about whether they had ever made a claim on any type of insurance policy with a majority of survey respondents indicating that they had (61%). At this point in the survey, anyone who had not made a claim was asked to proceed to question 27 as the remainder of the questions related to the claims process.

Respondents who had made an insurance claim in the past were asked about whether the claim was related to mental illness, either directly or indirectly. Of those who had made a claim in the past, 31% had made a claim that was directly related to mental illness and the same proportion had made claims where their history of mental illness was relevant during the claims process. At this point in the survey, people who had not make claims where their mental illness was relevant or directly related to the claim were asked to proceed to question 27. Overall, 90 of the survey participants had made claims where mental illness was directly related or at least relevant; therefore questions 19 through to 26 had a total of 90 respondents.

MENTAL ILLNESS RELEVANT TO INSURANCE CLAIM

Respondents were asked which specific mental illness related to their insurance claim. For survey respondents whose claim related in some way to a mental illness (n = 90), 61% of respondents indicated that the illness the claim related to was depression. The next most common mental illness that related to the claims process was anxiety disorder (32%). Just over one quarter of respondents (26%) selected 'other' in response to this question.

Of those who responded with 'other', five respondents mentioned post traumatic stress disorder; three mentioned an eating disorder and two people used this as an opportunity to give some explanation of the cause of their illness. For example, one participant spoke of a physical condition which had played a part in causing their mental illness:

Chronic eye pain and reduced vision which resulted in my depression and anxiety as it has gone on for 25 years and I have had 25 eye surgeries and all have failed.

TABLE 3: Claims history of survey respondents

	% Ever made a claim (n = 405)	% Directly related to mental illness (n = 249)	% Mental illness relevant to claim (n = 249)
Yes	61	31	31
No	39	69	69
Total	100.0	100.0	100.0



Furthermore one participant used this space to explain that the insurance company ‘...didn’t recognise borderline personality disorder, only bipolar II. Which is astounding... They [sic] are just as debilitating as bipolar, yet it was all that was recognised. I find bipolar to be MORE manageable, personally!’. This illustrates the complex relationship between mental illness and insurance. These responses reveal something about the nature of mental illness stigma, particularly diagnosis-specific stigma, and the perceived necessity to give some explanation for the illness.

Survey respondents who had lodged an insurance claim related to mental illness were asked how long ago they lodged their claim. Many

respondents had lodged their last claim recently, within the last year (29%). However the same proportion had lodged their claim more than five years ago (29%).

OUTCOME OF INSURANCE CLAIM

Survey respondents whose claim related to a mental illness were asked about the outcome of their insurance claim. Several respondents indicated that their claim was accepted without any problems (41%). However, many respondents had problems getting their claim accepted (13%) or had their claim partly declined (12%) due to mental illness.

FIGURE 18: Mental illness relevant to the insurance claim (n = 90)

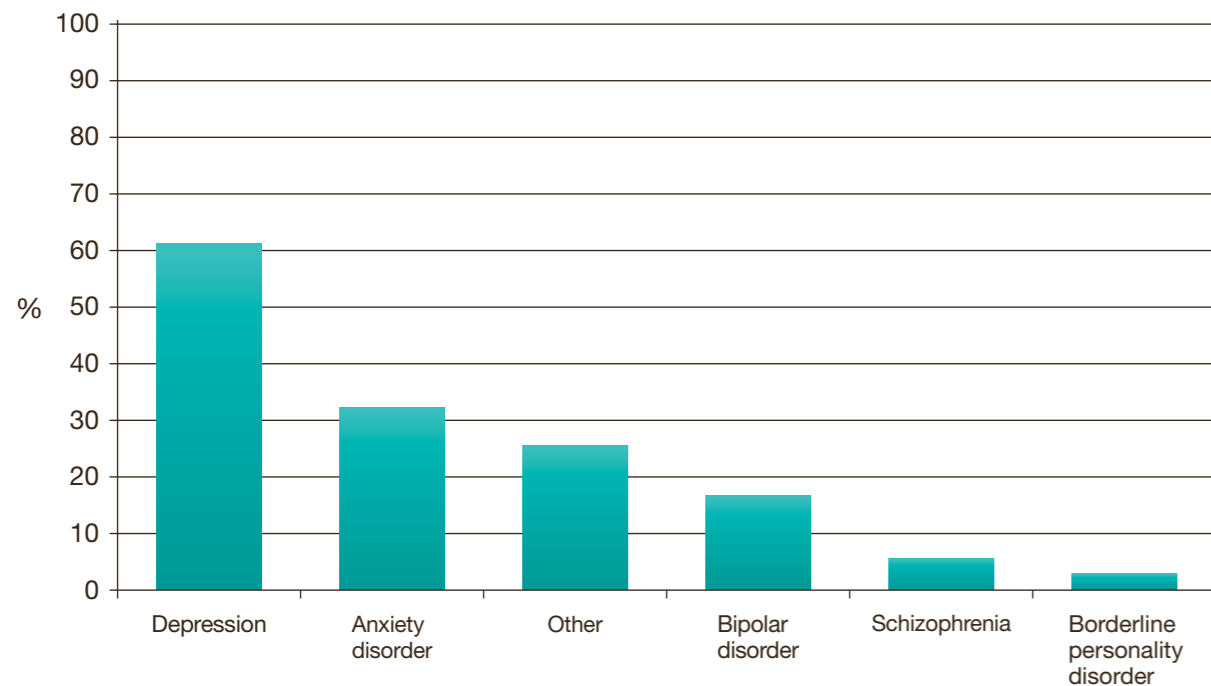


FIGURE 19: When did you lodge the claim (n = 86)?

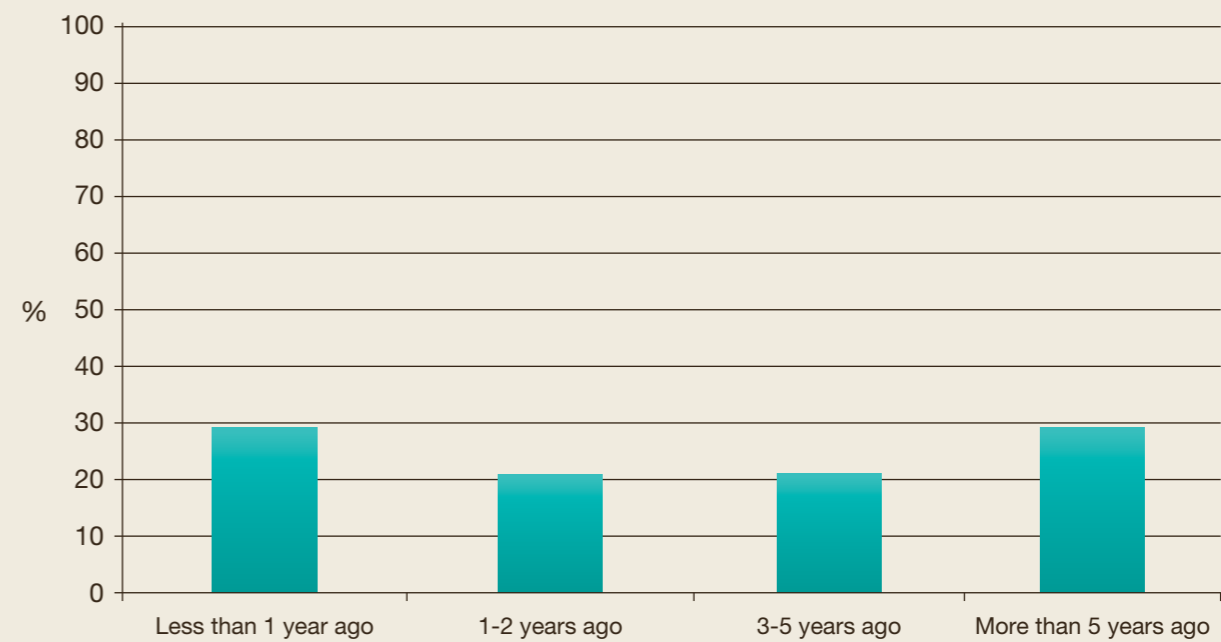
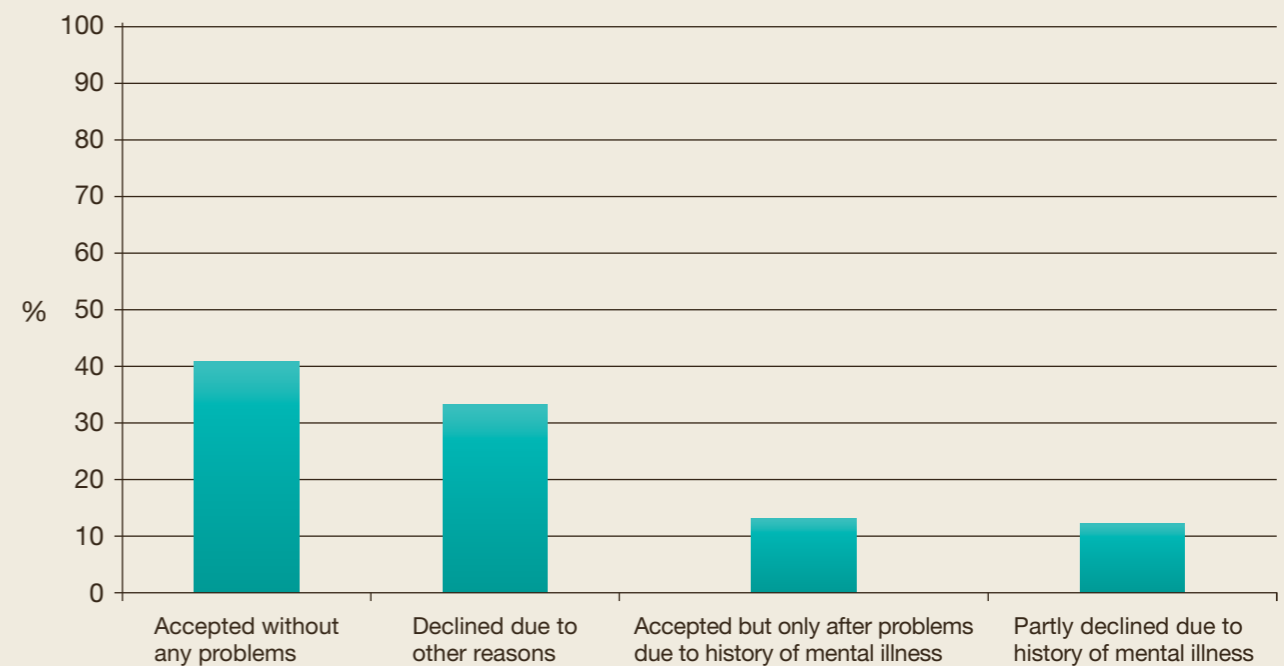


FIGURE 20: Outcome of insurance claim (n = 90)



The 30 respondents who chose the option 'declined due to other reasons' were asked to specify the other reasons. Many of the people who entered text in this field shared stories of frustration and long-tail²³ claims processes that, at times, spanned over years, as in the following example:

The claim was accepted after about 5 years - they lost the original claim, then lost the next one, then delayed whilst sending me to a lot of specialists at my cost. Whenever the specialist reported in my favour they would send me to another at my cost. I never recovered the cost of specialists.

Several of the answers in this section also pointed to the fact that many participants had had their insurance declined due to mental illness and not due to 'other' reasons. This is evidenced in the following participant quote:

My daughter's claim was straight declined due to her mental illness. My own claim was also declined because of my daughter's mental illness because her psychiatrist told me that I should stay here supporting my daughter instead of going on the trip on my own.

The consistent theme to emerge was for respondents to have a claim declined as the mental illness was considered to have been 'pre-existing'. Others described protocols that involved having their diagnosis questioned by the insurer or a specialist chosen by the insurer:

[The specialist employed by the insurer] said I was fit for work and not suffering depression.

Survey respondents who had made insurance claims relating to mental illness were asked which insurance company they lodged their claim with. Respondents mentioned a wide variety of insurers who they had lodged their claim through. The most common were: Tower insurance, Medibank Private and ING, each of which were mentioned by five respondents. As stated previously, when naming insurance providers, these results should be interpreted with caution as figures may be related to the size and number of insurance products offered by the individual companies. These results may not necessarily reflect particularly good or poor performance by a particular insurance company.

The independent medicals are liars and not independent and a solicitor had to be engaged.



RELATIONSHIP BETWEEN MENTAL ILLNESS AND OUTCOME OF CLAIM

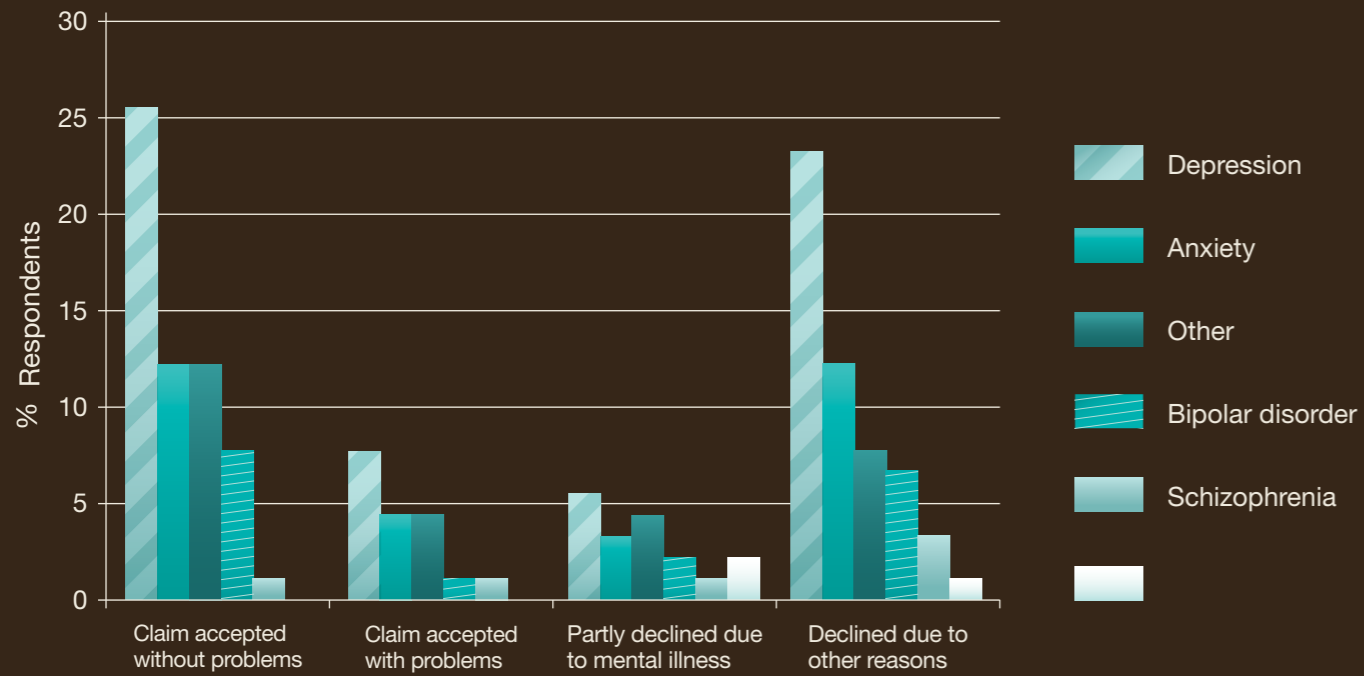
Respondents were asked what the outcome of their last claim was and which mental illness was relevant to their last claim. Each of these questions allowed for multiple responses so respondents could choose more than one outcome of claim and more than one mental illness. In total, 26% of all respondents had depression and were able to claim without any problems, while 8% were able to claim however there were problems during the claims process. Twenty-three per cent of respondents had depression and had their claim declined for 'other' reasons and 6% had their claim declined due to mental illness. While each of the claim outcomes featured a high percentage of people with depression, this was due to how common depression was among survey respondents. As this stage of the survey only related to the claims process, only respondents who had made a

claim on insurance that was somehow relevant to mental illness answered these questions. Thus, there were only 90 respondents who answered these questions, and the majority (61%) of the respondents indicated that depression was the mental illness that was relevant to their claim.

In order to allow for statistical testing of the relationship between mental illness and the outcome of a claim, responses to these questions needed to be recoded to remove overlap. For the most part, respondents only chose one option in response to the question about the outcome of their claim. Only in one instance did a respondent choose two options, and upon inspecting the text response, it was clear that the claim had been partly declined due to mental illness, so the response was coded as such. Respondents who indicated that their claim was declined for other reasons were not included in this analysis. Respondents who did not choose any response were treated as missing data and excluded from analysis.

²³ An insurance industry term for when the time between the incident and the claim payout is long (several months/years).

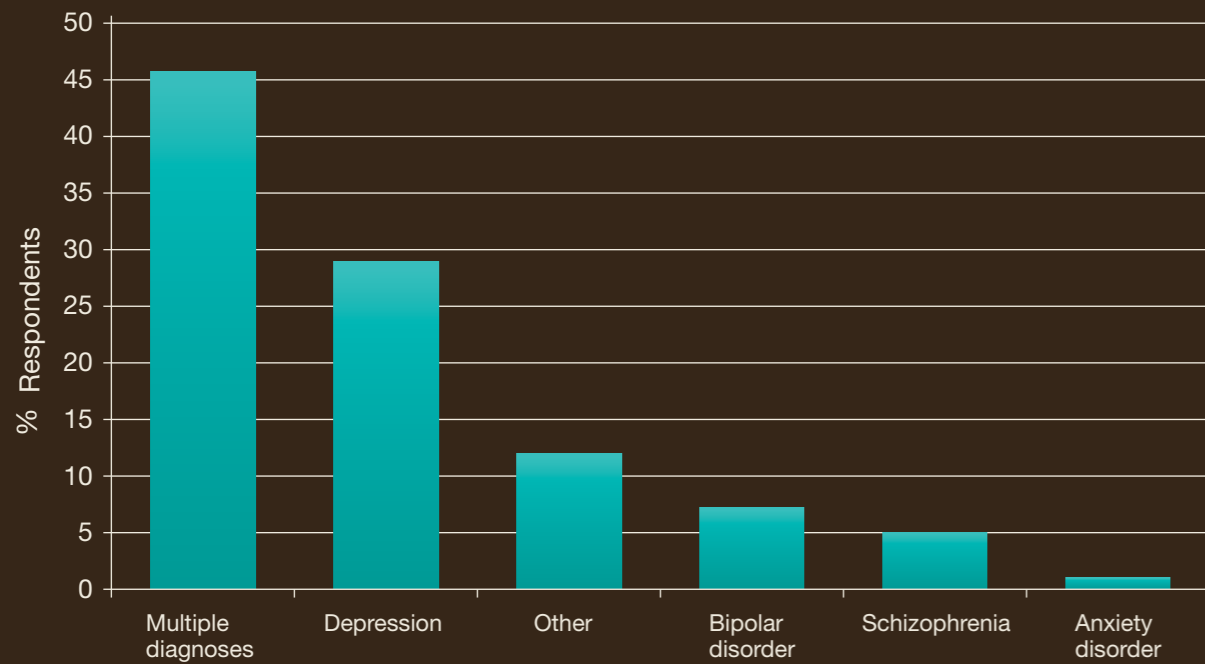
FIGURE 21: Outcome of claim and mental illness (n = 90)



Mental illness was recoded so that those respondents who selected more than one diagnosis were recoded as 'multiple diagnoses'. If respondents did not answer this question they were treated as missing data and excluded from analysis. Once the responses were recoded, the

proportion of respondents within each category for mental illness changed. Multiple diagnoses was the most common category for mental illness (46%) and depression was the second most common diagnosis (29%).

FIGURE 22: Mental illness relevant to claim following recoding (n = 83)



The outcome of respondents' most recent claim was compared with the mental illness that was relevant to their claim, and a chi-square test was used to test for any associations. Due to low cell counts, the chi-square test was corrected using Fisher's Exact. Although the test for association did not reach statistical significance ($p = 0.821$), there were some slight differences in the proportion of people from each mental illness category who had their claims accepted, accepted with problems or declined. Due to the very low numbers of respondents in each category the results need to be interpreted with

caution. Although people with bipolar disorder were most likely to have their claim accepted with no problems (83%) there were only six participants who indicated that bipolar disorder was relevant to their claim. The trend overall, across all mental illnesses was for a claim to be accepted without problems, with the exception of those for whom schizophrenia was relevant to the claims process. Again, the results for people with schizophrenia need to be interpreted with caution as there were only three respondents in this category.

FIGURE 23: Outcome of claim and mental illness (n = 57)

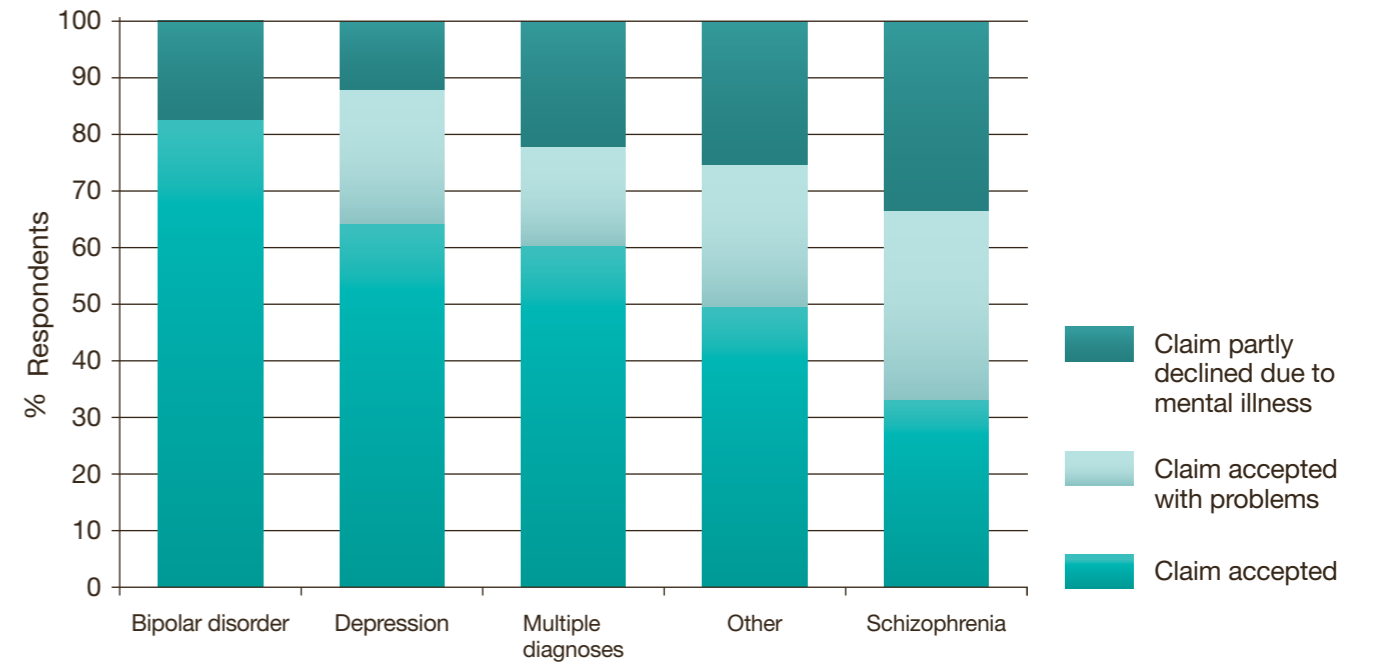


TABLE 4: Outcome of claim and mental illness (n = 57)

	Claim accepted %	Claim accepted with problems %	Claim partly declined due to mental illness %	Total %
Bipolar disorder (n = 6)	83	0	17	100
Depression (n = 17)	65	24	12	100
Multiple diagnoses (n = 23)	61	17	22	100
Other (n = 8)	50	25	25	100
Schizophrenia (n = 3)	33	33	33	100

$\chi^2 = 4.718, df = 8, p = 0.821$ (chi square has been corrected using Fisher's exact)

TAKING ACTION AGAINST INSURANCE COMPANIES

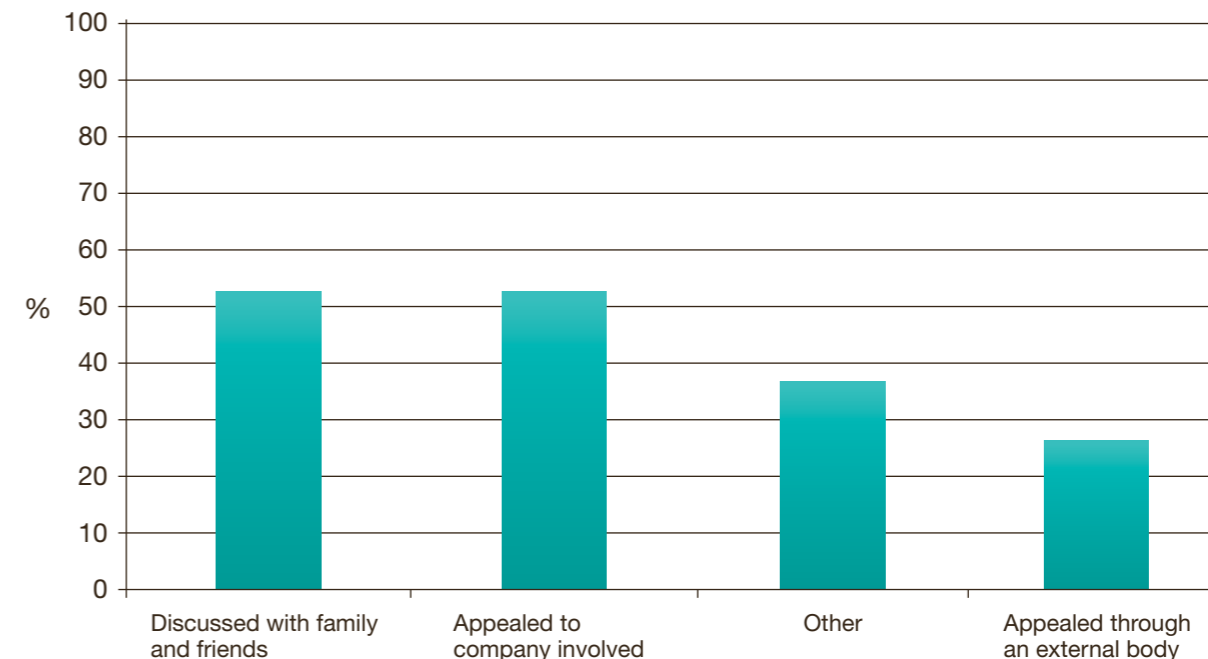
Respondents who had made a claim in the past that related to mental illness (n=90) were asked whether or not they had ever taken action as a result of an insurance claim or application being declined. Almost one-quarter of respondents (22%) had taken further action because they had a claim or application declined by an insurer.

Respondents who had taken further action were asked what kind of action was taken. Of the 18 respondents who had taken further action against an insurance company the most common form of action involved talking to family and friends (53%), and appealing directly to the company involved (53%). Just over a quarter (26%) of respondents took further action against an insurer through an external body.

The respondents who had appealed against the insurer with an external body were asked to specify who they had lodged their appeal with. Two of the respondents had appealed through the Financial Industry Complaints Service/Financial Ombudsman Service, three had appealed through a broker or the bank that had organised the insurance, and one person had appealed through the Australian Human Rights and Equal Opportunity Commission.

When respondents had appealed via other means, they were also asked to specify how they had appealed the decision made by the insurer. Six of these respondents mentioned legal action and two mentioned the use of medical practitioners including psychologists, psychiatrists, GPs and specialist medical reports.

FIGURE 24: Further action taken by survey respondents against insurance companies (n = 19)



Thirty-one respondents provided an answer to question 25 'how did you become aware of your right to appeal?' Of these respondents, nine people stated that they were not aware they could appeal. Some respondents mentioned that they had been informed of their right to appeal by the insurer, either within policy documentation or as part of the correspondence regarding the claim or policy.

Thirty-six participants provided a response to question 26 'were you satisfied with the eventual outcome?'. Of these, 13 respondents expressed their satisfaction with the outcome. Five respondents stated that they were still awaiting final decisions and three stated that they were partially satisfied with the outcome. Twelve respondents were not satisfied with the outcome of their appeal. Several of the respondents mentioned how the whole process had resulted in negative mental health outcomes:

The whole process actually made my illness worse and forced me into having ECT [electro-convulsive therapy]

APPLYING WITH OTHER INSURERS

All eligible survey respondents were asked about whether they had applied for insurance with another company due to having an application or claim declined and of the 424 participants, 55 responded to this question. Respondents tended not to apply for insurance through alternative companies after having an application or claim declined (40%). A small proportion of respondents applied for insurance successfully (9%) and an even smaller proportion were unsuccessful in their application for insurance elsewhere (5%).

Those who had not applied for insurance elsewhere were given the opportunity to elaborate on this decision. Thirteen of these respondents had not applied elsewhere as they no longer needed the insurance or they were happy with their current company or insurance product. Eleven of the respondents expressed futility in the act of applying for insurance elsewhere due to '...little hope of success' and a lack of trust in insurance companies.

I don't trust what they say they will cover me for.

Some of the respondents mentioned the stress associated with applying for insurance as a reason for not applying with another company:

... do not want to go through the stress of it all again.

There were also references to the cost of insurance being prohibitive:

I figured that if the premium was high (and at that stage I hadn't been hospitalised) it would only get higher now that I've been in for a month and also had ECT, so I've not bothered.



FURTHER COMMENTS

Participants were given the opportunity to contribute any further comments at the conclusion of the survey. Two hundred and fourteen respondents provided further comments, 15 of which were excluded from analysis as the response was either unrelated to the survey topic or they stated that they had nothing further to add. Each response was read and coded according to the topics and main ideas that were conveyed. This resulted in 25 separate but linked codes being created. Several codes were related to each other in a broader sense and overarching themes were generated to explain the relationships between codes and give an overall picture of the comments made by respondents.

The five overarching themes were:

- Exclusion
- I'm different
- The morality of insurance companies
- Mental illness and insurance are incompatible
- The nature of mental illness.

Each theme was made up of several codes and some codes were related to more than one theme.

Not all codes were explored using thematic analysis as some were not as relevant in explaining the broader experiences of mental health consumers. Codes that were not explored in the thematic analysis included: comments on the survey instrument, advice, and case specific details. Comments on the survey instrument will be taken into consideration for the development of the next survey. Advice was given by some respondents on how to get insurance, this was an extension of the strategies and tactics code that emerged in question 9 when participants were asked about the outcome of their most recent insurance application. Case specific details included instances where the respondent had given more specific, factual details of what had occurred when they had applied for insurance or lodged a claim, however the details tended to be more factual rather than expressive thus limiting interpretation. A concept map has been provided in order to explain the relationships between each of the codes and themes that were included in the thematic analysis. Each theme will be discussed broadly, followed by a table describing each of the codes with exemplar quotes provided.

FIGURE 25: Have you ever applied for insurance with another company due to a declined application or claim (n = 55)?

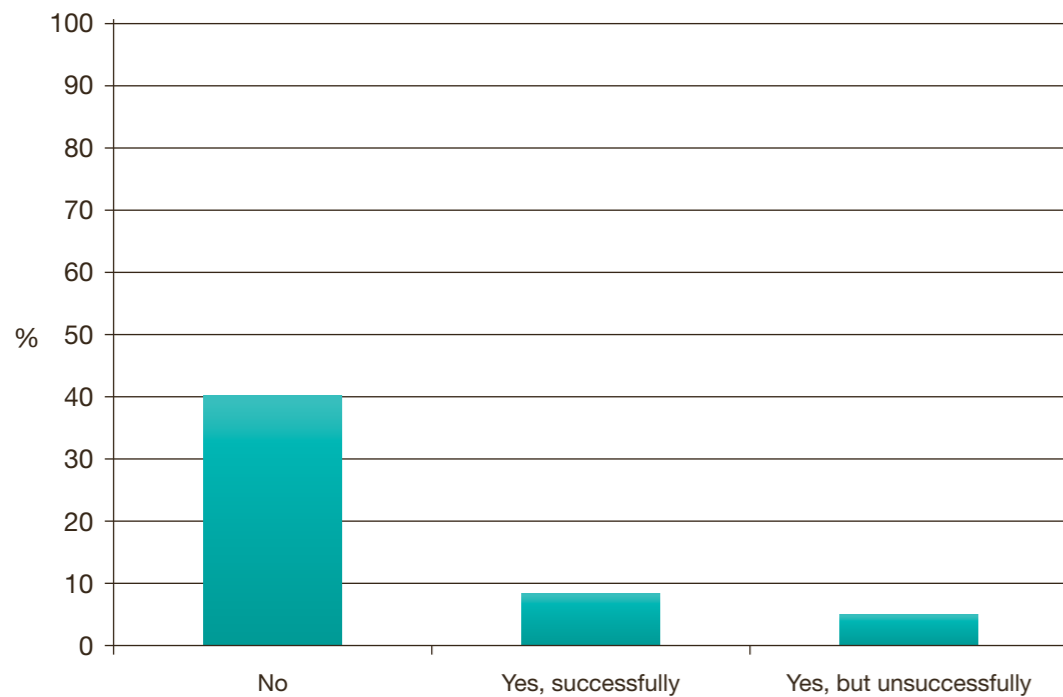
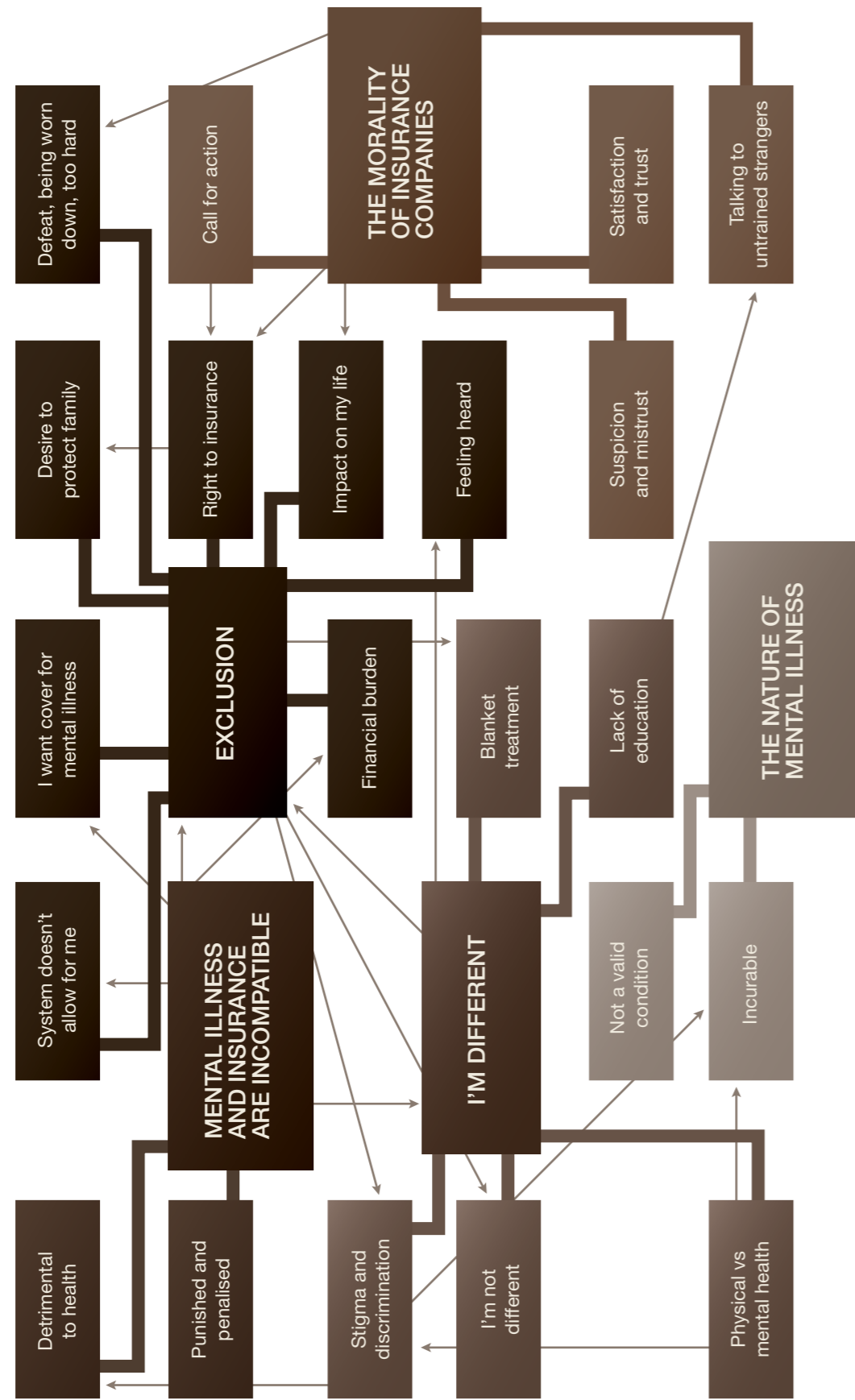


FIGURE 26: Concept map illustrating coding and thematic analyses for Question 29 'Do you have any further comments you would like to make?'



MENTAL ILLNESS AND INSURANCE ARE INCOMPATIBLE

Respondents reported that mental illness and insurance were incompatible. Some of the examples given that related to incompatibility included concern around the detrimental impact on their health. Specifically, detriment to personal health was linked to interacting with insurance companies both for application and claims purposes. Most commonly, respondents spoke of the increased stress that the claims process inflicted, particularly the impact of prolonged processes with extensive evidence required, and examinations undertaken by unfamiliar medical professionals working for insurers:

The whole process of dealing with [an insurer] has been an added stress and burden... I have found it further impacted on my illness and my mental health declined significantly... their approach does in no way facilitate the improvement and recovery of people suffering from anxiety and depression.

Respondents also commented on the counterproductive policies that insurers often impose:

It is unfortunate that doing something to improve your health, i.e. a short voluntary admission to prevent illness by changing medication, means that you are punished by becoming ineligible for important things like insurance. This is definitely a disincentive to seek treatment.

If a person with mental health problems actively seeks treatment – they are penalised with respect to their insurance. It is outrageous.

Some respondents spoke about the tendency for insurers to ask clients to commit to a timeline for recovery, or a date when return to work would be achieved. This type of pressure was seen to discourage a speedy recovery.

Talking to untrained strangers was seen as being detrimental to health and gave further evidence of the incompatibility between mental illness and insurance. Of great concern were the comments that referred to the 'matter-of-fact' way insurers ask questions about suicide. Many respondents mentioned feeling humiliated, embarrassed, undignified, and violated after revealing personal and complex information about their experiences of mental illness.

Further from this, there was an expressed disconnect between activities that promote good mental health and activities that insurers encourage. To further illustrate this point, respondents spoke about the need to forgo treatment and medication in order to be accepted for income protection insurance, despite the fact that their illness would be excluded from the cover in any case. Respondents who considered they were proactive in managing their mental health felt penalised and punished for doing so as seeking treatment meant that their insurance application would be declined. The threat of penalty or punishment could serve as a disincentive to seeking treatment, which was considered to be counterproductive to achieving good mental health.

I'M DIFFERENT

Seeking treatment was also talked about within the theme 'I'm different'. Respondents reported being penalised by insurance companies for seeking treatment. They also expressed the desire to be treated individually and differently, depending on their current situation. Some respondents mentioned that their illness was controlled effectively with medication so they could not understand why insurers applied blanket exclusion to all people with any prior diagnosis of mental illness. Others spoke about insurers not being willing to make exceptions and tailor the insurance product to their circumstances. Interestingly, respondents were willing to accept compromise and accepted that mental illness could be excluded from the policy if necessary; they just wanted to be treated individually.

The way mental health was treated by insurers was perceived to be different to the way physical health was treated. In some instances respondents gave examples of how mental and physical health conditions had been treated differently by insurers:

I have been unable to find any insurance companies that will allow me to purchase life insurance because of my mental illness and yet if I have a physical illness or disease this is okay.

I am much fitter and healthier physically than the average person, yet they approve income protection insurance to clinically obese, sedentary, office workers who I treat regularly in my clinic for not looking after themselves properly.

Often mental illness was much less likely to be treated as an insurable illness than physical illness. The difference in the way mental illness was treated, when compared with physical illness was sometimes referred to by respondents as stigmatising and discriminatory:

Our whole system – from Centrelink to these rehabilitation 'experts' does not authentically support or truly recognise mental illness.

Respondents spoke extensively about discrimination and stigma. While some respondents expressed their fear of being discriminated against and stigmatised, others gave specific examples of situations in which they had been discriminated against or stigmatised. Some respondents spoke about their perception of discrimination and stigma. There were elements of frustration and indignation around the perceptions and experiences of discrimination and stigma. Unfortunately, there were also some expressions of resignation, where respondents felt that the discrimination had always been there and would prevail in the end anyway:

Accordingly, many respondents also pointed out the lack of education about mental illness, linking this to both discrimination and blanket treatment from insurers. Lack of education was also linked to the lack of ability for brokers and agents to advocate on behalf of their clients:

Also, I think brokers need to be educated about mental illness. My agent didn't really get it and I don't think he was a good advocate.

The concept of difference was challenged by some respondents who expressed that they were no different to anyone else who wanted insurance. Vivid portraits of successful and fulfilling lives were given to illustrate that the only point of difference was the diagnosis of mental illness, which had minimal impact on the respondent's life:

I am a mental health practitioner with masters level qualifications and have trained in and developed a significant skill base that allows me to lead a highly functional life.

THE NATURE OF MENTAL ILLNESS

The propensity for insurers to provide a different service to people with mental illness compared with people with physical illness may be somewhat governed by perceptions about the nature of mental illness. Several respondents expressed the ways in which insurers insinuated that mental illness was an incurable illness. This was expressed by respondents who had been living without the need for medication or treatment or both for a number of decades yet still experienced exclusions on their insurance policies. Other respondents spoke about their illness or diagnosis coming into question, for example some respondents felt that insurers did not consider some mental illnesses and conditions to be 'real' or valid conditions.

THE MORALITY OF INSURANCE COMPANIES

The nature of insurance companies also came under question. Several respondents expressed suspicion and mistrust of insurers, particularly when it came to making claims on insurance

policies. Insurers were seen as unlikely to pay out in the event of a claim. However, two statements made by other respondents contradicted the notion that insurers were untrustworthy, with one respondent specifically mentioning the honesty of their insurer.

Morality of insurers was also challenged by respondents suggesting action needed to be taken. This was also strongly tied in to idea of the right to insurance. As well as a call for more access to insurance there were calls to action around the claims process. The lengthy claims process was mentioned by some respondents to be detrimental to their mental health. Another respondent took this further and suggested:

EXCLUSION

In line with questioning the morality of insurance companies, participants adopted the language of 'rights' to describe the unfair exclusion that some respondents experienced when it came to insurance. Some respondents did not accept that mental illness should determine whether or not someone is eligible for insurance. Respondents accepted that there might be a different premium or exclusions applied to their policy, however they did not accept a blanket refusal of insurance on the basis of mental illness.

There should be mandated guidelines as to the length of time to assess insurance claims. 1.5 years or longer is not acceptable. Also the information required should be very clear as well as the companies sending out a copy of the insurance policy and details of the wording to assess information required to support the claim.

Contrary to this, some respondents spoke about the futility of insurance when it would not cover mental illness. For some respondents, mental illness was the only aspect that they wanted cover for or required cover for. There was a level of frustration in the way that the insurance system worked when it came to acquiring cover for mental illness:

Private Health Insurance is ridiculous. In order to be covered for psych care, you have to have comprehensive EVERYTHING. I've been looking and looking. It doesn't matter if you don't need EVERYTHING ELSE and just need the psych cover, you still have to pay through the roof for it, and guess what? The mentally ill that are unemployed and REALLY in desperate need of this health cover cannot afford it.

General exclusion from insurance was linked, by many respondents, to their unmet desire to protect their family and children through insurance products like income protection and life insurance. Additionally, several respondents gave complex examples of when the system had failed them and not allowed for them. Respondents expressed the ways in which they fell through the cracks and were not catered for by the system with disappointment and frustration at the incompatibility of insurance and mental illness.

Exclusion by way of financial burden was discussed by several respondents. Expensive premiums and substantial premium loadings were described, and while some respondents chose to pay for the insurance, others explained that this was not feasible. Some respondents expressed a defeatist attitude towards being granted affordable insurance and explicitly spoke about the futility of applying for insurance. The threat of financial exclusion was described so comprehensively by these participants that they had given up on trying to obtain insurance.

Yet for others, the financial burden was as a result of not having insurance in the first place:

At only 24 years old I am over \$20 000 in debt, and this is a direct result of an inability to work due to Mental Illness, and associated high medical costs for myself and my unwell family member ONLY. An ability to get income protection would have completely changed the course of my life, in preventing this debt from having occurred. However, I never even bothered to investigating [sic] to get it, as I am 100% sure I would never be granted it at a rate I could possibly afford given the massive instabilities in my life.

As demonstrated, the relationship between financial exclusion and insurance is complex and multifaceted.

Participants also believed that insurers encouraged self-exclusion by trying to wear people down on purpose so they would just give up; this was specifically mentioned with regard to the claims process. Not being granted insurance or having to endure lengthy claims processes and just general day-to-day dealings with insurers were often described as having a significant impact on the person's life. This was experienced in terms of the impact on the respondent's mental health but also, as in the aforementioned example, in terms of financial strain and stress, and the flow on effects. In this way, some respondents drew on the significant impacts of the incompatibility of mental illness and insurance that were seen to perpetuate a cycle of exclusion.

Many respondents mentioned their gratitude at being given a voice on this issue, suggesting that they had been excluded from having a voice about this in the past. This was coupled with expressions of thanks that this research was being conducted, highlighting the importance of this research to many respondents.

TABLE 5: A selection of survey quotes which exemplify thematic codes

CODE	DESCRIPTION OF CODE	EXEMPLAR QUOTE
DETRIMENTAL TO HEALTH	Insurance was seen as being detrimental to mental health. The processes and protocol stipulated by insurers were perceived as counterproductive and not encouraging improvement in mental health outcomes.	'The whole process of dealing with an [unnamed] insurer has been an added stress and burden... I have found it further impacted on my illness and my mental health declined significantly... their approach does in no way facilitate the improvement and recovery of people suffering from anxiety and depression.' '...and the idea of going 5 years without treatment for them to reconsider is counter-productive.'
PUNISHED AND PENALISED	Being proactive and seeking treatment was experienced as a disadvantage for consumers who applied for insurance. Consumers who had sought treatment experienced higher premiums and exclusions, which were viewed as unfair.	'It is unfortunate that doing something to improve your health, i.e. a short voluntary admission to prevent illness by changing medication, means that you are punished by becoming ineligible for important things like insurance. This is definitely a disincentive to seek treatment.' 'If a person with mental health problems actively seeks treatment – they are penalised with respect to their insurance. It is outrageous.'
STIGMA AND DISCRIMINATION	Stigma and discrimination were talked about in three distinct ways: people having experienced stigma and or discrimination, a fear or threat of stigma and/or discrimination and the respondent's perception of the prevalence of stigma and/or discrimination.	<i>Experienced stigma or discrimination</i> 'The initial broker we dealt with at [bank] commented to me when filling out the form "you are not one of those people that have any mental health issues are you?"' 'I have even been told that some insurance companies associated with airlines believe that I have no right whatsoever to travel at all as it would be deemed to be my fault if an incident occurred' 'The way I was treated by the insurance companies made me feel so low, I was just devastated. They make you feel sub-human' 'I was made to feel damaged and humiliated'

CODE	DESCRIPTION OF CODE	EXEMPLAR QUOTE
STIGMA AND DISCRIMINATION		<p><i>Fear of stigma or discrimination</i></p> <p>'I would be a bit reluctant to disclose a mental illness if I were to make a claim given the potential discrimination I could face as a result.'</p> <p>'I did not have any difficulties but it still remains a fear – I won't be applying to increase my superannuation in the future...'</p> <p><i>Perception of stigma and discrimination</i></p> <p>'...even the insurance executives have suffered depression and I cannot understand why they would discriminate.'</p> <p>'...I feel that there will always be a stigma attached to mental health diseases and that therefore people in general will discriminate against you'.</p>
I'M DIFFERENT	Some respondents believed that insurance companies categorised or defined them along the lines of their mental illness diagnosis, and the negative connotations and stereotypes associated with that diagnosis. These respondents took the time to explain how they were different from these stereotypes or generalisations.	<p>'I would also like to point out that I am a member of the local community, a member of [another local organisation], I work for Lifeline fulltime and am a wonderful mother and wife.'</p> <p>'I am a mental health practitioner with masters level qualifications and have trained in & developed a significant skill base that allows me to lead a highly functional life.'</p> <p>'...I have managed, despite my 'illness' to work full time as a successful physiotherapist. I even just purchased a house earlier this year ... I am a 25 year old extremely fit and active person.'</p>
PHYSICAL VS. MENTAL HEALTH	There was a perceived difference in the way mental health and physical health was treated in terms of the risk associated with each. Some respondents had experienced this, while some gave anecdotes of others' experiences.	'I am much fitter and healthier physically than the average person, yet they approve income protection insurance to clinically obese , sedentary, office workers who I treat regularly in my clinic for not looking after themselves properly.'

CODE	DESCRIPTION OF CODE	EXEMPLAR QUOTE
		<p>'I think it is highly unfair to deny coverage for income protection and life insurance to people with a history of mental illness ... It is also inconsistent because I have direct experience with people with other conditions (eg heart disease) being routinely insured and reinsured (even after an incident)...'</p> <p>'I have been unable to find any insurance companies that will allow me to purchase life insurance because of my mental illness and yet if I have a physical illness or disease this is okay.'</p>
LACK OF EDUCATION	Insurers were perceived as having a lack of education when it came to mental illness. This was seen to be a cause of stigma and discrimination as well as a barrier to being eligible for insurance.	<p>'Regarding Insurers; NONE of them understand the nature and magnitude of the risk they are trying to guard against. This leaves them feeling unprotected and us needlessly uninsured!'</p> <p>'Also, I think brokers need to be educated about mental illness. My agent didn't really get it and I don't think he was a good advocate.'</p> <p>'Insurance companies are completely uninformed about mental illness and therefore we are discriminated against.'</p>
BLANKET TREATMENT	Mental illness was thought to be treated the same regardless of the diagnosis or current situation. Insurers were seen to treat all mental illness the same way in terms of risk.	<p>'...I have been working now for at least 17 years full time since I was off work for my depression, but this is not taken into account at all.'</p> <p>'...There does however seem to be a blanket attitude amongst insurance companies either not to insure mental health consumers or to give insurance at a greatly higher premiums or exclusions. Perhaps a need to have individual consumers more closely assessed for risk...'</p> <p>'... I think it is unreasonable to be excluded without looking beyond the diagnosis to take into account the management of the condition and compliance with treatment.'</p>

CODE	DESCRIPTION OF CODE	EXEMPLAR QUOTE
NOT A VALID CONDITION	Respondents felt that insurers did not acknowledge the gravity and reality of a mental illness diagnosis. Diagnoses were questioned by insurers. Mental illness was thought to be an illness that one could 'fake'	'The psychiatrist acting for the insurance company said that I didn't have depression. This was after being scheduled.' 'They make you feel like MDD is not a real illness and they just shrugged it off.'
INCURABLE	Mental illness was seen as being a life long condition and was treated as such by insurers. This meant that seeking treatment or having a prior diagnosis, no matter how long ago, was considered a risk for insurers.	'As I heard someone say in an in-patient unit recently: "you can't really get a clean bill of health one you have a diagnosis of a mental illness- at least not on paper anyway!" 'So someone has decided you never recover from mental illness!!!! Go figure.'
CALL FOR ACTION	Strong suggestions and calls for action were made by respondents who felt that specific aspects and broad aspects of the insurance industry had to be changed.	'There should be mandated guidelines as to the length of time to assess insurance claims. 1.5 years or longer is not acceptable. Also the information required should be very clear as well as the companies sending out a copy of the insurance policy and details of the wording to assess information required to support the claim.'
SUSPICION AND MISTRUST	Insurers were not trusted by mental health consumers. Even when consumers had an insurance policy they doubted that claims would be paid due to prior or current diagnosis of a mental illness.	'To the credit of the insurance companies I may(?) get the exclusions removed at some stage down the track if I stay well(?).....who knows what that means or if it just a placation!!!' 'They are more than happy to take your hard earned money but are reluctant to pay out at the very time you need it most.' '... I don't trust insurance companies to not connect unrelated events to a mental illness.'
TALKING TO UNTRAINED STRANGERS	Giving specific details about mental health conditions and sensitive topics like suicidal ideation was an uncomfortable and sometimes humiliating experience for mental health consumers.	'...I felt embarrassed that they would ask the question and that I would have to give personal medical details to a stranger.' '...its obvious to me she does not have any experience working with mental illness and she is trained to treat all clients as liars and work avoiders.'

CODE	DESCRIPTION OF CODE	EXEMPLAR QUOTE
		'I was very concerned about the way in which these [questions] were asked eg (verbatim) "Are you currently suicidal or do you have plans to commit suicide within the next twelve months? Have you had suicide attempts? We need to know all of this because it will impact on your [sic] policy and ability to make claims. I can add it as an inclusion that suicide may be a possibility, but you will likely have to pay more. Would you like me to include that suicide is a possibility".' 'All very undignified and humiliating, giving complex medical history to a stranger over phone.' 'It is very unpleasant to have numerous questions about my mental illness from people who don't understand.'
SATISFACTION AND TRUST	Some respondents trusted that insurers were doing the right thing and they expressed their satisfaction in their insurer.	'The company I am insured with has always been co operative and honest in communication of all information regarding cover and claims.' 'Neither myself or my husband have encountered any problems with insurance in the past.'
SYSTEM DOESN'T ALLOW FOR ME	The intersection between employment, insurance, income and government benefits was described by some respondents who felt that they had slipped through the cracks.	'Our whole system – from Centrelink to these rehabilitation 'experts' does not authentically support or truly recognise mental illness.' 'By receiving the Income Protection Insurance that is only enough to pay my mortgage I am only eligible to receive a small Centrelink sickness allowance of \$44 a fortnight to cover all my other expenses. Accordingly although I had the foresight to take out this insurance, the reality is that I will eventually lose my home as my savings decreases.'

CODE	DESCRIPTION OF CODE	EXEMPLAR QUOTE
I WANT COVER FOR MENTAL ILLNESS	Having a diagnosis of a mental illness was the primary motivation for some respondents to get insurance however it was also the primary reason for exclusion for insurers.	<p>'Feel discriminated against re protection of income for mortgage as my mental health is the main reason I would want that protection.'</p> <p>'In order to be covered for psych care, you have to have comprehensive EVERYTHING. I've been looking and looking. It doesn't matter if you don't need EVERYTHING ELSE and just need the psych cover, you still have to pay through the roof for it...'</p>
DESIRE TO PROTECT FAMILY	Products like income protection and life insurance were desired by some respondents in order to protect not just themselves, but their families. However this was often an unmet desire.	<p>'It has had a profound effect on me personally and on my ability to protect myself my husband and my family.'</p> <p>'Most people taking out life insurance or income protection do so because they have family to consider if anything happens to them during the normal course of living.'</p> <p>'I wanted cover because I was now a single parent of two children and if I died in a car accident tomorrow I wanted piece of mind...'</p> <p>'I have since started a family with my wife and would dearly love to have some insurance.'</p>
IMPACT ON MY LIFE	The insurance application process was seen to impact adversely on respondents' lives in a significant way in other areas that were on the surface, unrelated to insurance.	'If it [income protection] had been possible, I would like to re-iterate how different the course of my life would now be – I believe I would never have ended up with mental illness myself (I believe due in large part to the financial stress caused by carer responsibilities), and I believe I would have been able to continue with my university studies, which I will not be in the financial position to commence for at least another 10 years...'
FEELING HEARD	Respondents were thankful that they were given a voice on the matter and that something was being done about this issue.	<p>'I would also take this opportunity to thank you for this survey as I have felt unheard for so long.'</p> <p>'Thank you for giving me a voice on this issue- much appreciated.'</p> <p>'Thank you for the opportunity to speak.'</p>

CODE	DESCRIPTION OF CODE	EXEMPLAR QUOTE
		'Thank you for listening and conducting this important survey!'
FINANCIAL BURDEN	Insurance itself was seen as expensive and cost prohibitive, but also the financial burden of not being able to gain insurance was experienced by some respondents.	<p>'I was outraged at the premium I was asked to pay. For income protection insurance I was asked to pay 200% of the premium I would have paid had I not had a mental illness.'</p> <p>'At only 24 years old I am over \$20,000 in debt, and this is a direct result of an inability to work due to Mental Illness, and associated high medical costs for myself and my unwell family member ONLY. An ability to get income protection insurance would have completely changed the course of my life, in preventing this debt from having occurred.'</p>
DEFEAT, FEELING WORN DOWN	Respondents felt that there was no point in applying for insurance anyway as they would only be declined, or it would be too expensive. They also felt worn down by insurers when it came to claiming and the large amount of detail requested by insurers around the treatment received for mental illness.	<p>'I have not applied for income insurance after reading the forms and finding them overwhelming, as I had to provide a lot of information about my history of depression.'</p> <p>'I had a workers compensation claim and a superannuation income protection claim proceeding at the same time and they both "lost" my claims so I feel it is just a standard response to anyone making a mental health claim in the hope that it will go away or that they will force the claimant into suicide – which I considered on many occasions.'</p> <p>'Eventually I dropped the claim.'</p> <p>'I am convinced the workers comp systems agenda is to get people to succeed at suicide, as all claims are then null and void.'</p>
RIGHT TO INSURANCE	Insurance was perceived as a basic right for all people regardless of mental health status.	<p>'Mentally ill people have a right to insurance, as have the mentally well, and I would advocate for this to occur.'</p> <p>'There is no reason why they should not be able to offer an exclusion clause or higher premium straight up when you apply. You shouldn't have to make a discrimination claim to be treated like any other human being.'</p>

CONCLUSION

Mental Health, Discrimination and Insurance: A survey of consumer experiences 2011 reports upon the survey of experiences of Australians with mental illness accessing insurance products and making claims against their insurance policies. This survey has found that Australians experiencing mental illness face significant difficulties when seeking insurance products, or trying to make claims against their existing policies. The findings of this survey, and research undertaken in this area to date, demonstrate that these findings are not unique to Australia and that much needs to be done to break down misinformation and the lack of knowledge that exists within the insurance and financial sectors in relation to mental illness.

As this survey is the first of its kind to be published in Australia, it will be interesting to see what changes are made and whether consumer and carer experiences improve over time. The results from this survey will be used to advocate attitudinal changes through improved knowledge and awareness about mental illness within the insurance and financial sectors.



beyondblue
the national depression initiative
www.beyondblue.org.au